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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.

Tues., Oct. 1.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Old Students' Dinner, 7.30 p.m.
Fri., ,, 4.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Sat., ,, 5.—Rugby Match *v.* Old Millhillians. Home.
Mon., ,, 7.—Special Subject: Clinical Lecture by Mr. Elmslie.
Tues., ,, 8.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Wed., ,, 9.—Surgery: Clinical Lecture by Sir Holburt Waring.
Fri., ,, 11.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., ,, 12.—Rugby Match *v.* Richmond. Away.
Association Match *v.* R.M.A. Woolwich. Away.
Hockey Match *v.* Beckenham II. Home.
Mon., ,, 14.—Special Subject: Clinical Lecture by Mr. Rose.
Tues., ,, 15.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed., ,, 16.—Surgery: Clinical Lecture by Sir Holburt Waring.
Fri., ,, 18.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Medicine: Clinical Lecture by Dr. Morley Fletcher.
Sat., ,, 19. Rugby Match *v.* Bristol. Away.
Association Match *v.* Emmanuel College, Cambridge. Away.
Hockey Match *v.* Woolwich Garrison. Away.
Last day for receiving matter for the November issue of the Journal.
Mon., ,, 21.—Special Subject: Clinical Lecture by Mr. Just.
Tues., ,, 22.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Wed., ,, 23.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Rugby Match *v.* Cambridge University. Home.
Hockey Match *v.* R.N.C. Away.
Thurs., ,, 24.—**Abernethian Society: Address by Sir Leonard Rogers at 8.30 p.m.**
Fri., ,, 25.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., ,, 26.—Rugby Match *v.* Coventry. Home.
Hockey Match *v.* Radlett. Away.
Mon., ,, 28.—Special Subject: Clinical Lecture by Mr. Rose.
Tues., ,, 29.—Prof. Fraser and Prof. Gask on duty.
Wed., ,, 30.—Surgery: Clinical Lecture by Mr. Harold Wilson.

EDITORIAL

ON Thursday, October 24th, Sir Leonard Rogers is to deliver the Inaugural Address to the Abernethian Society on "Climate and Disease: forecasting epidemics in connection with Smallpox, Cholera and Plague."

The rise of preventive medicine, rapid as it has been in the past few years, and pregnant as it is with future benefit for mankind, presents some terrifying features to the imagination. The trouble which already surrounds vaccination and vivisection, so essential a part of the antitoxic therapy of the few preventable diseases, is not likely to diminish, and when finally preventive medicine is enthroned, who can but pity the schoolboy of the future? He will purchase dearly his prophylactic metamorphosis into the lean and slipper'd pantaloon; vaccinated, duly Pirquet'd, be-Dick'd, be-Schick'd, and all the rest, he will have good cause to whine. If anything can save him it is the accurate forecasting of epidemics, so that he can be protected only as the need arises.

The forecasting of diseases has still a mediæval flavour, calling to mind the antics of Alcofribas Nasier and his Pantagruelian prognostication "of the Diseases of the Year"; wherein he confesses that "desirous to satisfie the Curiosity of every good Companion, I have tumbled over and over all the Pantarchs of the Heavens, calculated the quadrates of the Moon, hook'd out whatever all the Astrophyles, Hypernephelists, Anemophylaxes, Uranopetes, Ombrophores, and the Devil and all of them have thought." The majority of us, only dimly aware of the considerable advances which have been made in the subject since those times, could gain enlightenment from no one more expert than Sir Leonard Rogers.

* * *

We extend our hearty congratulations to Dr. C. F.

Harris, who has been appointed Physician-in-Charge of the Children's Department.

* * *

Congratulations to Mr. E. T. C. Spooner on his election to a Research Fellowship at Clare College, Cambridge, and to Mr. H. J. Burrows, who has been given the Beaverbrook Scholarship of the Royal College of Surgeons of England for 1930 and 1931.

MORE MEDICAL NOTES.

By Sir THOMAS HORDER, Bt.

ON SEPTIC ENDOCARDITIS.

(1) The most appropriate name for the disease variously termed "infective," "malignant" and "ulcerative" endocarditis is probably the still older one, "septic endocarditis." Objections to each of the alternative adjectives are obvious. It has been advanced that the word "septic" in this connection is not suitable because the lesions present are ofttimes not suppurative. But suppuration is by no means an essential part of either acute or chronic sepsis.

(2) In acute septic endocarditis, a disease which is much less common than formerly, the heart shares in a general infection, the existence of which is generally manifest, and to which are now added the features of an arterial pyæmia. In chronic septic endocarditis, a disease which is much more common than formerly, the state of general infection, if it exists prior to the cardiac involvement, has been latent, so that the patient comes under observation on account of chronic arterial pyæmia from the first.

(3) Septic endocarditis of the right heart occurs under two conditions: (i) Infection of the heart may occur in congenital *morbus cordis*. The course of the disease is usually chronic or subacute and the complication generally constitutes a terminal event. (ii) Infection may occur at the pulmonary or tricuspid orifices in pneumonia or other forms of pulmonary sepsis. The course of the disease is usually acute and probably always fatal.

(4) The chief diagnostic feature of septic endocarditis of the right heart is repeated pleuro-pulmonary infarction. Whenever this occurs the heart should be scrutinized carefully for signs of infection. The bouts of pleuro-pulmonary inflammation may be very numerous, and the systemic blood-stream, despite the fact that the patient is gravely ill, may be sterile for several weeks.

(5) Every patient who is the subject of valvular disease, and who comes under observation on account of an obscure illness, however mild, should be suspected of septic endocarditis, and submitted to a routine investigation from this point of view. Evidence of the existence of fleeting attacks of the disease prior to the onset of the final one is so definite that this fact leads to a reasonable hope that very early detection of the disease may reduce the gravity of the prognosis as at present taught.

(6) The cardinal signs of septic endocarditis are these: Signs of endocarditis, pyrexia, a positive blood-culture and multiple arterial embolism. Of these, the last-named is the most important, and without evidence of it a diagnosis cannot be made.

(7) Apyrexial periods, not seldom lasting for several days, and very occasionally for some weeks, are not very uncommon in chronic septic endocarditis. They must not be taken of themselves to indicate improvement in the patient's state.

(8) On the other hand, exacerbations of the pyrexia do not necessarily indicate that the patient is losing ground. They are often concomitant with embolic events, and especially with splenic embolism. After such exacerbations the temperature may take a lower range for several days, and during this period the symptoms may show definite remission.

(9) Arthralgic pains, carefully studied, are of definite diagnostic value in chronic septic endocarditis. Three features distinguish them: the suddenness of their onset, the difficulty the patient may have in locating them, and the absence of any recognizable signs of effusion when the affected part is a joint.

(10) A striking difference between rheumatic heart disease and septic endocarditis is the degree to which the myocardium is affected in the two diseases. In the former the disease is notoriously a "carditis"; in the latter it is an "endocarditis vera." This great difference explains why in septic endocarditis the heart maintains its functional capacity in a very striking manner. An interesting example of this is the fact that in septic endocarditis auricular fibrillation rarely occurs.

MEDICAL HISTORY TAKING.

By GEOFFREY BOURNE, M.D., F.R.C.P.

INTRODUCTION.

THE ultimate object of the examination of all patients is cure. In order that this may best be accomplished three ideals are generally held in view, the discovery of the diseased process present, the determination of the rate of advance of such a process, and a decision as to the type of treatment to be undertaken. These are as a rule briefly alluded to under the heads "Diagnosis," "Prognosis" and "Treatment."

In order to avoid a too complacent acceptance of purely academic facts or theories it is as well to have in mind always prognosis, for this forecasting of the course of a disease will necessitate an answer complete in all the other respects. "How will this end?" will be the question before the examiner's mind, though from the patient's point of view successful treatment is the greatest of the three.

Diagnosis is a science, medical practice is an art. The lure of science is apt to make diagnosis loom large in the mind of the doctor, and when he has made his diagnosis, reaction is liable to set in and treatment to take a second place. The illness, however, makes treatment the essential in the eyes of the patient; and treatment is the *raison d'être* of the medical profession. Treatment is either therapeutic or prophylactic.

HISTORY AND PHYSICAL EXAMINATION.

In the elucidation of these problems two methods are employed—history and physical examination.

The first of these is subjective, use being made of the patient's account of what he himself knows, feels or has felt; the second is objective, and comprises all the varying methods of search used by the doctor.

They differ from one another in two important particulars—time-relationship and intimacy.

Physical examination deals with the physical condition upon one day of the patient's life. What physical characteristics are present upon that day may or may not be detected. If the examination be repeated upon some other day the same findings may persist, or new ones may have arisen.

The two days will be analogous to two isolated pictures taken from two distant parts of some lengthy cinematograph reel. What lies between, or what came before, remains hidden.

History, however, gives a continuous record limited only in duration and accuracy by the patient's memory; and memory—at least the subconscious part—is almost photographic in its exactitude. Everyone, on revisiting some place after months or years, may at a sudden turn of the road or by some trick of local suggestion remember that previously, at that place, he passed in the street individuals having this or that appearance. Thus, if only time and trouble enough be given, a history of very considerable accuracy may be unravelled.

Physical examination deals with the state at one time. History embraces all periods of its development.

The other great difference between physical examination and history is in intimacy.

Physical examination is limited to what can be seen, felt, heard or otherwise physically deduced from the surface of the patient's body. The means at the examiner's disposal range from his fingers to the use of the electrocardiograph, from the ophthalmoscope to the Wassermann reaction; but they are each and all objective. The findings may have nothing to do at all with the disease which is at the moment active and needing treatment. A tabetic with a subacute appendicitis may die or live, to curse the Wassermann reaction that led the too clever doctor to think of gastric crises.

In cases like this an adequate history is the best guide.

History, in contradistinction to physical examination, is subjective. The duodenal ulcer or the inflamed pleura is in direct physical continuity with the patient's brain; there is no intervening link in the shape of test-tubes, stethoscope, or even the examiner's fingers. The sufferer receives from his own diseased area earlier and much more sensitive impressions than does any outside observer. This is the true distinction between symptoms and signs.

Symptoms are the sensations sent to the patient's own brain by his disease; signs are the abnormalities physically detected by another individual.

The priority of history or physical examination as regards importance in diagnosis or prognosis varies greatly with different diseases. Carcinoma of the breast may lurk unheeded until a lump is felt by chance by the doctor, who has been called in to treat an attack of bronchitis. Here the early disease is in a "silent area"; symptoms are absent.

On the other hand loss of appetite, discomfort after food and lassitude may be present and even clamorous for some long time, while the decision hangs in doubt as between tuberculosis of the lung or cancer of the stomach. Only by experience will the relative importance of the two methods of examination in various conditions be learned. It is perhaps true (in most cases) that, as symptoms precede signs, so will history help earlier than will physical examination.

DIFFICULTIES IN OBTAINING A CORRECT HISTORY.

The patient is, as a rule, not a trained observer, and is unable to supply in their proper proportions all the pieces of evidence he may possess relative to his complaint. Some aches, pains or other abnormalities may have been so minor that he has actually forgotten much of what he was at one time well aware. Thus, although he acts as the receptor of all stimuli arising from the diseased area in his body, he is an imperfect recording instrument, and is unable often to supply evidence of the first importance. Even here a careful attempt at taking a complete history may help to unearth some of the buried memories.

The human instrument, besides often being an uncertain recorder, is never exactly duplicated. Individuals react differently to pain, discomfort and worry; and a considerable knowledge of psychology is used consciously or unconsciously in the effort to interpret their complaints. This variation in sensibility is a racial as well as a personal characteristic.

Stimuli that in one case cause intense anxiety or even suffering will in another remain mentally suppressed, the one individual will make the most of his ills, even enhancing them by unconscious repetition; the other will belittle them. Even when suspicious that all is not well, the fear of disease produces in one person silence lest his fears be found to be facts, in another exaggerated statements, lest they be dismissed too lightly. Recognition of this may enable the doctor to assess the evidence in both cases, by means of an estimation of the varying psychologies.

It must never be forgotten that the most loquacious and fussy patient may actually be suffering from a severe disease. Garrulity is not a guarantee of health. Talkativeness has the advantage that perpetual questioning is not so necessary, and the danger of asking leading questions is less. Ideally statements, criminal and pathological, should be spontaneous and not evoked by prompting. The more leading the question the less is the value in evidence of the reply.

Besides this under- or over-sensibility to their own stimuli, some people, often presumably well educated, seem to be quite unable to answer a question. A query as to the earliest appearance of some symptom is answered by a detailed account about the health of a husband. But even here it must be remembered that the health of a tuberculous or syphilitic husband may have a direct bearing upon the health of the patient. The stream of words should be followed, so to speak, to its source, after which a return can be made to the main river, which can then be traced further. Impatience in the examiner is inimical to completeness in the history. A vital point frequently arises amid a farrago of irrelevant facts.

There remain a few more obvious difficulties in obtaining a history. The patient may be deaf or dumb, or suffering from aphasia. Smaller degrees of deafness may be overcome by placing the stethoscope in the patient's ears and speaking into the mouthpiece. A patient with motor aphasia can frequently comprehend very readily, as indeed may a very weary one. The difficulty may be overcome in either case by framing questions so that "Yes" or "No" can be indicated, by look, nod or word in the reply.

A history can frequently be obtained from a child, but care must be taken to put questions simply. An involved question not only may be unanswerable, it evokes an attitude of shyness and reserve in the answers that follow. Furthermore, a child is always rather too ready to please, and will answer "Yes," if that is presumably what the doctor wants. Questions therefore are much better put in the negative: "You haven't had a pain in your tummy, have you?"

If there has been no pain the child will answer "No"; if there has, an attitude of mild resentfulness against the doctor's stupidity will elicit the reply, "Yes, I have."

If the original question has been put the other way, "Have you had a pain?" the answer "Yes" would frequently be given merely, from the child's point of view, to please the silly man and have done with him as soon as possible.

Similarly, on palpating the abdomen it is wise to say, "That doesn't hurt, does it?" The answer "No" will result everywhere except over the place where it really does, and there a very emphatic "Yes" comes out. The opposite question will be answered in the affirmative every time.

A child is very wishful to please, in order to protect its littleness; similarly it will over-react if in danger of being hurt or of being misunderstood.

Apart from this its evidence is free from the complexities that cloud that of an adult, and should be credited accordingly.

HOW TO TAKE A HISTORY.

History, for practical purposes, is divided into the following sub-headings; these, needless to say, occasionally overlap:

Complaint (a list of the symptoms complained of).
History of present condition.
Past history.
Family history.

The patient's name, address and occupation are first written down with the date of the examination.

COMPLAINT.

This should be a catalogue of the various individual symptoms of which the patient complains. They should, when possible, be the actual words used by the patient.

In asking a patient to supply this list, care should be taken to use a reasonable form of words. "What is the matter?" lays the questioner open to the justifiable retort, "That, doctor, is what I have come to ask you."

"What exactly do you complain of?" or "I want you to tell me the different things that are worrying you," are better. The patient's reply may be "Pain in the stomach," and may threaten to be of considerable length. It is as well at this stage to seize an opportunity to interrupt and ask, "Besides the pain in the stomach what else do you complain of?" The reply may be "Diarrhœa." "What else?" "Blood in the motions." "What else?" "Weakness." "Is there anything else?" "No." "Pain in the stomach, diarrhœa, blood in the motions, weakness. So those are all the things you complain of? You are quite sure there is nothing further?" "Yes, I am."

Having obtained this simple list the examiner can then proceed to the history of the present condition.

HISTORY OF THE PRESENT CONDITION.

Relation to past history.—The history of the present condition dates from the last occasion upon which the patient was in good health, or in his usual state of health.

It is sometimes difficult to divide this from the "past history," especially where the latter contains isolated illnesses, from which recovery was apparently complete, although the sequel proves their relation with the present condition.

Since, however, it is upon the present condition that immediate prognosis usually depends, it is wisest to keep the two things logically distinct. The course of a former attack of syphilis has no bearing at all as regards immediate prognosis upon syphilitic disease of the aortic valve or upon tabetic disease of the spinal cord. Most syphilitics escape both. There are, on the contrary, diseases upon whose severity directly depends the liability to future troubles. Such diseases are often inflammatory, and in them the amount of scar formation varies directly with the virulence of the process. Bronchiectasis or fibrosis of the lung are more likely to follow a prolonged and severe broncho-pneumonia. Here the secondary disease depends upon the severity of the reaction against the primary process. Syphilis is an example of the opposite, for frequently in cases of tabes or general paralysis it is difficult for a patient to remember his original primary infection in the absence of secondary phenomena.

It is wise, therefore, to place in the past history all definite known illnesses in chronological order; and not to add to the history of the present condition any illness separated definitely from this by a period of good health.

Here it must be remembered that previous illnesses fall under three categories: Firstly, there are those such as scarlet fever, rheumatism, frequent tonsillitis or broncho-pneumonia, upon whose severity depends directly the probability of sequelæ such as nephritis, morbus cordis, arthritis or pulmonary fibrosis. Secondly comes the group such as syphilis and amœbic dysentery, where the original severity has no connection with ultimate liability to general paralysis or hepatic abscess.

Thirdly there are illnesses that predispose to others apparently quite unconnected ætiologically with them. Measles and pertussis in children are the frequent immediate precursors of active tuberculosis of the lung, peritoneum or meninges. It would seem in this case that the effect of the primary disease is so to alter the patient's resistance that a latent and hitherto arrested process is given a fatal lease of life.

Scope of the history of present condition.—The history of the present condition is the longest and most intimate account of the patient's illness. Its completeness is only curtailed by the inquirer's knowledge of medicine, though other qualities are of course necessary in addition. A perfectly full history is thus humanly unattainable; but as knowledge grows, so will the value of the history increase.

It attempts, by a collection of all available facts, to define in chronological order the onset of each symptom in turn, its exact character, intensity, duration and relation to any others.

Furthermore, an estimation is made as to the acuteness or virulence of the disease and the resistance of the patient. The resultant of these two factors will indicate the spread of advance, the presence of arrest, or the rate of recovery. This is immediate prognosis. The full prognosis also entails an answer to the questions, "What permanent vital changes will remain after recovery?" "Does this illness expose the patient to any remote sequelæ?"

Seeing that a complete, adequate history can be taken only by a person who knows all facts in their true perspective about all diseases, it is obvious that nobody can afford to dismiss an apparently irrelevant piece of information with the words "*nil ad rem.*" Such a statement implies at the worst omniscience, and at the best unforgivable arrogance. Every fact must be chronicled and adequately described, prominence naturally being allowed to any whose relation to the disease

is known. Thus only will the science of early diagnosis grow, and thus only will the observer add to his personal value to the community. Leading questions must be avoided.

ON TAKING A HISTORY OF THE PRESENT CONDITION.

The taking of a history should be divided into three portions. At first the patient is asked about, and encouraged to remember accurately, all he can about his individual symptoms in their due order. The date of onset of each symptom should be noted. This should be done in terms of day of the month and year, or alternatively in terms of years ago, months, weeks or days ago. An unforgivable and all too common error—due largely to the laudable desire to quote accurately the patient's words—is to use such phrases as "last Tuesday week," "Sunday night," "the following Friday." What these refer to may be plain at the moment, but the passage of time will soon transform them into a hopeless and impenetrable maze.

Secondly, the questioner, using his expert knowledge of disease, attempts if possible without asking leading questions to obtain answers upon points he knows to be relevant to the disease, which he may by now suspect to be present.

Thirdly, he inquires as to the function of systems other than that of the one apparently diseased.

The first point to be ascertained is the date at which the patient first suffered any unusual symptom. The time-worn opening, "When were you last quite well?" can scarcely be improved upon. It is always wise to reinforce this by some such phrase as "So you never had any trouble at all before that?" This may well excite the reply, "Well, of course, for some months I had not been feeling quite myself," to which is repeated the original question, "Well, when were you last *quite* well?"

In that way it is generally possible to fix accurately the commencement of the first symptom of illness. Unless care is taken to make certain of the time at which the patient was "last quite well," a false idea may easily be obtained. It is remarkable how often the second move, so to speak, of the gambit will reveal that the original reply was inaccurate. The commonest reason for this is that the patient feels that only a really sharp pain, or a really good big symptom, is worthy of the attention of the medical brain. Doctors, in his mind, and unfortunately sometimes in their own, have too much to do to be bothered with vague pains and minor abnormalities.

There is a second answer which is apt to disconcert the beginner, and that is, "I never have been quite well, doctor." The correct counter here is, "When were you last in your usual health?" Thus even from those who "enjoy" ill-health a correct starting-point for the history of the present condition may be obtained.

Having thus defined the first symptom, possibly a pain or discomfort, a correct idea must be formed of its nature when it originally appeared. Its character, position, direction of spread, its duration estimated by the patient specifically in seconds, hours or days; the changes produced upon it by various processes, positional, such as standing, lying and sleeping; occupational and muscular, such as lifting weights, jolting or running; alimentary, such as eating, swallowing and digesting; excretory, such as passing water and defæcating, these must all be determined. The effect of treatment by the patient, such as the application of pressure, heat or cold, or by some previously consulted medical man, must be elucidated.

Again, has the symptom progressed or changed at all since its commencement? If so, in what manner? Any intervals of complete remission or of partial relief must be made quite clear.

Having thus obtained an apparently clear account of the first symptom, the others complained of must in their due order be completed. They may, for example, be in all, pain, anorexia, vomiting, constipation and loss of weight.

The anorexia is next dissected. "Has it been permanent since its origin?" "Is it especially noticed after any particular type of food?" That of carcinoma of the stomach is often chiefly in reference to meat. Similarly are treated the vomiting, constipation and loss of weight as fully as possible.

When the list is presumably completed the patient is reminded briefly of the individual symptoms and is asked, "Besides these is there anything else that you have noticed abnormal, or anything else that you think I ought to know?"

This is the first part of the history. It deals with the complaint from the patient's point of view and from that of his subjective sensations.

The second part is the attempt on the part of the trained observer to dig up from the patient's consciousness any other hitherto forgotten facts that, from his knowledge of medicine, or his personal experience, may help to reveal the morbid condition; for by now he will have made a guess at the system or organ chiefly at fault.

For example, if he suspects epilepsy he asks: "Are you subject to fainting attacks?" "When you fall do you know beforehand that you are going to fall or do you find yourself lying on the ground?" "Do you ever hurt yourself when you fall?" "Do you find that you have passed water when you come to?" "When you have recovered are you as well as before?" The last is an attempt to fish for the answer, without asking a leading question. "No, I have a headache for the rest of the day." The earlier questions will distinguish the abrupt cerebral blow of an epileptic fit from the gradual cutting off of cerebral blood-flow, and therefore of consciousness from the brain, of someone who faints.

The first part of the history could be taken fairly adequately by a person with no especial knowledge of medicine at all.

The only requirements are patience, tact, and a logical brain. The second part is dependent upon previous knowledge. Those who commence to clerk in the wards may thus be expected to deal efficiently with the first part; and in reference to the second they will have some knowledge of anatomy and physiology upon which to base their questions. After every fresh case they will add gradually to their store.

Upon taking over a case for the first time the beginner in medicine should take what history he can. After the questions and physical examination he should write as complete an account as is possible. Upon what he finds and in the light of his own physiological, anatomical and general knowledge he will form an opinion of his own.

Then, and not until then, having made a diagnosis, should he, on his return home at night, open his books. Should the disease have interfered with normal function, his physiological knowledge may explain the manner of this. Failing this, reference to a text-book of medicine will show what signs and symptoms he has omitted to find. On returning to the patient upon the following day a new examination may reveal the presence of those, or, indeed, their continued absence.

By attempting to discover at first all he can for himself, his clinical powers will receive the greater stimulus. Reference to the answer at the end of the book deprives any problem of its educative value. If during three months' work in the ward a dozen cases are dealt with in this manner as texts for reading they will produce mental pictures vivid enough to form the outline of all medical knowledge that follows. Upon them will gradually be grouped a continually growing series of clear impressions.

Personal examination of a patient is a clear-cut experience and the mental picture is sharp as an etching; a clinical lecture is necessarily vague for the mental pictures are all second-hand, and often as vague, vaporous and sleep-compelling as are the visions of any other type of narcosis.

The third part of the history deals with the systems, which may appear superficially to have no connection directly with that which is disordered. For example, inquiries concerning the nervous, digestive and urinary systems should always be made in cases of heart disease. There are two reasons for this: unsuspected complications may be discovered or suspected ones excluded, and some second and quite unconnected disease may come to light; for the presence of two concurrent diseases is not very uncommon. In either case the discovery may lead to treatment that will remove some of the patient's handicap in his fight against the more serious condition.

Thus in a patient suspected or convicted of tuberculosis of the lungs, questions relative to the gastro-intestinal system will be useful. A good appetite is one of the best instruments of successful treatment, or diarrhœa due to tuberculous ulceration of the intestine is one of the first indications of a fatal outcome. Again, questions as to the urinary function may reveal the increased frequency of micturition which is often a first sign of tuberculous disease of the kidney. Should this prove to be advanced and unilateral, surgical treatment may be of value. Attention directed to the cardiovascular system in a phthisical patient may show some degree of anæmia whose progress can be accurately measured by the hæmoglobinometer, thus providing a valuable check upon the progress of the tuberculous process as a whole.

In this case the attempt to obtain a clear idea as to the condition of the systems other than that of respiration may reveal points of the utmost value in diagnosis, prognosis and treatment. Finally, the very asking of systematized questions will bring to the mind much underlying knowledge with regard to the disease in general and its relation to the patient in particular which the questioner was quite unaware that he possessed.

(To be concluded.)

THE HEART AS A TEMPLE OF SURGICAL RASHNESS AND SURGICAL FRIGIDITY.

"The abyss is worth a leap, however wide,
When life, sweet life, is on the other side."

THAT open-handed benefactor of the profession, Sir John Bland-Sutton, has recently presented to the Library of the Royal College of Surgeons a MS. account in Italian (with translation) by Guido Farina of Rome of his first adventure in heart surgery in March 1896. A man 30 years of age had been stabbed in the heart with a very fine and sharp dagger, the wound penetrating the right ventricle. The surgeon sutured the rent in the heart with silk. The patient died of right-sided broncho-pneumonia, and at autopsy

the heart was found to be perfectly healed. This account which was made known to the English medical world in 1910* forms an important chapter in the fascinating story of the evolution of cardiac surgery.

The human heart by which we live, cynically secure behind the living fortification of chest-wall and pericardium, from time immemorial has been assaulted by love and man with weapons fair and foul. A flood of drugs has been let loose upon it, when lazy to provoke it to activity, to call it back to duty in hours of intoxication. Agents other than drugs have been recruited in the warfare: rest and recreation, diet and climate, and the virtue and vice of psychotherapy.

Since the days of Abner,† who "with the hinder end of the spear smote him under the fifth rib, that the spear came out behind him; and he fell down there, and died in the same place," surgeons have fondled the illusion that injuries to the heart are rapidly fatal.

One day Paré acquainted the scientific world with the tale of a Turin nobleman‡ "who, fighting a duel with another, received a wound under his left breast which pierced into the substance of his heart, yet for all that he struck some blows afterward and followed his flying enemy some two hundred paces," before Death caught him up in the race. Whereupon there went forth such a gasp of astonishment that the dust of ages rose in clouds from the works of Hippocrates, Aristotle, Pliny, and Galen and wellnigh choked the imagination. The conservative profession, having learnt that injuries to the heart need not cause instant death, once more fell asleep. It was left to Farina to open up the field of cardiac enterprise, which surgeons fully exploited during the Great War. A few months after Farina's pioneer operation, Rehn of Frankfurt-am-Main successfully treated a patient who had been stabbed with a kitchen knife.§ Since that time examples of surgical interference with the living heart have multiplied. Ten years after his first successful case, Rehn was able to collect 124 cases in which cardiorrhaphy had been performed with 40 per cent. recovery. We now know that the heart is very tolerant of traumatic insults (Bland-Sutton). The last few years have seen the introduction of operations on the heart of farm animals. In the cow, pieces of wire, knitting needles, meat skewers, and nails may find their way from the rumen through the diaphragm into the pericardium and the heart muscle. The success of their extraction‖ is all the more amazing when one reflects on the conditions awaiting the bovine patient after operation—a cowshed instead of a clean bed; instead of nurses day and night farm labourers whose peaceful life has never been shaken by the Listerian Revolution.

In 1902, Sir Lauder Brunton then aged 58 suggested in a one-page communication to the *Lancet* (i, 352) the possibility of treating mitral stenosis by surgical methods:

"Mitral stenosis is not only one of the most distressing forms of cardiac disease, but in its severe forms it resists all treatment by medicine. On looking at the contracted mitral orifice in a severe case of this disease one is impressed by the hopelessness of ever finding a remedy which will enable the auricle to drive the blood in a sufficient stream through the small mitral orifice, and the wish unconsciously arises that one could divide the constriction as easily during life as one can after death. The risk which such an operation would entail naturally makes one shrink from it, but in some cases it might be well worth while for the patients to balance the risk of a shortened life against the certainty of a prolonged period of existence which could hardly be called life, as the only conditions under which it could be continued might to them be worse than death. I was much impressed by the case of a man under middle age whom I had under my care at St. Bartholomew's Hospital. For no fault of his own, but simply because of his disease, this man was really exiled from his family and one might almost say imprisoned for life inasmuch as he could only live in a hospital ward or a work house infirmary. Whenever he left the hospital or infirmary with an amelioration of his distressing symptoms and returned home, the exertion brought on an exacerbation and he had to leave home again in a few days to return to the hospital or infirmary. It occurred to me that it was worth while for such a patient to run a risk, and even a very grave risk, in order to obtain such improvement as might enable him at least to stay at home. But no one would be justified in attempting such a dangerous operation as dividing a mitral stenosis on a fellow-creature without having tested its practicability and perfected its technique by previous trials on animals. Accordingly I obtained a licence and certificates a year ago in order to make the necessary experiments, but unfortunately other calls upon my time have not allowed me to do more than make trial experiments of dividing stenosed valves in diseased hearts from the post-mortem theatre and on healthy valves in the hearts of cats, and also to try the proposed operation in the dead animal. It may be some months longer before I can get anything more done, and I therefore think that it may be worth while to write this preliminary note (a subsequent note never appeared), especially as, after all, if the operation is to be done in man, it will be the surgeons who will do it, and they must, of course, make their own preliminary experiments, however fully the operation may be described by others, and each must find out for himself the method which he will employ in each particular case. . . .

"In many experiments made for other purposes I have been astonished at the way in which the heart went on beating, apparently quite unaffected by pulling, compressing, and handling of any kind. . . .

"The good results that have been obtained by surgical treatment of wounds in the heart emboldens one to hope that before long similar good results may be obtained in cases of mitral stenosis."

This courageous and inspired article is spoilt by the scantiness and timidity of the experimental suggestions.

The *Lancet* in a leading article (1902, i, 461) devoted to "this sufficiently heroic therapeutic suggestion" speaks of "difficulties that only the boldest surgeons, with the best-balanced sense of the limitations of their science, could for a moment face. . . . Should our anticipations of failure be proved to be groundless, we shall indeed rejoice to witness an extension of surgery which might be attended with great

* *Brit. M. J.*, 1910, i, 1273, 1309; reprinted in Bland-Sutton, Selected Lectures and Essays, 1920. *Vide* also *Centralbl. f. Chir.*, 1896, xviii, 1224.

† 2. Sam. ii, 23.

‡ Johnson, Th., *The Works of A. Parey*, London, 1678, 259.

§ *Centralbl. f. Chir.*, 1896, xxiii. p. 1048: *Lancet*, 1897, i, 1306, 1436; *Arch. f. klin. Chir.*, 1907, lxxxiii, 723.

‖ *Proc. Roy. Soc. Med.*, 1929, xxii (Sect. Comp. Med.), 19.

alleviation of human suffering. But we can only repeat that the mere suggestion of surgical operation for the relief of mitral stenosis casts a grave responsibility upon Sir Lauder Brunton, and a responsibility that he does not lessen by now leaving it to other workers to prove or to disprove its value."

Brunton's reply to this ill-disguised sarcasm was brief and dignified (i, 547). The temptation to quote from the correspondence appearing in the *Lancet* at this time is too strong. Sir Arbuthnot Lane wrote (1902, i, 547): "This suggestion was made by me to my colleague, Dr. Lauriston Shaw, some years ago (about 1890). . . . I was quite prepared to act as soon as he succeeded in finding a case likely to derive benefit. It was entirely due to his perhaps wise caution that the operation has not yet been performed by me. The method by which I proposed to divide the contracted valve through the ventricle was practically identical with that described by Sir Lauder Brunton. Personally I believe that the operation is feasible and, under certain circumstances, justifiable." Lauriston Shaw, however, had definitely abandoned the idea (1902, i, 619); "Sir Lauder Brunton's chief task is not to show his surgical colleagues that it is possible to enlarge the stenosed mitral orifice, but to persuade his medical colleagues that such a proceeding is useful. It is possible to do many things that are useless and some things that are harmful."

Dr. D. W. Samways then (1902, i, 548) drew attention to a suggestion which must often have come to the mind of many a physician and which he had thrown out four years previously in a paper on Cardiac Peristalsis (*Lancet*, 1898, i, 927): "I anticipate that with the progress of cardiac surgery some of the severest cases of mitral stenosis will be relieved by slightly notching the mitral orifice and trusting to the auricle to continue its defence."

SIR LAUDER BRUNTON.

Lauder Brunton was not privileged to see his suggestion rise triumphant above scorn and prejudice. A disappointed man he went down into the silence. There is immortality of the tomb and immortality of the resurrection. The credit of having carried the inspired dream of a sick man into the world of reality belongs to Professor Elliott C. Cutler of the Western Reserve University, Cleveland, Ohio. Cutler, working with S. A. Levine and C. S. Beck, had perfected his technique in numerous and laborious experiments upon animals and had familiarized himself with the working of that delicate organ—the heart. There came to him the opportunity to try his skill on the human subject. His

first patient was a girl of 11 years, bedridden and orthopnœic, suffering periodically from such alarming hæmoptysis that she was expected to die daily. Cutler operated in all on seven cases, each presenting the typical signs of mitral stenosis. To each patient the risk involved was carefully explained, and in the first case the family was warned that no similar operation had ever been performed on a living human being. The patients accepted the risk. The first patient survived the operation: her general condition was improved for a time, and there was no recurrence of hæmoptysis. The girl lived for four and a half years a life of restricted activity, interrupted by periodic admissions to hospital for rest in bed. At autopsy the mitral valve was found to be moderately stenosed and thickened. The scar in the left ventricle was well healed. The fate of some of the other patients taught Cutler that "surgery must be reserved for the cases of pure mitral stenosis in which the mechanical obstruction is the dominant feature, and in which the myocardium is relatively intact." In his work Cutler has employed two instruments: the cardiovalvulotome, whose cutting edges are arranged as a shear, and the cardioscopic valvulotome which carries both a light and a knife. Cutler's operative technique was briefly described by Geoffrey Bourne in this *Journal* (1927, xxxv, 22). Cutler* acknowledges his debt to his physiological colleagues who elaborated instruments and methods for creating experimental defects in the heart valves. The operation was performed in this country in 1925 by H. S. Souttar† who approached the mitral valve through the left auricular appendix. Finding only a moderate degree of stenosis and little thickening of the valve, he contented himself with dilating the latter with his finger. The patient made an uninterrupted recovery though there seems to have been little change in the physical signs since the operation. "To hear a murmur is a very different matter from feeling the blood itself pouring back over one's finger. I could not help being impressed by the mechanical nature of these lesions and by the practicability of their surgical relief."

In France, E. Doyen‡ before the War operated on a case diagnosed as congenital pulmonary stenosis which at autopsy revealed an interventricular communication. Tuffier§ in 1913 operated on a young man with marked aortic stenosis which he dilated with his little finger. The patient was reported to be alive and improved in 1924.

In 1926 Pribram* of Berlin unsuccessfully applied Cutler's technique to a patient suffering from aortic and mitral stenosis.

In the American literature Allen and Graham† record an unsuccessful operation on a case of mitral stenosis in 1922.

The total mortality of the above 12 cases is 83 per cent., the mitral stenosis mortality alone being 90 per cent.

"It is our conclusion that the mortality figures alone should not deter further investigation both clinical and experimental, since they are to be expected in the opening up of any new field for surgical endeavour." (Cutler, 1929.)

In the cool of the evening, Lauder Brunton walks the Square. How his heart would throb with pride and joy if the idea which he suggested twenty-seven years ago for the frowning entertainment of his professional brethren be granted a permanent and honourable place in cardiac therapeutics by this the straitest sect of the Hunterian School of Surgery.

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W. R. BETT.

* *Arch. f. klin. Chir.*, 1926, cxlii, 458.
† *Jour. A. M. A.*, 1922, lxxix, 1028.

* *Boston M. & S. J.*, 1923, clxxxviii, 1023; *Arch. Surg.*, 1924, ix, 689; *ibid.*, 1926, xii, 212; *ibid.*, 1929, xviii, 403.
† *Brit. M. J.*, 1925, ii, 603.
‡ *Presse Méd.*, 1913, xxi, 860, 987; *ibid.*, 1914, xxxv, 282.
§ *La Chirurgie du Cœur, Cinquième Congrès de la Soc. Int. de Chir.*, Paris, 1920, Rapports, L. Mayer, Bruxelles, M. Hayez, 1921, 5.

WRITING UP TO THE PROFESSION.

THE *papers are periodically full of letters from people who protest that plays are grossly inaccurate in matters in which they are experts. But though electrical engineers should protest that the latent period of lighting is* not *three seconds after the switch is fumbled with, or pianists that actresses should not caress the treble notes of a pianola in response to coy rumblings in the bass, no one thinks of doubting the most amazing medical manifestations, which unlike mere lighting and soft music, may be turning points in a plot.*

The time has come to take a firm stand against the apparently safe anæsthesia that takes place after two dramatic gasps at a handkerchief soaked in chloroform, the convenient and impossible paralyses that attack the "heavy fathers," injections that render men mad, and baths which dissolve dead bodies with no more chemical fuss than a few green fumes. We need an example to be set to the promoters of crook plays, a play which shall satisfy the medical experts. And a sample has been submitted. If the lay public protests it has never heard of tetany, G.P.I. and bronzed diabetes, it must be told firmly (preferably by one of the more spicy and authoritative Sunday papers) that it must accept the rarer manifestations of a known pathology with the same credulity with which it endorses the wilder evidences of a non-existent one.

Act III.

Darkness. Suddenly a light gleams from left back, illuminating a stone staircase descending to a cellar, whose walls gleam with damp efflorescence, and whose floor is littered with barrels and riverside junk. A doorway, right back, opens directly on to the River Thames. Edward, the detective, and Maisie, the heroine, come down the stairs. They light one candle and Edward hides under the staircase.

MAISIE: Do you think he'll come in answer to my note?

EDWARD (*enigmatically*): He may come. He may not come. (*Edward is like that.*)

MAISIE: Why do you pursue him so relentlessly?

EDWARD: If I catch him the Yard will raise my pay, and then—(*he stops, shyly*).

MAISIE: Yes, Edward?

EDWARD (*taking the plunge*): Some time ago a surgeon removed my thyroid gland—only too well. The parathyroids went too. Now all my salary goes in buying parathyroid extract. If only——

MAISIE (*changing the subject*): But doesn't *he* interest you?

EDWARD: Yes. His methods are those of Cutt, a famous criminal, said to be a man of wide education and culture, who disappeared years ago. This man can't be the same, for he is known to be some sort of half-caste. Yet I swear they're the same.

MAISIE (*intelligently*): But I don't understand.

EDWARD: Both take a delight in surrounding themselves with queer retainers. We arrested a man called Slowcoach William the other day, and another called Flap-footed Fred. They're safely under arrest and——

MAISIE: Sh——.

(*Another light gleams, and a tall, swarthy, emaciated gentleman in evening clothes* [immaculate] *comes down the stairs. He bows ironically to Maisie and walks to the door, right, opens it. There is a sound of muffled oars and oaths, and two men enter. One shuffles in, his head forward, his arms slightly bent, and a thin trickle of saliva from his mouth gleams in the candle-light. The second boldly, if erratically, stamps into the room. The gentleman speaks.*)

Bill, Fred, are you ready?

BOTH: Yes, Chief.

THE CHIEF (*to the hidden Edward*): You may come out now.

EDWARD (*blinking a little*): There has been a mistake.

THE CHIEF (*grimly*): There has.

(*At his signal the two men set on Edward. A wild fight ensues, in which Edward momentarily gets the better of his two opponents. Picking up a handy crowbar he yells at Slowcoach Bill, "Look there," pointing to the river door. Bill slowly turns to see what is there, and receives a violent kick behind, whereupon he rapidly festinates out of the door. A dull splash is heard, and Edward overturns the candle. In the dim light Fred is seen stamping helplessly about on a wide base, and succumbs to a smack from the crowbar. The Chief calmly re-lights the candle. Edward is seen lying panting on the stairs, helpless in the grip of a violent tetanic spasm.*)

THE CHIEF (*propping him considerately against the wall*): Enjoy your spasm before I kill you. (*He tilts his chin up and shakes his head reminiscently.*) Ah, I made pretty collar incisions in those days.

EDWARD (*as well as his larynx lets him*): Then *you* did it? Ah, Cutt, you swine!

THE CHIEF: Now, little girlie, don't be afraid. Tell me where the papers are and —— (*Big Ben strikes 10 p.m. off.*) That reminds me. (*He takes out a syringe, fills it, and injects himself.*)

MAISIE (*with intolerable scorn*): Drug fiend!

THE CHIEF (*winces and says hotly*): It isn't. (*With pathos.*) It's insulin.

MAISIE (*with womanly logic*): It's the same thing.

(*Meanwhile Edward has rolled over and is busily licking the calcium salts from the cellar wall. As the Chief advances upon Maisie he springs up, whirling his crowbar, and chases the Chief over the barrels till he is exhausted. He stands, about to surrender, and suddenly falls paralysed to the ground.*)

EDWARD: Aha! You see your insulin has proved to be no use—(*he pauses for breath*)—whatsoever.

(*He stoops and takes something out of the Chief's pockets. Police descend the stairs at his whistle, and having carried off the recumbent Fred, who is offering them cheques for £10,000 on the Bank of Borneo, return to force the hemiplegic gentleman up the stairs.*)

(*Edward and Maisie are turning towards one another when the Sergeant speaks.*)

SERGEANT: 'Ere, 'ow are we to shift this blighter, sir?

EDWARD (*one arm round Maisie, holds out the stuff he took from the Chief's pocket*): The answer is a lump of sugar.

And as the snarling and now hyperglycæmic Chief is frog-marched up the stairs, Edward turns and says to Maisie: And I, likewise, need something sweet.

[*Curtain.*] M.

SOME INTERESTING CASES OF "ASTHMA."

ASTHMA can be defined as any form of dyspnœa of expiratory type occurring in paroxysms.

The following cases of asthma, described from a general practitioner's point of view, illustrate the difficulties in diagnosing the various types and of the treatment of this very distressing condition:

CASE 1.—M. S—, male, æt. 17. Had scarlet fever when a child, and since then had persistent albuminuria. Never suffered from any chest trouble until one very foggy night, when he had a severe attack of dyspnœa—sitting up in bed panting for breath, chest full of wheezing rhonchi, particularly expiratory. He was diagnosed as a case of bronchial asthma and an injection of morphia gr. ¼ with atropine gr. $\frac{1}{100}$, was given. He was much better the next morning, but had another severe attack of dyspnœa a week later, necessitating another injection of morphia. He was not very much relieved after this injection, and so was sent to the hospital. There he was diagnosed as a case of renal asthma, and after about three months he died in hospital.

CASE 2.—Mr. Z—, æt. 50. Was seen complaining of a persistent cough and loss of weight. Fine crepitations were discovered in the right base and he had a temperature of 100° F. Pulmonary tuberculosis being suspected he was sent to a chest hospital, but no definite diagnosis was made. One morning, while yet in bed, he had a sudden and very severe attack of dyspnœa, lying in bed panting for breath, markedly pale and sweating, lips cyanosed and with a rapid pulse. The chest was full of wheezing rhonchi. Coronary thrombosis was diagnosed, and morphia gr. ¼ with strychnine gr. $\frac{1}{60}$ were injected subcutaneously. After a few hours the attack abated somewhat. A very bad prognosis was given and he was kept in bed for a fortnight. He was then seen in consultation with a physician, who discovered a dull patch in the right lower lobe, but while he was being examined the patient had an extraordinarily severe attack of dyspnœa. He became pale and sweaty, with blue lips and with a very anxious expression on his face. His pulse became irregular, was easily compressed and was over 120 to the minute. An immediate injection of 7 minims of liquor adrenalin (1 in 1000) and of morphia gr. ¼ was given. A diagnosis of pneumonia (? T.B.) with acute right heart failure was made and he was kept in bed for a few days, during which time he was given digitalis *per os* and injections of strychnine gr. $\frac{1}{60}$ night and morning. When his condition had improved somewhat he was sent to the Hospital. He was there for nearly two months, and despite the fact that his chest was X-rayed nothing definite was found. He had only been discharged from Hospital about a week when he had another very severe attack of dyspnœa. A very dull patch was found in the right base of his lung extending up to the level of the scapula. A hypodermic of morphia gr. ¼ and strychnine gr. $\frac{1}{60}$ was given, and he was sent back to the Hospital, where he is improving gradually.

CASE 3.—Mr. B—, æt. 55. Was quite well until one day while out walking he felt a "discomfort" in the left side of his chest, accompanied by severe shortness of breath. He managed to get to his house, where he was seen panting for breath, very sweaty, his lips blue, while the rest of his face had a yellowish tinge. The pulse was hardly palpable, rapid and irregular. The area of cardiac dullness was slightly enlarged. The chest was full of *râles* and rhonchi, the heart-sounds being inaudible. A diagnosis of coronary thrombosis was made, and stimulants and morphia gr. ¼ were given. For the following few weeks he was kept quietly in bed, but despite this he had repeated attacks of dyspnœa necessitating more injections of morphia. He was then seen in consultation with a physician, who confirmed the diagnosis, and gave an intramuscular injection of 6 minims of liq. adrenalin (1 in 1000). This seemed to have a markedly beneficial effect on the patient. The blueness of his lips disappeared, his dyspnœa improved and the expiratory rhonchi in his chest were not so marked. The injections of adrenalin were then repeated night and morning, but as there was no further improvement he was transferred to hospital, where, after some more attacks of dyspnœa, he died suddenly in his sleep.

CASE 4.—Mrs. B—, æt. 59. Was quite well until a year ago, when she had a sudden and severe attack of dyspnœa in the middle of the night. She was seen sitting up in bed panting for breath, very pale and sweaty; hands cold; pulse slow; the chest full of wheezing rhonchi and with a very anxious expression on her face. There was no albuminuria. She was thought to have bronchial asthma, and ¼ gr. of morphia was injected. She was also given tr. bellad. and tr. stramonii, combined with expectorants, and was greatly relieved. During the following six months she had repeated attacks of dyspnœa, always at night, and which were only relieved by morphia. Owing to the attacks becoming more and more frequent she was sent to the hospital, where a diagnosis of renal asthma was made. She died in hospital a few weeks later.

CASE 5.—Mr. G—, æt. 54. Had suffered from severe bronchitis and pharyngitis for some years past. Was of a very nervous disposition and was a very heavy smoker. Two years ago he coughed up some blood. His chest and sputum were examined, but beyond severe bronchitis nothing else was discovered. Four months ago he was seen complaining of a cough. Temperature and pulse were normal, but the chest was full of *râles* and rhonchi. A week later he complained of shortness of breath, this being thought to be due to bronchial asthma. He was kept in bed and given pot. iod. and tr. stramonium, but with no improvement. By that time his temperature had gone up to 100° F. He was seen in consultation, and a diagnosis of bronchitis and asthma following influenza was made and injections of adrenalin for the attacks were suggested. There was no improvement in his condition, however, the dyspnœic attacks coming on whenever the patient moved in his bed. One foggy night he had a persistent and very severe attack of dyspnœa, which lasted the whole night through, sitting up in bed, pale and sweaty, and gasping for breath. He was given hot coffee to drink and intramuscular injections of adrenalin were given, but with no relief. Morphia gr. ¼ was then injected, with only slight relief as a result, so that two hours later another ⅛ gr. had to be given. This relieved the patient, but after a few hours' sleep the dyspnœa returned. Morphia and adrenalin had to be injected every night in order to give the patient some rest, but while about to inject the morphia on the fourth evening after the severe attack of dyspnœa the patient collapsed. Artificial respiration was tried, strychnine, adrenalin and camphor were injected, but after a few feeble beats his heart stopped beating altogether.

CASE 6.—Mr. S—, æt. 71. Had suffered from bronchitis for a number of years. On the same very foggy night as mentioned in the last case he had an extraordinarily severe attack of dyspnœa, so much so that the noise he made when he breathed could be heard from the ground floor. The chest was full of rhonchi. He refused to have any kind of injection and was given pot. iod. and tr. stramonium in an expectorant mixture. The next morning he was out of bed quite relieved.

CASE 7.—Mr. R—, æt. 66. Was quite well until three years ago, when he had bronchitis with slight œdema of the legs. He improved with medicine, but he always had attacks of dyspnœa whenever the weather was at all foggy. While on a holiday by the seaside he had a sudden and severe attack of dyspnœa, which, despite all kinds of medicine, persisted. He was then brought up to London and was diagnosed as a case of cardiac asthma. All kinds of injections were given, including adrenalin, caffeine and ephedrine, but with no relief. Morphia was not given immediately, as it was not thought advisable to do so as the chest was full of *râles* and rhonchi and the patient an old man. Ultimately morphia gr. ⅛ had to be injected, as the patient was getting exhausted through lack of sleep. After a few hours' sleep he felt much better, but from time to time had further attacks of dyspnœa. Suddenly, in an attack, his pulse and respirations became very rapid, he lost consciousness and died within a few hours after having been in bed for over six weeks.

It will be seen that in the cases cited all the patients had *râles* and rhonchi in their chests, making it difficult to diagnose the type of asthma. As regards treatment, morphia was the only drug that was of any real service.

H. SIMMONDS.

STUDENTS' UNION.

RUGBY CLUB.

It is hoped that all freshers who play rugger will continue to play at the Hospital this season, as fixtures have been arranged for six sides, and their support will be badly needed.

A Freshers' trial match will be held on *Wednesday, October 9th*, at Winchmore Hill, and we shall be glad to see all who can turn up.

So far the ground has been too hard to have any trial games, and we have had to content ourselves with training in tennis shoes.

It has been most encouraging to see such good attendances, and it is evident not only that the "1st," but that the "A" has every prospect of a successful season, especially in the Junior Hospital Cup, which they won so handsomely last year from Guy's.

J. M. J.

ASSOCIATION FOOTBALL CLUB.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the Association Football Club was held on May 7th, 1929. In the absence of the President, Sir Charles Gordon-Watson, Mr. E. G. C. Darke took the chair.

The following officers were elected:

President.—Sir Charles Gordon-Watson.

Vice-Presidents.—Mr. R. Foster Moore, Dr. A. E. Gow, and Dr. W. H. Hurtley.

Captain.—C. A. Keane.

Hon. Secretary.—A. W. Langford.

Captain 2nd XI.—G. H. Brookman.

Hon. Secretary 2nd XI.—H. J. Roache.

Captain and Hon. Secretary 3rd XI.—S. Barigrasser.

Committee.—A. Caplan, R. G. Gilbert, W. Hunt.

The following were awarded Honours for the season 1928–29: J. H. Watkin, R. McGladdery, G. R. Morgan, A. W. Langford, C. A. Keane, J. R. Crumbie, A. M. Gibb, I. E. Phelps, W. J. Burgess, W. Hunt and R. A. Sykes.

C. A. K.

HOCKEY.

We extend a hearty welcome to all Freshmen who wish to play hockey this season, and we ask them to sign the sheet on the notice-board in the Abernethian Room. On Saturday, October 5th, there will be a trial game at Winchmore Hill, details of which will be posted on the board.

Before dealing with the prospects for this season, let us review last season briefly. The 1st XI did splendidly, due to the example and leadership of Church. They won 19 games, drew 3 and lost 3. In the Inter-Hospital Championship they were runners-up, losing to U.C.H. by 1 goal to *nil*.

The 2nd XI were not quite as successful as they have been during the last few seasons. In the Junior Inter-Hospital Championship they were runners-up. The 3rd XI were handicapped by the poverty of their fixture list, but it has been improved for this season, and steps have been taken to bring it up to normal for future seasons.

What are the prospects for this season? There are several vacancies in the 1st XI to be filled, mostly in the forward line; and I think we shall be able to build up a line which will carry us through the "Cuppers" at the end of next term. There is one vacancy in the half-back line, and there are several promising candidates for the position. So the prospects on the whole are rosy.

P. M. W.

SAILING CLUB.

Small boat sailing amongst medical students is becoming increasingly popular, judging by the large and enthusiastic attendance at the Inter-Hospital Regatta held at Burnham-on-Crouch under the flag of the Royal Corinthian Yacht Club last month, which is reported below.

So much so that a word or two about the facilities offered to medical students of the London teaching hospitals might be in season at this, the beginning of the academic year.

There is a United Hospitals Sailing Club which keeps seven 14-foot dinghies and one 21-foot half-decker at Burnham-on-Crouch for the use of members. This club was started in 1924, when it had one dinghy, and the progress it has made is obvious from the size of its fleet at present. There are two cups to be competed for, one presented by Mr. Harold Wilson for single-handed dinghy racing, the other, the Sherren Cup, to be competed for by a crew of four from each hospital.

Races have been arranged for the Club every Bank holiday week-end by the Burnham clubs, and a race every day of Burnham week, which is held during the last week in August.

Dr. Lander, a Bart.'s man in practice in Burnham, owns a four-ton Bermudan rigged sloop, with two berths, which he has very kindly offered to lend to any Bart.'s members any week-end when he is not using it himself, provided they will take full responsibility. Applications to be made through the Secretary of the Bart.'s Sailing Club.

Strenuous efforts are being made this autumn to provide a club-house or headquarters of the club at Burnham. This would take the form of a floating hull or a hut on shore with accommodation in the form of ten or twelve bunks in it. It is confidently anticipated that before the next season opens at Easter, 1930, something of the sort will be in existence.

The Autumn General Meeting, to be followed by the Annual Dinner, will be held in November, the precise date to be announced later. It is hoped that large numbers will turn up. Anyone wishing for information about the Sailing Club should apply to the Secretary, who will be pleased to help them in any way.

INTER-HOSPITAL REGATTA.

The Inter-Hospital Regatta was held at Burnham-on-Crouch on September 14th and 15th. The Royal Corinthian Yacht Club very kindly took charge of the races and made all members of the hospitals present honorary members for the week-end.

Bart.'s are very fortunate in having such enthusiastic flag-officers, for the Commodore, Dr. Dudley Stone, arrived on Friday evening and stayed till late on Sunday evening, and both Dr. Harris and Dr. Cullinan, the Vice- and Rear-Commodores, arrived on Saturday in time to see the race for the Wilson Cup.

The final for the Wilson Cup was sailed off on Saturday afternoon. As there was only a light south-westerly air the course was shortened to once round the "Old Roach" course. The only Bart.'s representative left in for the final was F. T. J. Hobday, the other three competitors, C. F. Watts, J. T. Rowe and J. Hopton, being unfortunate in coming second in each of their heats sailed earlier in the season. The race resulted in Bart.'s, the holders, losing to C. Harvey, of the Middlesex, F. Gibson, of the London, second, and F. T. J. Hobday, of Bart.'s, third.

In the evening an entertaining dinner was held in the Corinthian Club, at which a large number of Hospital members were present. Dr. Cullinan added greatly to the enjoyment of the evening by performing some very clever conjuring tricks.

The Sherren Cup was sailed off on Sunday. There were two races, each twice round the course, thus making four rounds, each member of a crew of four to take the tiller once round the course. Owing to the prevailing conditions the course was a shortened "Old Roach" course. The first race started in a very light westerly air at 10.15 a.m., Bart.'s being represented by V. C. Thompson and J. Hopton. The wind held until the beat up the Crouch started, when it dropped, and a flat calm prevailed for two hours. Those boats in shallow enough water kedged. Bart.'s were unfortunate in being caught in deep water and were rapidly carried back past the Spit Buoy by a strong ebb tide, so gave up and rowed in. At 2 o'clock a light easterly wind sprang up and the race was signalled when one round was completed. The second race was sailed over a very much shortened course, and resulted in a dead-heat between the London and Middlesex; Bart.'s, who were represented by C. F. Watts and F. A. Richards, were disqualified owing to fouling a mark. The tie was sailed off at once and resulted in Middlesex winning the Sherren Cup.

No account of this season's activities would be complete without some mention of W. F. Richards, one of our ablest helmsmen, and the holder of the Wilson Cup, who has been seriously ill. The Club extends its sympathy, and looks forward to seeing him at the helm once again.

J. HOPTON,
Hon. Sec.

SWIMMING CLUB.

The Club has had no fixtures since July, but it is not too early to begin thinking about next season. The team will in all probability present several gaps next May, and these must be filled as soon as possible in order that the newcomers may play in several fixtures which will be arranged during the winter.

This article is, therefore, mainly addressed to freshmen coming up this term who are, or at any time have been, associated with the aquatic world. For their benefit we might state a few facts: The Club mainly plays water polo, but takes part in swimming events as they arise. Club nights during the summer are on Fridays at 8 o'clock at Pitfield Street Baths, and during the winter as may be arranged. Lastly, we won the Inter-Hospital Water Polo Cup for the first time this year, and we want all the support we can get, not only to achieve this again, but also to carry off the Swimming Cup as well next year.

May we earnestly implore all new swimmers to turn up without fail at the Freshers' Tea, and communicate with the Secretary?

J. F. FISHER,
Hon. Sec.

REVIEWS.

RADIUM AND ITS SURGICAL APPLICATIONS. By H. S. SOUTTAR, D.M., M.Ch.(Oxon.), F.R.C.S.(Eng.). (London: William Heinemann, Ltd., 1929.) Pp. 60. Illustrated. Price 7*s.* 6*d.* net.

This little book appears at a critical period in the history of radium treatment. The research work of physicists and clinicians in the past few years has created an interest in the possibilities of radium therapy which is spreading rapidly beyond the medical profession. The clinicians have satisfied themselves that in radium they possess a powerful weapon to combat cancer—how powerful it is impossible as yet to say. The layman, taking the guarantee of the expert's word, starts to set in motion financial machinery designed to provide radium to meet the demands of the profession. He will soon require a return for his money, and the medical man must see to it that his part of the bargain is fulfilled.

The conscientious practitioner will want to know how radium works, how to select cases suitable for its use, how it is to be used, and what is to be expected from it. It behoves those having special knowledge to instruct their brethren, and to be circumspect in their speech, especially in regard to end-results.

Mr. Souttar can speak with the authority of one who is familiar with the action and uses of radium. And though a book of this size cannot give sufficient detail to be a real guide to the uninitiated, yet it sets forth in a clear and readable form some of the essential points in regard to the physical properties of radium and the methods of its application. The portions of the work which call for severe criticism are those in which illustrative cases are quoted. In many cases the diagnosis has been made on clinical grounds alone, unconfirmed by pathological investigation, and the accounts are illustrated by drawings and diagrams which are unconvincing as evidence of the nature or magnitude of the tumour. Isolated cases are quoted without any facts to show whether or not the response has been what one may expect as a rule from the radiation of such a tumour.

That radium sometimes acts like a charm nobody will deny; but to quote cases of tumours which have "vanished" dramatically will neither instruct the novice nor convince the sceptic. We feel that there is in this book an element of optimism which may be misleading, and a suggestion of "cancer-cure" which may be difficult to justify in our present state of ignorance.

HERMAN'S DIFFICULT LABOUR. Seventh Edition. Revised by CARLTON OLDFIELD, M.D., F.R.C.S., F.R.C.P. (London: Cassell & Co., Ltd., 1929) Pp. 560. Price 16*s.* net.

In this edition Mr. Oldfield has made a number of changes and additions to Herman's excellent book, and yet has maintained the general style and arrangement of the original writer. The chapter on the Mitigation of Pain in Labour is perhaps too short and condensed; many private practitioners would appreciate more detailed information. Puerperal sepsis is much before the eyes of the public and the profession at the present time, and the advice as to the relative circumstances under which rectal or vaginal examinations should be carried out is well worthy of consideration. One or two small points of criticism present themselves. Forceps are often applied in the lithotomy position, but there is no description of the application in this position. Four pages are given to the discussion of interlocked twins, which are, as the author states, "excessively rare." With regard to the technique of suture of the uterine muscle after the extraction of the child in Cæsarian section, it would seem more complete if silkworm gut also were mentioned, as it is the suture used (in lieu of catgut) by many operators. Eight excellent X ray plates serve to remind the reader of the increasing use of radiology in midwifery, and the mention of ultra-violet light treatment for osteomalacia is of interest.

If perhaps the book is too detailed for the student at the commencement of his study of midwifery, it will certainly be of great assistance to those who require more than is contained in the smaller treatises, to resident midwifery assistants, and to general practitioners for reference, when called in to deal with difficult labour.

THE DISEASES OF CHINA. By JAMES L. MAXWELL, M.D., B.S. Second Edition. (Shanghai: A.B.C. Press, 1929.) Pp. ix, 530, with 176 illustrations. Price 20*s.* net.

The first edition of this book appeared under the joint authorship of Drs. Jefferys and Maxwell. Owing to the retirement from China of the former, the whole task of bringing the present edition up to date has devolved upon the present author. The advances which have taken place in all branches of medicine within the last few years have necessitated a very considerable alteration in the form and contents of most of the chapters with the exception of that on tumours. The object of the author is to assist physicians in China, particularly those in more or less isolated situations, and this object is adequately achieved.

The material consists largely of an expression of the author's personal experience, combined with copious references to the work of other observers scattered throughout the whole of China. The resultant mixture makes interesting reading and, from the clinical point of view, contains much information of value, although, in a future edition, we hope to find a fuller and clearer description of the pathological findings in the more definitely Oriental diseases.

The illustrations are, on the whole, well reproduced.

PHYSIO-THERAPY IN GENERAL PRACTICE. By E. BELLIS CLAYTON, M.B., B.Ch.(Cantab.). (London: Baillière, Tindall & Cox, 1928). Pp. x, 231. Figs. 53. Price 12*s.* 6*d.* net.

In the medical curriculum no provision is made for the teaching of physio-therapy, yet this is an item of considerable importance in the proper treatment of most medical and surgical conditions. The wide scope of such therapy is well shown in this extremely useful book.

The second edition has been enlarged and made more complete by the inclusion of a chapter on ultra-violet light, radiant heat, diathermy and other forms of electrical treatment. The first two chapters deal with massage, exercises and electrical treatment in general, and the remainder of the book with the appropriate physio-therapeutic treatment of various injuries and diseases. In the treatment of empyema after rib-resection the author advises the commencement of exercises on the day after operation. This would probably help to prevent the bronchiectasis and deformity of the chest which frequently follow.

The terms used by the medical gymnast sound strange to the uneducated ear, and it is fortunate that a glossary is provided. The exercises are illustrated by excellent photographs. To those who wish to extend their range of therapeusis this is a book which can be thoroughly recommended.

HANDBOOK OF BACTERIOLOGY. By J. W. BIGGER, M.D., F.R.C.P.I. Second edition. (London: Baillière, Tindall & Cox, 1929.) Pp. xvi, 453. Illustrated. Price 12*s.* 6*d.* net.

This edition is a worthy successor of the first, and maintains its use as a short text-book of bacteriology, supplying in a clear manner the essentials of the subject, without including those elaborations of interest only to the expert.

Two new chapters have been added to the book—one on the *rôle* of bacteria in the body in health, and the other on the classification of bacteria. The latter, in view of the various classifications at present in use, is valuable for reference.

A large amount of recent work in bacteriology has been included, *e.g.* bacterial variation and serology, streptococci, including *S. scarlatinæ*, food-poisoning bacilli and yellow fever. The chapter on diseases due to filterable viruses contains much useful information difficult to find elsewhere.

The book is to be especially recommended as a manual to be read whilst taking a practical course in this subject for the final M.B. examinations.

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

ANDREWES, C. H., M.D. "Virus III in Tissue Cultures. I. The Appearance of Intranuclear Inclusions *in vitro*." *British Journal of Experimental Pathology*, April, 1929.

——— "Virus III in Tissue Cultures. II, Further Observations on the Formation of Inclusion Bodies. III, Experiments Bearing on Immunity." *British Journal of Experimental Pathology*, August, 1929.

APPLETON, A. B., M.A., M.D., M.R.C.S., L.R.C.P. "On the Morphology of the Cervico-costo-humeralis Muscle of Gruber." *Journal of Anatomy*, July, 1929.

——— (and GREY, P. H. R.). "An Example of the Cervico-costo-humeral Muscle of Gruber." *Journal of Anatomy*, July, 1929.

BATTEN, LINDSEY W., M.B., M.R.C.P. *See* SIMPSON and BATTEN.

BRAIMBRIDGE, C. V., F.R.C.S.(Edin.). "Some Remarks on the Relation between Rainfall and Prevailing Diseases in Nairobi." *Kenya and East African Medical Journal*, June, 1929.

BUCHANAN, Sir GEORGE S., C.D., M.D., F.R.C.P. "Collective Public Effort in Dealing with Cancer." *Report International Conference on Cancer*, London, 1928.

BURROWS, HAROLD, C.B.E., M.B., F.R.C.S. "The Induction of Inflammation in the Treatment of Malignant and other Local Diseases." *Lancet*, September 21, 1929.

CANTI, R. G., M.D. "The Relationship of Intensity of Radiation and Time." *Report International Conference on Cancer*, London, 1928.

COCHRANE, R. G., M.D., M.R.C.P., D.T.M.&H. "The Use of Alepol in the Treatment of Leprosy." *Leprosy Notes*, April, 1929.

——— "Leprosy Relief in Cyprus." *Leprosy Notes*, July, 1929.

CORSI, H., F.R.C.S. "Leiomyoma Cutis Multiplex." *Proceedings of the Royal Society of Medicine*, August, 1929.

COYTE, RALPH, M.B., B.S., F.R.C.S. "Stone, weighing twelve ounces, removed from Right Kidney." *Proceedings of the Royal Society of Medicine*, August, 1929.

——— "Skiagram of Large Stone, three inches in length, removed from Right Ureter." *Proceedings of the Royal Society of Medicine*, August, 1929.

——— "The Treatment of Hernia in Children." *Clinical Journal*, September 11, 1929.

DALTON, C. H. C., M.A., M.D., M.R.C.S., D.M.R.E. "Arsenical Poisoning, with Special Reference to Treatment with the Galvanic Current." *British Medical Journal*, August 17, 1929.

DONALDSON, MALCOLM, F.R.C.S. "The Advantages of Radiation in the Treatment of Cancer of the Cervix Uteri." *Report International Conference on Cancer*, London, 1928.

FINZI, N. S., M.B., D.M.R.E. "The Latent Period." *Report International Conference on Cancer*, London, 1928.

FRASER, FRANCIS R., M.D., F.R.C.P.(Edin.). "The Place of Human Physiology in the Training of Medical Students." *British Medical Journal*, August 31, 1929.

GORDON-WATSON, Sir CHARLES, K.B.E. "Radiation in the Treatment of Cancer of the Rectum." *Report International Conference on Cancer*, London, 1928.

TIMES OF ATTENDANCES IN THE OUT-PATIENTS' AND SPECIAL DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Out-patients	Dr. Graham 9 to 10 a.m.	Dr. Hilton 9 to 10 a.m.	Dr. Hinds Howell 9 to 10 a.m.	Dr. Gow 9 to 10 a.m.	Prof. Fraser 9 to 10 a.m.	Dr. Geoffrey Evans 9 to 10 a.m.
Surgical Out-patients	Mr. Dunhill 9 to 10 a.m.	Mr. Girling Ball 9 to 10 a.m.	Mr. Vick 9 to 10 a.m.	Prof. Gask 9 to 10 a.m.	Mr. Roberts 9 to 10 a.m.	Mr. Keynes 9 to 10 a.m.
Diseases of Women	Dr. Shaw 9 to 10 a.m.	—	Dr. Donaldson 1.30 to 2 p.m.	Dr. Donaldson and Dr. Shaw 1.30 to 2 p.m.	—	Dr. Shaw 9 to 10 a.m.
Orthopædic Department	Mr. Elmslie 1 to 1.30 p.m.	—	—	Mr. Elmslie 1 to 1.30 p.m.	—	—
Throat and Nose Department	Mr. Bedford Russell 1 to 1.30 p.m.	Mr. Rose 9 to 9.30 a.m.	—	Mr. Bedford Russell 9 to 9.30 a.m.	Mr. Rose 1 to 1.30 p.m.	—
Aural Department.	Mr. Sydney Scott 1 to 1.30 p.m.	Mr. Just 9 to 9.30 a.m.	—	Mr. Sydney Scott 9 to 9.30 a.m.	Mr. Just 1 to 1.30 p.m.	—
Ophthalmic Department	Mr. Rupert Scott 1 to 1.30 p.m.	Mr. Foster Moore 1 to 1.30 p.m.		Mr. Rupert Scott 1 to 1.30 p.m.	Mr. Foster Moore 1 to 1.30 p.m.	—
Skin Department .	—	Dr. Roxburgh 9 to 10 a.m.	Dr. Roxburgh 9 to 10 a.m.	—	Dr. Roxburgh 9 to 10 a.m.	—
Children's Department	Dr. Harris 1 to 1.30 p.m.	—	—	—	Dr. Harris 1 to 1.30 p.m.	—
Dental Department	Mr. Hankey 9 to 10 a.m.	Mr. Coleman and Mr. Hankey 9 to 10 a.m.	Mr. Cowan 9 to 10 a.m.	Mr. Hankey 9 to 10 a.m.	Mr. Fairbank and Mr. Cowan 9 to 10 a.m.	Mr. Cowan 9 to 10 a.m.
Electro-Therapeutics	Dr. Cumberbatch 1.30 p.m.	Dr. Cumberbatch 1.30 p.m.	—	Dr. Cumberbatch 1.30 p.m.	Dr. Cumberbatch 1.30 p.m.	—
X-Ray Department	Dr. Stone 9.30 a.m. Dr. Finzi and Dr. Stone 1.30 p.m.	Dr. Stone 9.30 a.m. Dr. Finzi and Dr. Loughborough 1.30 p.m.	Dr. Loughborough 9.30 a.m.	Dr. Loughborough 9.30 a.m. and 1.30 p.m.	Dr. Finzi 9.30 a.m. and 1.30 p.m.	—

HILL, NORMAN H., M.D., M.R.C.P. "The Clinical Significance of Jaundice in the Newly Born." *Clinical Journal*, August 7, 1929.

HORDER, Sir THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "A Consideration of Cancer Cachexia." *Report International Conference on Cancer*, London, 1928.

HUME, J. BASIL, M.B., F.R.C.S. "The Results of Lead Treatment at St. Bartholomew's Hospital, London." *Report International Conference on Cancer*, London, 1928.

KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. "Radium Treatment of Carcinoma of the Breast." *Report International Conference on Cancer*, London, 1928.

McDONAGH, J. E. R., F.R.C.S. "The Nature and Treatment of Asthma." *Practitioner*, July, 1929.

——— "Asthma and Hay Fever." *Lancet*, August 10, 1929.

MILES, W. ERNEST, F.R.C.S. "The Problem of Treatment of Cancer of the Rectum in Relation to the Facts of Surgical Pathology." *Report International Conference on Cancer*, London, 1928.

OKELL, C. C., M.C., M.B., B.Ch., M.R.C.P., D.P.H. (C. J. MONTAGU LAWRENCE, L.M.S.S.A., and C. C. O.). "The Association of Human and Canine Jaundice, with an Illustrative Case." *Lancet*, August 17, 1929.

PAYNE, REGINALD T., M.B., B.S., F.R.C.S. "Hunterian Lecture on the Treatment of Varicose Veins and Varicose Ulcers by Injection." *Lancet*, August 17th, 1929.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Epoch-making Books on British Surgery. IX The Works of Percivale Pott." *British Journal of Surgery*, July, 1929.

ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., D.C.L., LL.D., F.R.C.P. "Antagonistic Phases." *Practitioner*, September, 1929.

ROXBURGH, A. C., M.D., M.R.C.P. "Alopecia Areata." *Clinical Journal*, September 4, 1929.

SIMPSON, R. H., M.D., M.R.C.P., D.P.H., and BATTEN, LINDSEY W., M.B., M.R.C.P. "Some Points in the Diagnosis of Cardiac Lesions in Children." *Lancet*, August 24, 1929.

SOUTHAM, A. H., M.D., M.Ch., F.R.C.S. "Mule-Spinners' Cancer." *Report International Conference on Cancer*, London, 1928.

VERNEY, E. B., F.R.C.P. "The Value of Physiological Tests of Renal Function." *British Medical Journal*, August 3, 1929.

WALKER, KENNETH M., O.B.E., F.R.C.S. "Chronic Infections of the Urinary Tract." *Clinical Journal*, August 21, 1929.

WEBER, F. PARKES, M.D., F.R.C.P. "Blood Diseases." *Practitioner*, September, 1929.

——— "A Note on Tumours of Endocrine Glands." *British Medical Journal*, September 21, 1929.

WHITEHEAD, F. E., O.B.E., M.R.C.S., L.R.C.P. "Leprosy in Nyasaland." *Leprosy Notes*, July, 1929.

EXAMINATIONS, ETC.

Royal College of Surgeons of Edinburgh.

The following has been admitted a *Fellow*: Spackman, W. C.

CHANGES OF ADDRESS.

ADRIAN, E. D., St. Chad's, Grange Road, Cambridge.

ANDERSON, H. G., West China Union University, Chengtu, Szechuan, China (*viâ* Siberia).

BARNES, W. A., The Shrubbery, Woburn Sands R.S.O., Bucks. (Tel. Woburn Sands 2.)

BRIGSTOCKE, P. W., The Victoria Hospital, Damascus, Syria.

CLARK, W. ADAMS, Beaufort, British North Borneo.

CORBETT, R. S., 29, Dryden Chambers, Oxford Street, W. 1. (Tel. Welbeck 2635.)

EVANS, E. W. S., 8, Havelock Road, West Marlands, Southampton.

GLOVER, L. G., 22, Upper Wimpole Street, W. 1. (Tel. Welbeck 0117.)

MACKENZIE, A. V., 22, Belmont, Shrewsbury.

NELSON, H. P., 4, Harley Road, N.W. 3.

POLLARD, Surg.-Lt. E. B., R.N., Royal Naval Hospital, Portland, Dorset.

ROGERS, K., "Namouna," 25, West Cliff Road, Bournemouth, Hants.

SKAIFE, W. F., c/o Addington Hospital, P.O. Box 977, Durban, Natal.

SYMONDS, H., Caledon Street, George, Cape Province, South Africa.

TAIT, H. B., 68, Southwood Lane, Highgate, N. 6.

APPOINTMENTS.

BEVAN, F. A., M.B., B.S.(Lond.), appointed Honorary Surgeon to Out-Patients at the Southend Victoria Hospital, Southend-on-Sea.

BUTTERY, J. W. D., F.R.C.S.E., appointed Honorary Assistant Surgeon to the Royal Victoria Hospital, Folkestone.

CLARK, W. ADAMS, M.R.C.S., L.R.C.P., appointed Government District Surgeon and Estates Medical Officer at Beaufort, British North Borneo.

CROOK, E. A., M.Ch.(Oxon.), F.R.C.S., appointed Assistant Surgeon to the Gordon Hospital for Diseases of the Rectum.

JONES, D. STANLEY, M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Alexandra Hospital for Sick Children, Brighton.

SKAIFE, W. F., M.D.(Oxon.), appointed Assistant Medical Superintendent to Addington Hospital, Durban.

BIRTHS.

BRADFORD.—On August 28th, 1929, at Goodrington, South Devon, to Doris Mary, wife of Ernest Cordley Bradford, M.A., M.B., B.C.(Camb.), of Laneside, Horsham, Sussex—a son.

JOHNSON.—On September 9th, 1929, at 1, Queenswood Avenue, Wallington, to Margaret, wife of Dr. R. S. Johnson—a son.

LONGFORD.—On September 12th, 1929, to Elizabeth (*née* Dunn), wife of Dr. W. U. D. Longford, Holywood, co. Down, Ireland—a son.

OGIER WARD.—On September 10th, 1929, at 16, Bryanston Mansions, W. 1, to Mr. and Mrs. R. Ogier Ward—a son.

ROLES.—On September 14th, 1929, at 25D, Fitzjohn's Avenue, Hampstead, N.W. 3, to Joan (*née* Crace-Calvert), wife of Francis C. Roles, M.R.C.P.—a daughter.

TOPHAM.—On September 4th, 1929, to Dr. Helen Topham, wife of Dr. E. J. E. Topham, 2, West Avenue, Exeter—a daughter.

MARRIAGES.

ELGOOD—FRANCIS.—On September 9th, 1929, at St. Martin-in-the-Fields, London, John Elgood, M.B., F.R.C.S., elder son of Dr. and Mrs. Elgood, late of Windsor, to Christine Phyllis Francis, M.B., B.S., elder daughter of Mr. and Mrs. J. E. Francis, of the Athenæum Press, London.

POWELL—FARADAY.—On September 7th, 1929, at the Church of St. Peter and St. Paul, Aldeburgh, by Canon Goldsmith, assisted by Rev. Danvers and Rev. Snowden Smith, Ronald Rees Powell, M.A., M.R.C.S., Farlsridge, Redhill, to Thelma, daughter of Mr. and Mrs. P. Michael Faraday, Thellusson Lodge, Aldeburgh.

DEATH.

GIFFARD.—On September 15th, 1929, at a nursing home in Bournemouth, Douglas William Giffard, M.R.C.S.(Eng.), L.S.A., formerly of Brighton, aged 81 years.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The British Journal of Venereal Diseases—Bulletin de l'Hôpital Saint-Michel—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East African Medical Journal—The Medical Review—The Nursing Times—Porto Rico Review of Public Health and Tropical Medicine—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecine—St. Bartholomew's Hospital League News—The St. Thomas's Hospital Gazette—Sydney University Medical Journal.

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, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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. 1. Telephone: City 0510.*

St. Bartholomew's Hospital Journal.

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

VOL. XXXVII.—No. 2.] NOVEMBER 1ST, 1929. PRICE NINEPENCE.

CALENDAR.

Fri., Nov. 1.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Medicine: Clinical Lecture by Dr. Morley Fletcher.

Sat., ,, 2.—Rugby Match *v.* Moseley. Away.
Association Match *v.* Keble College, Oxford. Away.
Hockey Match *v.* Trinity College, Cambridge. Home.

Mon., ,, 4.—Special Subject: Clinical Lecture by Mr. Scott.

Tues., ,, 5.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.

Wed., ,, 6.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.

Thurs., ,, 7.—**Abernethian Society. Clinical Evening, 5.30.**

Fri., ,, 8.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Medicine: Clinical Lecture by Dr. Langdon Brown.

Sat., ,, 9.—Rugby Match *v.* Northampton. Home.
Association Match *v.* Caius College, Cambridge. Away.
Hockey Match *v.* University of Reading. Home.

Mon., ,, 11.—Special Subject: Clinical Lecture by Mr. Elmslie.

Tues., ,, 12.—Dr. Langdon Brown and Mr. Harold Wilson on duty.

Wed., ,, 13.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.

Fri., ,, 15.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.

Sat., ,, 16.—Rugby Match *v.* London Irish. Away.
Association Match *v.* Old Mercers. Home.
Hockey Match *v.* Old Cranleighans. Home.

Mon., ,, 18.—Special Subject: Clinical Lecture by Mr. Bedford Russell.

Tues., ,, 19.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Last day for receiving matter for the December issue of the Journal.

Wed., ,, 20.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.
Hockey Match *v.* Keble College, Oxford. Home.

Thurs., ,, 21.—**Savoy Hotel.—9.0 p.m.: St. Bartholomew's Hospital Dance.**

Fri., ,, 22.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Medicine: Clinical Lecture by Dr. Langdon Brown.

Sat., ,, 23.—Rugby Match *v.* London Welsh. Home.
Association Match *v.* University College. Away.

Mon., ,, 25.—Special Subject: Clinical Lecture by Dr. Cumberbatch.

Tues., ,, 26.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.

Wed., ,, 27.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.

Thurs., Nov. 28.—**Abernethian Society: Address by Dr. T. H. G. Shore, 5.30.**

Fri., ,, 29.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.

Sat., ,, 30.—Rugby Match *v.* Devonport Services. Away.
Association Match *v.* Old Brentwoods. Home.
Hockey Match *v.* Emmanuel College, Cambridge. Away.

EDITORIAL.

THE HOSPITAL APPEAL.

NEWS has reached us of a stupendous appeal for money shortly to be launched by the Hospital. Impenetrable mystery and unbreakable silence cloak the details of the scheme, but we are assured that every known resource of modern advertising technique and some newly invented for the occasion will be brought into play. The essence of good generalship is surprise, and it appears that not only we of the Hospital but the citizens of London are in for some breathless surprises. The campaign is likely to last for a twelvemonth or more, during which time the students of St Bartholomew's will find their services required for many a strenuous sally into London's pockets. The business-like spirit of the organizers bodes ill for the modern counterparts of Godric, the butcher, of whom it is told in the *Liber Fundacionis* that he was "a man of excessive sternness and of a mind niggardly beyond what was becoming, who was wont not only to give nothing to those that asked him, but even to insult them with scornful words." By the time the propaganda has done its work, the Godrics will have either paid up or fled the country.

While the schemes for building up the credit account are strategically hidden, the schemes for destroying it are open to inspection, and the organizers have furnished this summary of how the money is to be spent.

"Bart.'s needs a million pounds"

To pay off the balance due on the new Surgical Block and on the extension of the Nurses' Quarters (£133,000)
To reconstruct the South, East and West blocks of the Square, which are 200 years old
To recondition the Maternity Department
To provide an In-Patient Children's Department
To extend the present Out-Patients' Department
To extend the Medical School
To increase students' accommodation, lecture rooms, etc., and to provide residential quarters for students
And last, but by no means least, to endow research and teaching, for no such endowment exists to-day.

For the year ending December 31st, 1928, the ordinary revenue was £186,147, and the ordinary expenditure (apart from new apparatus, equipment, building reconstructions and additions), £201,774—a deficit of £15,627.

Let us hope that the appeal will loose the needed flood of gold upon the Hospital.

* * *

The Old Students Annual Dinner was held on Tuesday, October 1st, in the newly renovated Great Hall. After "The King" Sir Frederick Andrewes opened his speech with a welcome to the assembled guests, amongst whom were Lord Stanmore, the Masters of the six City Companies, and the Editors of the *Lancet* and of the *British Medical Journal*.

Sir Humphry, he said, could be welcomed as an Old Bart's man, or as a Professor of Medicine, or if need for a representative of the Services arose, as a naval man.

The Old Students had lost during the year Sir William Church, in his ninetieth year, Sir Dyce Duckworth, Mr. Elkin Cumberbatch, and the well-beloved Sir Anthony Bowlby.

Reviewing the year, Sir Frederick praised the cleaning, re-lighting and re-flooring of the Great Hall. The other great change was the approaching completion of the new Surgical Block—a feat due to the architect, present at the Dinner. The arrangements of the building were in every way conducive to the comfort of the surgeon, whose need of the rest-rooms provided was real, in contradistinction to the physicians, whose professional exercise was only a little light tapping of the chest. Anæsthetists, with their materials laid on in all theatres, would soon do no more than play fantasias on a keyboard remote from the patient.

But all these changes needed money, and with its expenditure of £201,000 per annum, exceeding its income by £15,000, he wished to appeal to Old Bart.'s men present to help the Hospital, and suggested a tour of the new buildings on the morrow to stimulate potential givers. Sir Frederick hoped that his appeal would have effect beyond the confines of the Dinner.

Lord Stanmore replied for the guests, and proposed the health of Sir Frederick.

Coffee in the Library gave opportunity for an informal rounding off of an exceedingly pleasant dinner.

* * *

THE POST-GRADUATE RADIUM COURSE.

The success of the Radium Course, assured though it was from the very start, exceeded all expectations. The course was originally planned for thirty-six students, but so many applications were received that by ingenious duplication it was expanded to take two such groups and to accommodate seventy-two. Even then many applicants had to be refused, on whose behalf we venture to hope that a second course, or something like it, will take place in the near future.

The Dean has put into our hands the following letter, which we publish with great pleasure:

CUMBERLAND INFIRMARY,
CARLISLE,
October 3rd, 1929.

DEAR DR. SHORE,—We have been requested by the members of the Post-Graduate Class on Radium to convey to you, as representing the Medical College, our great appreciation of the way in which this course was conducted. It was very apparent to all who were present how much time and trouble must have been taken by those who conducted the course, in the preparation and organization for our benefit.

The members of the class feel most grateful, not only to those who taught us, but to the clinical assistants, sisters and nurses, patients, and all who contributed to the great success of this very instructive and enjoyable class.

Will you kindly convey our thanks to them, and to the Council of the Medical College?

Yours truly,
J. W. GEARY GRANT (*Section* 1).
NORMAN MACLAREN (*Section* 2).

We hope to publish in six months' time a short note, and in a year, perhaps, some fuller account of the progress of the cases operated upon during the demonstration.

The *Lancet*, after eighty-two years in Bedford Street, has moved to No. 7, Adam Street. The house is an Adam house of great charm and beauty. A brief notice of its history, and of the wanderings of the *Lancet* offices, will be found in the number of September 19th. We wish our distinguished contemporary as much prosperity in the new home as it has always enjoyed in the old.

* * *

Dr. Morley Fletcher will take the chair at the Fifty-third Anniversary Dinner of the Cambridge Graduates Club of St. Bartholomew's Hospital, which will be held at the Mayfair Hotel on Wednesday, November 20th, at 7.15 for 7.30 p.m. The price of the dinner is 12*s.* 6*d.*, exclusive of wines, and no tickets are required.

* * *

We regret to announce the death of Sir Thomas Jenner Verrall, which occurred on October 5th, at the age of 77. He was for many years a member of the General Medical Council, and a prominent member of the British Medical Association. He was educated at Marlborough, and was a student at St. Bartholomew's in the 'seventies.

* * *

The following gentlemen have been nominated to House Appointments from November 1st, 1929:

Junior House Physicians	
Dr. Morley Fletcher	R. D. Robinson.
Sir Percival Hartley	J. F. Varley.
Prof. F. R. Fraser	R. K. Price.
Sir Thomas Horder	C. N. Evans.
Dr. Langdon Brown	H. P. Hutchinson.
Junior House Surgeons—	
Sir Holburt Waring	W. A. Elliston.
Mr. L. Bathe Rawling	P. J. Richards.
Prof. G. E. Gask	A. Philps.
Sir C. Gordon-Watson	R. C. Bennett.
Mr. Harold Wilson	V. C. Thompson.
Intern Midwifery Assistant (Resident)	A. Bennett.
Intern Midwifery Assistant (Non-Resident)	K. W. D. Hartley.
Extern Midwifery Assistant	H. V. Knight.* / E. J. Neill.†
H.S. to Throat and Ear Departments	R. W. Raven.
H.S. to Ophthalmic Department	W. A. Nicholson.
H.S. to Skin and Venereal Departments	W. V. Cruden.* / D. A. Langhorne.†
H.S. to Orthopædic Department	G. H. Bradshaw.
Junior Resident Anæsthetists	A. M. Boyd. / R. Rait-Smith.
Casualty House Physicians	B. H. Gibson.* / J. S. Whiting.* / C. Sanderson.* / A. W. Franklin.† / J. O. Williams.† / C. B. Prowse.†
Casualty House Surgeons	E. M. Sharples.* / J. R. J. Beddard.†

* 3 months, November. † 3 months, February.
All others for 6 months.

§

The Students' Union will hold its Annual Dance on Thursday, November 21st, at the Savoy Hotel. The Night Watchmen have been engaged to play. The Ball begins at nine and ends at three. Single and double tickets, which cost 21*s.* and 35*s.* each respectively, may be had from Mr. E. V. Frederick and Mr. G. D. S. Briggs.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

ON SOME ABDOMINAL DISEASES.

(1) Because a patient suffering from ulceration of the stomach is elderly it is not uncommon to argue that this fact favours malignancy. The argument is fallacious, because peptic ulcer is quite common in men over seventy years of age. Age, of itself, therefore gives no help in differential diagnosis.

(2) In the differential diagnosis of simple from malignant ulcer of the stomach too little stress is often laid upon the significance of a frank hæmatemesis. In the presence of this complication simple ulcer becomes highly probable, for erosion of an artery rarely occurs in carcinoma, whereas it is a common event in simple ulcer.

(3) The association of enlargement of the spleen with hæmatemesis occurs in splenic anæmia and in cirrhosis of the liver. The differential diagnosis is usually not difficult. But there is a third possibility, though a rare one—an old-standing peptic ulcer which, by dense perigastric adhesion, has caused thrombosis of the splenic artery.

(4) It is fairly well known that an enlarged spleen, whatever its associations, not seldom becomes much smaller after an attack of hæmatemesis or melæna. It is interesting to observe that, in splenic anæmia at all events, a large spleen may become so small when the patient is under ether anæsthesia that the organ cannot be palpated just prior to a laparotomy. This fact no doubt accounts for the discrepancy which sometimes occurs between the state of the spleen as recorded before operation and observation as to the condition of the organ during it.

(5) Portal thrombosis can scarcely be diagnosed with certainty. But if a patient, known to suffer from cirrhosis of the liver, develop signs of intestinal obstruction with enterorrhagia, there is strong presumptive

evidence that this is the nature of his trouble. This diagnosis may also be found to be correct if, with acute abdominal symptoms, a patient who has previously shown a tendency to venous thrombosis, but is free from cardiac and renal disease, develops ascites within the space of a few days.

(6) Ascites arising insidiously in a woman in whom there are no other symptoms or signs (*e.g.* of heart, kidney or liver disease) is generally due to ovarian adenoma. The growth, being sometimes very soft in consistency, may not be felt by vaginal examination, and so may require laparotomy for its demonstration.

(7) The most frequent antecedent to suppurative pylephlebitis (portal pyæmia) in this country is operation for a septic appendix. Desperate though the condition is, recovery does occasionally take place, the patient living long enough to admit of coalescence of the multiple foci of suppuration and evacuation of the abscess so formed.

(8) Single abscess of the liver, when not due to dysentery, is most often due to *Staphylococcus aureus*. The condition may give rise to an obscure pyrexia for many weeks, in this particular exceeding perinephric abscess, with which disease it has affinities in causation and in the difficulties which may surround the diagnosis.

(9) Eosinophilia in disease of the liver is not peculiar to hydatid disease. It may occur in some other diseases of this organ as in neoplasm, especially if the growth be a rapid one.

ACKNOWLEDGMENTS.

The British Journal of Nursing—Bulletin de l'Hôpital Saint-Michel—L'Echo médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—Leprosy Notes—The London Hospital Gazette—Long Island Medical Journal—The Nursing Times—The Post-Graduate Medical Journal—St. Mary's Hospital Gazette—University College Hospital Magazine.

OVERHEARD IN THE SQUARE.

First Path. Clerk: One million is a bit low for a red count, isn't it?

Second ditto: Oh well, multiply it by four.

OVERHEARD IN THE SURGERY.

Q.: Are your bowels well open, ma'am?

A.: Yes, thank ye kindly doctor—I allus keeps them open with them *sarcastic* pills.

MEDICAL HISTORY TAKING.

By GEOFFREY BOURNE, M.D., F.R.C.P.

(*Concluded from p. 7.*)

PAST HISTORY.

The past history includes, besides illnesses previous to the patient's last period of good health, any other information about his life hitherto that may throw light upon the disease present.

For the sake of clearness these categories can be separated into past events, past diseases and past habits.

Past events.—A premature child often owes its early ill-health to its prematurity. A baby with a cerebral diplegia may owe its trouble to an abnormally long and difficult labour with resulting meningeal hæmorrhage. An inquiry here as to the length of the labour or the use of instruments may be instructive. In the case of infantile dyspepsia, marasmus, rickets, scurvy and similar early troubles, an exact inquiry as to how long the baby was at the breast, and concerning the nature and duration of any artificial feeding, is essential. Again, in the case of suspected mental deficiency in a young child, the ages at which it first cut teeth, walked, talked and acquired sphincter control are important, as in such a case these are almost always delayed.

A child should cut its first teeth about the sixth month or soon after, should walk at a little after twelve months, and at about the same age begin to say a few words.

Sphincter control varies with the intelligence of the mother. In hospital cases it is not uncommon for the former still to be lacking up to the age of three, but where a child is properly cared for clean habits are acquired at least a year earlier.

During the school age this section of the past history ceases to yield information of great importance, except upon psychological and intellectual matters.

In adult life the effect of work becomes a matter for consideration. Certain types of work are liable to produce diseases. Certain trades, in spite of stringent precautions, still bring contact with poisons. Lead poisoning occurs among those who work in paint, in accumulator factories and in red and white lead, particularly the latter. Arsenic is present in weed-killer and sheep-wash; mercury is occasionally absorbed by thermometer makers. Nor is play devoid of risks. Lead poisoning from sucking toys is not unknown among children, and alcohol in toxic quantity is occasionally absorbed in secret by the most unlikely individuals.

Apart from these toxic causes, there has to be considered the effect of almost any type of work upon certain diseases. The patient with morbus cordis may be well able to do the work of a clerk, and quite unable to shovel coal. The phthisical hairdresser working below ground by artificial light may take a new lease of life if he can find open-air employment. The compatibility of work with the disease must be considered carefully in every case separately. Much of a man's success in practice depends upon the wisdom with which he can arrange, satisfactorily to the patient, such pathological and financial compromises. It is useless to advise a poor man to spend two years in a Swiss sanatorium. Such counsel merely oppresses the patient with the hopelessness of his case, and may thus actually shorten life.

Again, a man suffering from a raised systolic and diastolic blood-pressure and arteriosclerosis is working reasonably hard as a stockbroker. His income is £2000 per annum and his life is insured well. From the point of view of his health alone it may be strongly advisable for him to cease work. If he does he loses his earned income, and becomes unable to support his wife and three children at school without drawing upon capital.

If he continues at work he may—or may not—die in five years' time. By then his family will have found its financial feet without his help. To him five years of useful work has been worth twenty of invalidism.

The doctor who insists upon his retiring forthwith will probably be disregarded. The one who explains carefully the pathological chances will retain his patient's confidence, and may so, by periodic examinations and careful advice, be able to give valuable assistance.

It is not the doctor's function to insist inflexibly upon certain measures. He should be able to explain in accurate terms his opinion of the condition present and its probable outcome. It is the patient who, knowing all the circumstances of his own life, must ultimately decide.

There remain two further matters that may yield important information. Has the patient lived abroad? Has the patient been carefully examined at some previous period? Inquiries regarding the former will open the eyes to the possibility of a tropical disease, and regarding the latter will prove that upon the former occasion, such as life insurance or examination for the Army, Navy or some other service, the patient was in good bodily health. The tropical diseases of importance are malaria, dysentery, amœbic or bacillary, ankylostomiasis, bilharzia infection and infection by other worms.

Past diseases.—Accurate knowledge of diseases suffered from in the past can be useful for three main reasons. Some complaints are limited to one attack, complete immunity being produced; others generate sequelæ that follow weeks, months or years after the original attack, earning sometimes the dignity of an independent title. Others will predispose to attacks of some otherwise unconnected disorder.

Well-known diseases that are as a rule only suffered from once are variola, varicella, scarlet fever, mumps, pertussis, typhoid fever, syphilis.

Common diseases followed by sequelæ are rheumatic fever, chorea, scarlet fever, diphtheria, producing cardiac lesions, scarlet fever, tonsillitis, diphtheria producing nephritis, pneumonia, influenza producing fibrosis of the lung and bronchiectasis, syphilis, producing a host of cardiovascular nervous and other disorders.

It is a valuable rule when trying to gauge the likelihood of such a sequence invariably to ask, on learning of an acute specific fever, "How long were you," or "How long was your child away in the fever hospital?" or "How many weeks were you in bed with pneumonia?" Any residence in a fever hospital of over eight weeks for scarlet fever or diphtheria argues strongly in favour of some complication at the time, and for the increased probability of some serious sequela now.

With regard to syphilis, it is desirable to inquire as to the type, length of time and the vigour of the treatment given.

The frequency with which tuberculosis may follow directly upon measles and pertussis has already been mentioned.

Certain epidemics of true influenza appear to lower the immunity of the lungs against pneumococci and streptococci and other organisms; other epidemics appear to produce susceptibility to similar infections of the middle ear.

Past habits and environment.—The conditions of a patient's life in the past are also of importance. The state of his home as regards ventilation, light, humidity and size of rooms, the presence of overcrowding with the attendant difficulty of keeping clean; the type and quantity of the diet and the type and the proportion of fresh uncooked food in it; his habits as regards alcohol; these must all be defined. Finally, the psychological conditions of the home have a great effect upon health. Anorexia nervosa in hysterical young girls, enuresis in small children, pseudo-angina, unexplained sleeplessness or dyspepsia may all have as their basis domestic friction or misunderstanding.

The patient's work must also be considered. Does it give too much or too little exercise?

Does it expose to any added risk, chemical, bacterial or physical. A tabetic in a power station is in greater danger than is a careful worker in a lead factory.

FAMILY HISTORY.

Family history may have an importance relative to the diseased process, either by virtue of inherited

characteristics, or by that close approximation of individuals which is inherent in family life, and so by direct and continued infection.

Certain conditions are very curiously regular in their appearance. Hæmophilia and pseudohypertrophic muscular dystrophy are transmitted by the females who escape the diseases to the males who manifest them. Marie's hereditary ataxy, alkaptonuria, acholuric family jaundice, are also, as a rule, familial diseases.

So by all gradations a group is at length reached which is not as a rule strikingly familial in distribution, but where not infrequently familial examples undoubtedly occur. This includes such conditions as arteriosclerosis, cancer, diabetes, asthma and hay-fever. It is this group that led the older physicians to speak of diatheses, by which was meant a particular type of human soil that would be by its nature predisposed to produce certain definite diseases or groups of diseases.

Again, the position in the family seems to have some influence upon disease incidence. The eldest son is apparently more likely to be the victim of congenital pyloric stenosis; the last of a long family is said by some to be more liable to mongolianism.

Race, a rather larger division than that of family, determines the appearance of such diseases as amaurotic family idiocy and sickle cell-anæmia. The former is practically confined to Jews and the latter is restricted to negroes. Diabetes and Gaucher's disease are both common among Jews. Moreover, races differ in their resisting power. Tubercle and pneumonia are widely fatal to coloured peoples and syphilis and yellow fever the reverse.

The infective side of family influence upon disease is most apparent in connection with tubercle and syphilis. Many clinicians deny completely that the undoubtedly frequent family incidence of tuberculosis is due to any inherited weakness of resistance at all, and the evidence certainly appears to favour the view that the child of a tuberculous mother is more frequently tuberculous because of the excessive and repeated doses of the infecting organism.

The effect of syphilis as a marital or congenital infection needs no explanation. A succession of miscarriages preceding the birth of a viable child or apart from this should always arouse suspicion.

A third disease where there is an undoubted family incidence is acute rheumatism. It is common in a children's hospital to treat successively the children in one family as in-patients and out-patients for rheumatic disease of the heart. To what extent "diathesis" or infection are responsible it is difficult to determine.

EPILEPSY: ITS TREATMENT AND PROGNOSIS.

LET it be clearly understood that the term "epilepsy" as used in this article only covers the series of events classified under idiopathic epilepsy. The protean nature of such a malady requires that the treatment thereof should be considered from several points of view; but, at the outset, it may definitely be stated that there is no single specific remedy. For convenience the treatment of epilepsy will be discussed under the following headings:

1. The attack itself.
2. Medicinal.
3. Dietetic.
4. Institutional
5. Surgical.
6. *Status epilepticus.*

1. The Attack Itself.

The first consideration may be given to the question as to whether the attack may be arrested once the aura has commenced. The attacks in which abortive measures are likely to prove most successful are those with a peripheral aura; and the common method of ligaturing or compassing the arm as soon as the aura is felt in the hand is well known. Many other methods have been devised, but according to Herpin the most effectual are constriction and forced movement in the opposite direction. There is still doubt, however, as to the value of such treatment, as so many epileptics have minor attacks consisting of an aura alone, as well as full seizures. At most these measures are only of temporary use, becoming ineffectual as the disease progresses.

Once the seizure has commenced all that is usually required is to lay the patient on the floor and protect him from injuring himself. Active restraint of movement frequently appears to prolong and intensify the convulsive movements. Injury to the tongue may be avoided by inserting the handle of a spoon or a cork between the teeth; a pillow behind the head will avoid bruising of the scalp. Loosening of the collar may prevent facial congestion or may relieve it. The post-paroxysmal sleep should be encouraged, as it renders the subsequent headache less severe. Patients who suffer from nocturnal attacks are in danger of suffocation from rolling over on the face during the convulsion, but this danger is small, and Wilson relates how in 1398 patients treated as in-patients for epilepsy

15 died; of these only one or two died from asphyxia. To prevent such an accident careful attention is needed till the fit is over; consequently, in severe cases it may be advisable for another person to sleep in the same room.

2. Medicinal.

Though there is no single specific remedy in the treatment of epilepsy, the alkaline salts of bromine come nearest to this definition. Bromides may arrest the seizures immediately or within a short period of administration, temporarily or permanently. Bromides may reduce the severity and frequency of the attacks. Lastly, bromides may have no influence whatsoever on the attacks. It is of importance when administering bromides to study the amount, the frequency and the time of administration in individual cases. When nocturnal attacks occur alone, a dose of 15 to 30 gr. at bedtime is usually sufficient; but it should be remembered that nocturnal attacks may cease under treatment and diurnal attacks commence, so that in such cases, especially if the attacks are at long intervals, no medication at all may be more advantageous. With seizures occurring only during the day a dose of bromide salts taken after breakfast along with a smaller dose at bedtime proves most efficacious. The common practice of giving bromides thrice daily has many opponents amongst those dealing with large numbers of cases. The relative value of the various salts is difficult to assess: the potassium and sodium salts are possibly more useful, but a mixture of the three will sometimes act better than any single salt. The bromide salts are most conveniently given in water alone: the addition of arsenic appears to have little effect on the symptoms of bromide intoxication.

Within recent years luminal (phenyl-ethyl-barbituric acid) has become a recognized adjuvant in the treatment of epilepsy. It is given in a dose of ½ to 1 gr., with a maximum total in one day of 3 gr. This drug is of little value in cases of *petit mal*, and is much more efficacious in *grand mal*, especially if given with bromides. Sodium luminal, a soluble salt, is much less potent than luminal: Fox found that the majority of cases benefited at first, but that a progressive tolerance was established to this drug.

Belladonna either alone or in combination with bromides is sometimes effectual. In this case the dose has to be pushed above the usual pharmacopœial upper level. Chloral has also been found useful, but may lead to troublesome toxic symptoms. Paraldehyde in small doses may benefit the patient, but the aroma associated with its administration is a frequent contra-indication. Borax in the hands of the French has found much favour, although in this country similar favourable results have not been encountered.

3. Dietetic.

In considering the question of diet in its relation to the treatment of epilepsy two primary factors require consideration, namely, the nature of the condition leading to periodic fits, and whether this can be influenced by food or not. Many authorities regard epilepsy as a manifestation of disturbed metabolism, and Collier considers it a "metabolic dyscrazia." It is also well known that many epileptics are notoriously big eaters. From the purely biochemical stand-point Gosden and Fox, in a small series of cases, found by the lævulose tolerance test that there was a definite liver deficiency in epilepsy; but the value of this test as one of hepatic efficiency is doubtful. McQuarrie and Keith in a series of careful observations found an abnormality in the acid-base equilibrium, but concluded that this was not the fundamental factor in the production of fits. Gosden, Fox and Brain conducted an investigation into the blood cholesterol of epileptics and found it to be abnormal: they also found that preceding a fit, the blood cholesterol tended to fall. Krainski suggested ammonium carbamate as the causal factor. Many other works could be referred to which deal with this aspect of the disease: but it may be said that, as yet, no definite proof is forthcoming as to the character of the biochemical disorder. Be that as it may, Geyelin in 1921 found that rigorous starvation considerably reduced and often caused a complete arrest of fits. Later Wilder and Peterman suggested that the benefit thus derived was not due to starvation, but to ketosis produced by the abstinence from food. Working on such a hypothesis they were able to produce considerable amelioration of the number of fits in children by putting them on a diet calculated to produce a ketosis. Since then, their observations have been repeated by many who have found definite improvement in a certain number of cases. Brain and Strauss, in a review of the subject, found that a ketogenic diet freed 31% of epileptic children from their attacks and reduced the number of attacks in a further 23%. The elaboration of such a diet is, however, fraught with some danger, as shown by Nelson, who found that on a ketogenic diet the output of calcium and phosphorus exceeded the intake. The prolonged use of such a diet may therefore deplete the bodily stores of calcium and phosphorus, much to the detriment of the patient, unless enough calcium and phosphorus is given in the diet. Working out the diet is an elaborate calculation and is beyond the sphere of

this article, but reference to modern text-books of neurology or dietetics will furnish the necessary facts.

Apart from the special diet, there is little doubt that a careful regulation of quantity, quality and time of consumption of food may benefit epileptics. Frequent small meals are of more benefit than one or two large meals: the large meal at night should be carefully avoided. Sometimes a salt-free diet will permit of smaller doses of bromide controlling the fits, the type of convulsion most favourably influenced being the major seizure.

4. Institutional.

How frequently it happens that a case of severe epilepsy is admitted to hospital, and the house physician, in high hopes of seeing a fit, is still disappointed at the end of several weeks. The alteration of hours, of diet and of surroundings all benefit the epileptic: but probably what is of more consequence is the ward discipline and the regular habits inculcated thereby. On account of this it is found that epileptics do well in institutions. But apart from these considerations patients with many attacks and possibly some mental deterioration should be treated in institutions: their attacks and mentality have a detrimental effect on other members of a family. Also in institutions regular routine and outdoor employment help to alleviate the attacks, and the patients themselves become happier. Yet institutional treatment should at present only be employed in severe cases.

5. Surgical.

Since the advent of cerebral surgery, surgeons have shown a willingness to attempt to alleviate the epileptic by decompressive operations: this has been especially so in cases of local epilepsy. And there is little doubt but that, in selected cases, decompression may benefit the patients. When fits of a local type follow a definite trauma to the head, operation in the early stages may be advisable in order to correct any local damage if possible, and also in order to prevent the development of the convulsive habit. Generally speaking, surgical interference will benefit nearly all cases for a short period, but the attacks return with increased frequency and intensity. So it may be said that, as yet, the surgeon has not offered any radical means of alleviating this dire complaint.

Consideration as to the duration of treatment is worthy of a few words. Once medicinal treatment has been instituted and the attacks have been completely alleviated the drugs should be continued for a period of two years; the dose may then be gradually lessened until a minimum is being given, and after a low dose for some weeks the drugs may be stopped. The sudden cessation of drugs cannot be too strongly condemned on account of the severe risks to the patient. The literature abounds with examples of *status epilepticus* coming on after the sudden cessation of drug treatment. *Status epilepticus* is a condition dangerous to life.

6. Treatment of Status Epilepticus.

Rapidly recurring attacks with intervening periods of such short duration as hardly to permit the return to full consciousness constitute this syndrome. If the attacks are not early controlled the patient is likely to die. At post-mortem the organs will show a state of acute fatty degeneration. To treat such a condition the exhibition of powerful drugs in large doses is indicated. Bromides and luminal are as a rule unsatisfactory, morphia and hyoscine are unreliable, while ether or chloroform anæsthesia are attended with considerable risk. Two avenues of treatment are open, namely, the administration of paraldehyde in doses of 4 to 6 drm. with an equal quantity of olive oil *per rectum*; this method has proved of inestimable value and Collier strongly advocates it. Recently Weiss has used luminal-sodium intravenously, but in his publication he draws attention to the danger associated with such therapy; he injected the solution slowly, and found that the dose necessary to control the attacks varied from 0·4 to 1·0 grm. in twelve patients.

Prognosis.

Hippocrates, when describing the "Sacred Disease," wrote: "If it attacks little children, the greater number die. . . . If youths and young adults recovery may take place. . . . When it attacks people of advanced years it often proves fatal. . . . When the disease has prevailed for a length of time it is no longer curable." And in spite of the advance of medical science this remains substantially true.

In assessing the prognosis of an individual case help may be obtained from various quarters. Heredity has an undoubted influence: cures are less likely to occur in those with a family history of epilepsy than in those without, while the former also show less general improvement than the latter. Epilepsy commencing under the age of 10 years is most unfavourable as regards arrest or improvement, and such cases are most liable to become confirmed epileptics. The age of onset most favourable for improvement is between 16 and 20 years; above that cures decrease in numbers. The duration of the disease before regular treatment is also important, and the earlier treatment is instituted the more hopeful is the prognosis. Patients with daily attacks react poorly to treatment, while those with infrequent attacks respond better. The character of the attack is of importance, and there is little doubt that minor attacks are less amenable to treatment than major attacks: further, minor attacks, if frequent, are more commonly associated with progressive mental deterioration than major attacks. In conclusion, it may be stated that a cure of epilepsy is exceedingly difficult to establish, while a possible criterion of cure is the absence of attacks over a period not shorter than ten years.

In the preparation of this article the works of Collier, Turner, Wilson, Holmes, Brain and many others have been consulted and greatly appreciated. E. A. C.

A CASE OF RAT-BITE FEVER.

A CASE of rate-bite fever, recently in Mary Ward, is of interest from its comparative rarity and is here reported.

The patient was a Swiss girl, æt. 19, speaking practically no English, and employed as a children's governess at Horsham.

History.

At the beginning of June, 1929, patient picked up a rat, imagining it to be a rabbit, in order to rescue it from a dog. The rat bit her on the right index finger. The bite was treated with iodine, and *la blessure est fermée*.

About two weeks later the finger and arm became swollen, she suffered from sore throat and was febrile. The finger was incised but there was very little pus.

Four days later (on July 2nd) the girl was ill and febrile; she was admitted to a nursing home and the finger again incised.

Since that date until admission to St. Bartholomew's Hospital on August 13th her temperature chart has, in her own words, shown *très jolies montagnes* every four days, when her temperature used to rise to 105°. Two of these attacks were observed in hospital and her condition in them is recorded below.

Before admission she was treated, amongst other drugs, with arsenic and quinine, but made no improvement.

On physical examination during an afebrile period no abnormality or disease was discovered. On the posterior aspect of the right index finger about its middle was a punctured wound partly covered by scab and exuding serum. There appeared to be some thickening of the underlying periosteum, but an X-ray film revealed no abnormality in the phalanges. This wound soon became dry and healed. The epitrochlear, axillary and other lymph-glands were not palpable and the spleen was not enlarged.

In a febrile period patient was very distressed and restless, flushed, and at the height of the attack she shivered a little, but had no definite rigor. She vomited copiously a watery fluid containing bile and mucus. Over the abdomen and chest and to a lesser extent on the limbs were purple-coloured erythematous patches about 2 in. by 2 in. with areas of normal skin between them. This rash gradually faded and had completely disappeared in two days. There was no local change in the wound or any glandular enlargement.

INVESTIGATIONS.

Urine.—Natural both in attacks and between them.

Blood-count.—Hæmoglobin, 60%; red blood-cells, 4,160,000; white blood-cells (apyrexial), 9200; white blood-cells (pyrexial), 20,000; polymorphs, 17,200; lymphocytes, 1800; large mononuclears, 600; eosinophiles, 400.

Wassermann reaction.—Serum anti-complementary.

Sigma reaction.—Negative.

Blood-films.—No spirochætes seen by dark-ground illumination. A mouse inoculated with the patient's blood remained well.

The effect of intravenous arsenical preparations can be seen in the chart; the patient was afebrile after the second injection and remained so. In all 0·3 grm. of N.A.B. was given and 2·4 grm. of neokharsivan. She was discharged well on September 9th.

This case showed the more usual features of the disease, but no glandular enlargement, local or general, occurred. There was no headache or pain in the limbs—symptoms which are often severe. The bouts of fever are usually of longer duration than in this case. Only the later bouts of fever are shown in the chart. The earlier ones were of three or four days' duration.

Course of the disease.—The disease tends to recover spontaneously after a relapsing fever lasting for months. The mortality is said to be 10%, and death if it occurs is usually in the first febrile attack from toxæmia, or later from nephritis or exhaustion. Endocarditis is also described as a complication.

History.—Miyake, of Japan, first described the disease in detail in 1899, but much earlier references to it occur in Japanese medical literature. Sir Thomas Horder was the first to describe the disease in this country in a case under his care at the Royal Northern Hospital. In 1909 he wrote: "I think it probable that the *materies morbi* is of the nature of a protozoon, but in support of this I can adduce no evidence." Ogata ascribed the disease to a sporozoon, but later changed the causal agent to an aspergillus. Schottmüller grew an organism of the streptothrix group from a case, and in 1916 Blake grew a similar organism from a case, which was, however, in all probability not rat-bite fever, but a septicæmia and ulcerative endocarditis arising from an infected rat-bite.

It was left to Japanese workers, Futaki, Takaki, Taniguchi and Osumi, to isolate the causal agent. It is a highly motile spirochæte, with a body up to 2 to 5μ in length and terminal flagellæ. This spirochæte was isolated in a high proportion of cases suffering from the disease from the blood, skin and lymph-glands, both on direct examination and, more easily, by intraperitoneal inoculation of mice and other animals. The disease thus transmitted to animals is comparable to that in man in producing a relapsing fever, although animals infected do not always produce the disease by biting others and the exact mode of transmission is unknown. About 3% of Japanese rats are infected with the spirochæte, but the organism is not found in the saliva of these infected rats.

The disease is rare even in Japan. As far as I have been able to trace, only two other cases have been admitted to St. Bartholomew's Hospital since 1910.

Another case, tabulated as rat-bite fever, showed neither fever nor rat-bite, but developed subcutaneous swellings, following a dog-bite, which disappeared with N.A.B. injections. A case in 1926 under Sir T. Horder showed good signs and symptoms of the disease, but no spirochæte could be isolated. A case in 1927 under Prof. Fraser was reported in the Hospital *Reports* (1928, lxi) by Allott and Joekes. In this case Dr. Joekes isolated the organism by mouse inoculation with the blood of the patient.

I am indebted to Dr. Gow for permission to report this case, and to Dr. Bradford, of Horsham, for the temperature chart taken before admission and for the early history of the case.

E. G. C. DARKE.

THE LIFE AND WORKS OF EDWARD JENNER.

(*Wix Prize Essay*, 1929.

I.

"Scire potestates herbarum usumque medendi
Maluit, et mutas agitare inglorius artes."

VIRGIL.

IN 1770 came to London the youth who was destined to become the most famous man of his day, Nelson and Wellington not excepted. His name was Edward Jenner, and his native town was Berkeley. He was nineteen years of age, and he had received the education of a gentleman's son, his father having been the vicar of Berkeley. He had studied

surgery for six years in the manner of those days, as apprentice to a local surgeon, and he was now coming to London to complete his medical education by two years' work under the great John Hunter, in whose house he was to live as pupil-resident. He had no distinctions except a remarkably good knowledge of natural history based solely upon his own observations, from his earliest youth he had shown a keen interest in this kind of knowledge; he collected fossils, birds' eggs, nests of the dormouse and such odds and ends; he had a little museum of his own, carefully labelled.

The London to which he came was the ill-lighted, badly-paved London of the coffee-houses. The lad may have seen Johnson thumping the table, Boswell writing down in his notebook the mighty utterances of his friend, Goldsmith pathetically trying to distract attention from his ugly, smallpox-pitted face by the gay finery of his clothes; he may have gazed with wonder at these and other great men, whose fame he little expected to eclipse. But surely to him the most wonderful thing in London was John Hunter's house, with its menagerie and museum. Hunter soon noticed the keenness of his pupil and allowed him to prepare specimens for him. He recommended him to Sir Joseph Banks, that Mæcenas of science, who gave him the work of preparing and arranging the objects of interest brought home by Captain Cook, and even offered him the position of naturalist on Cook's next voyage. Jenner, however, did not lose sight of the fact that he was sent to London to learn medicine; he therefore declined the offer, as he subsequently declined to take part in Hunter's scheme for setting up a School for Natural History.

Jenner walked the wards of St. George's Hospital, where he was remarkable for the neatness of his dissections and his success in minute injections.

A firm friendship sprang up between Hunter and his pupil, and after Jenner's return to his native town a correspondence was kept up between them. All Jenner's letters to Hunter are lost, but Hunter's letters to Jenner, which have been preserved, give us some interesting glimpses of how he recruited his famous menagerie. Hunter encouraged the younger man to research, first and without much success upon the hedgehog, and later upon the cuckoo. These observations were more fruitful; they involved no mutilations, but only observations which were frequently delegated to his nephew and apprentice. The conduct of the young cuckoo described by Jenner was so amazing that for many years his account has been ridiculed by ornithologists, and the apprentice has even been accused of inventing it, to save himself the trouble of watching. The recent photographs and cinematograph film by Mr. Edgar Chance have, however, established the truth of Jenner's observations. His paper on the subject was written in the form of a letter to Hunter, who brought it before the Royal Society in 1787; Jenner was subsequently proposed for the Fellowship and elected in 1789.

Jenner's observations were made in the spare moments of a busy life, for he quickly built up a successful general practice in Berkeley. He visited Gloucester and Cheltenham, where, on account of his London experience, he was often called in consultation. Once during the illness of the senior surgeon he operated successfully on a strangulated hernia at Gloucester Infirmary. He was dissatisfied with the uncertain action of tartar emetic, and devised a better method of preparing it. Hunter wrote his approval in a characteristic breezy letter. In a letter to Dr. Parry, of Bath, Jenner gives a quaint account of his discovery of ossification of the coronary arteries during an autopsy; this was the basis of his suggestion that angina pectoris was due to some morbid change in the coronary arteries. "At this time," writes Jenner, "my very valued friend, Mr. John Hunter, began to have the symptoms of angina pectoris, this circumstance prevented any publication of my ideas on the subject." He mentioned these ideas to Cline and Home, who were sceptical, but Jenner's diagnosis was soon verified by Home's autopsy on Hunter, who died of his disease in 1793.

Some minutes of the Gloucester Medical Society, published for the first time in 1896, contain records of the foundation of the society at Rodborough in 1788, with five members, all personal friends—Parry, Hicks, Jenner, Ludlow and Paytherus. Extracts are given from papers by Jenner on hydatids of the kidney (on which he consulted Hunter), swine-pox, mitral stenosis; and reference is made to a paper on disease of the heart following acute rheumatism, illustrated by dissections. This paper is unfortunately lost, otherwise we might be able to attribute to Jenner the discovery of this important association. Jenner was a member of another medical society which met at Alveston; he continually tried to interest this society in cow-pox, and we hear that they threatened to expel him for being a bore. His love of experiment was shown by his making the first balloon seen in Gloucestershire.

That he was popular with his patients as well as with his fellow-practitioners we know from reading his letters. Educated people enjoyed his conversation, and used to accompany him for miles on his rounds, even at midnight.

In 1792 his practice was so large that he gave up surgery and obstetrics and devoted all his attention to medicine, taking the diploma of M.D. from the University of St. Andrews.

He took a great interest in public affairs, and held the offices of Mayor of Berkeley and Justice of the Peace of Gloucestershire.

II.

"This is an Art
Which does mend Nature: change it rather; but
The Art itself is Nature."

SHAKESPEARE.

Of Jenner's boyhood, spent in his "cool sequestered vale," one episode was well stamped upon his memory. At the age of eight he went through the regimen of inoculation for smallpox. This ordeal involved a preparation period of six weeks, during which the patient was bled and purged, and kept on low diet, with plenty of fluids "to sweeten the blood"; then came the inoculation and course of the disease. This was followed in Jenner's case by a long period of bad health, with night terrors for many years to come.

Smallpox was never absent from England in the eighteenth century, and every person was tolerably certain of contracting it sooner or later. For those who boasted of not having had smallpox there was the saying, "Nemo ante obitum beatus." At a time when England's population was about seven millions, smallpox carried off 44,000 people a year, and the only means of acquiring immunity was by an attack of the disease itself. Death or disfigurement was the price paid for this immunity. Almost any woman whose complexion was unsullied was ranked as a beauty in those days. In foreign countries the toll was even heavier, some tribes of Indians in North America having been completely exterminated by the disease.

In the latter three-quarters of the eighteenth century the cost in England was lower. Direct inoculation had been introduced from the East, and was advocated by Dr. Richard Mead in a work of 1747. The operation was in the hands of specialists, who were not always medical men, and perhaps the practice did as much harm by spreading the infection as good by protecting those who were inoculated. It was left for Jenner to expound how the individual might be protected without risk of conveying his disease to others, and thus salvation was offered from the most terrible scourge which afflicted humanity at that time, and Jenner saved more lives and averted more misery than it had fallen to the lot of any man to accomplish from the dawn of history to his day.

The story of Jenner's great conception of preventing smallpox by inoculation of cow-pox is classical in its brevity and simplicity. The chance remark of a dairymaid in Ludlow's surgery at Sodbury "rivetted Jenner's attention," and laid the foundation of his future observations to be published to the world thirty years later. During this interval he seems to have set the idea aside, and returned to it again and again with that curious mixture of perseverance and dilatoriness which is so characteristic of him. "People do not know," he says, "how often professional men are liable to interruptions."

The notion that an attack of cow-pox conferred immunity from smallpox was prevalent in many parts of England among farmers and milkers; it was known to the inoculators of smallpox, but few believed in it, since exceptions to this immunity were common. Reference to this belief is found in the works of Beddoes, Woodville and Adams. Many people are said to have infected themselves with cow-pox intentionally in order to obtain this immunity. Inoculation of cow-pox was actually practised with success by Jesty in Dorsetshire, and by Jensen and Plett in Holstein, but it appears that both were deterred from continuing the practice by the severe inflammation which sometimes resulted. Let Jesty and Plett both have the credit, that is their due, but they both passed away and left no records of their observations.

Jenner encountered many difficulties in his investigations. Cow-pox was a rare disease, and the term was applied to anything in the way of eruption, excoriation, abrasion or fissure that could attack the teats and udders of cows. Horse-grease was another all-embracing name, which is nowadays applied only to seborrhœa of the heels, but Jenner applied it to the now rare horsepox, which also attacks the heels of horses. The filth and darkness of the country cow-houses made observations difficult and unpleasant. Jenner had to avoid taking all sorts of extraneous matter; he had to decide whether matter either from the cow or from the human arm should be taken in the vesicular, pustular or ulcerative stage of the disease. With such materials it is not surprising that some of his first efforts were followed by "erysipelatous inflammation."

His activities were ridiculed by his colleagues; hence we find him confiding in his friend Gardner as they rode together between Gloucester and Bristol one day in 1780, because "Gardner will not talk about it," and because if anything untoward happens, "I shall be made, especially by my medical brethren, a subject of ridicule, for I am the mark they all shoot at." In 1787 he went with his nephew George into a stable to see a horse with diseased heels. "There," said he, "is the source of smallpox. I have much to say on that subject." In 1788 he took his drawing of a cow-poxed hand to London and showed it to Hunter and to Clines, who regarded it as an "interesting and curious object." "Why think—why not try the experiment," was Hunter's advice. Others sneered at Jenner's views, particularly Haygarth, the author of the isolation method for treating smallpox, which failed so dismally in Chester in 1794.

Jenner was discouraged, and was silent on the matter for some years. In 1795, however, Fosbrooke tells us that his work really began in earnest. In 1796 his classical experiment was made; he inoculated a boy of eight with cow-pox matter from a dairymaid's hand. The degree of severity of the reaction was not accurately described, but the boy was found to be immune from smallpox. Jenner describes this experiment in a triumphant letter to Gardner. He waited to collect a few more cases of failure of smallpox inoculation after cow-pox; he then felt enough confidence to write his paper on "Cow-pox," which was intended for the Royal Society.

This paper is preserved in its original manuscript at the Royal College of Surgeons. The author describes "grease" and cow-pox, and states the supposed connection between them. He then describes ten cases in which smallpox inoculation failed after cow-pox, and three cases in which it succeeded after "grease." He states one case in which cow-pox occurred three times, and cannot explain it. He describes the experiment on the boy Phipps. In conclusion he proposes to substitute cow-pox inoculation for smallpox inoculation.

This paper never came before the Society, since its appearance is not recorded in the archives. Probably Home showed it informally at a Council meeting, where it was rejected for further corroboration, and Jenner was advised not to risk the credit he had already gained by presenting anything so ostentatious and so much at variance with established knowledge on such slight evidence.

Jenner soon recovered from this blow; he was accustomed to the opposition of his colleagues. He set to work with renewed vigour to collect more evidence. But no cow-pox could be found anywhere in his neighbourhood. His impatience can well be imagined; he felt that the death of every smallpox victim lay at his door, if he relaxed his efforts or delayed a day longer than necessary in publishing his views.

Early in 1798 the cow-pox broke out again, a calamity to the farmer; but we can picture the joy of Jenner as he clapped his broad-rimmed hat on his head and his silver spurs to his heels and rode forth, a strange knight-errant, to make an end of a long, long quest.

III.

"The one talent which is most worth all other talents in human affairs is the talent of judging right on imperfect materials, the talent if you please of guessing right."
STEPHEN.

In 1798 Jenner published his famous *Inquiry*, a quarto volume of seventy pages, upon which his fame rests. It was dedicated to Dr. Parry, of Bath, and contained the substance of his rejected paper with a few additions. It was described by Baron as "the triumphant conclusion of more than thirty years' reflection."

Briefly, he held that the teats of cows are subject to various eruptions, of which only one was the true cow-pox; that it was derived from the "grease" of the horse; that cow-pox produced no general eruption in the human subject, and that any indisposition resulting from its inoculation was due to irritation and inflammation, not to the virus, and was therefore accidental and not essential; that matter for inoculation, whether of horse-pox, swine-pox or cow-pox, should be used before it becomes purulent, otherwise it will be ineffective; when smallpox matter is used to test the success of vaccination, the same rule should be observed; that the immunity conferred by proper vaccination is permanent. He assumes that cow-pox is smallpox of the cow, and coins the terms variolæ vaccinæ; also that "grease" (horse-pox) is smallpox of the horse; both these views have been hotly disputed, but are now regarded as correct. That the latter disease is parallel with the former and not parent of it, as Jenner thought, is a detail. The view that immunity was permanent was his most serious error and produced much perplexity later on. Eleven years later he wrote, "The human frame, when once it has felt the influence of cow-pox, is never afterwards at any period of its existence assailable by smallpox," and to this view he held tenaciously for the rest of his life.

It has been noticed recently that the *Inquiry* contains a description and explanation of the phenomenon of anaphylaxis, which is attributed to the dynamic effect of a permanent change in the blood during life.

The *Inquiry* came in the nick of time; by it Jenner transformed a local belief to a national one, and obtained first place as a medical observer and pioneer. The first man in London to try vaccination was Cline; he was amazed by its success and wrote to Jenner for more lymph, urging him to come to London and set up a practice there, promising him an income of £10,000 a year. Jenner did not accept this suggestion, and it would appear that his stock of lymph was exhausted. A fresh stock was obtained in December, 1798, but gave bad results; things were at a standstill.

At this point the scene changes to London, where an outbreak of cow-pox in Gray's Inn Lane provided material for a long series of experiments by Pearson and Woodville; the hands of the dairymaids presented an appearance exactly like the illustration in Jenner's book. Banks and others came and were struck by the similarity. A specimen of the lymph was sent to Jenner, who used it with excellent results, and similar specimens

were sent to Berlin, Vienna, Geneva, Hanover, America and elsewhere. Woodville, who was resident inoculator in the Smallpox Hospital, published a book based on six hundred experiments, reporting a general pustular eruption, which he took to be one of the phenomena of cow-pox. Jenner held that this result was due either to contamination of the vaccine lymph with smallpox, or to the inoculation test having been made too soon after vaccination. Woodville realized his mistake just a month after his book was published.

In March, 1799, Pearson was already lecturing on vaccination as if it were his own discovery, and Jenner received a letter from his nephew in London urging him to come and retrieve his laurels, or his fame and fortune would be lost. Pearson determined to organize an institute for vaccination; he obtained distinguished patronage, and wrote offering Jenner the position of "corresponding physician." Jenner declined with some asperity. The errors of Woodville and Pearson had involved him in a harassing correspondence with critics. Jenner's "Golden Rule" was to take the lymph from the arm at an early stage before the areola had appeared. This rule was openly scouted by several vaccinators, and entirely neglected for a long time in America, where a shirt-sleeve stiff with pus was cut into strips and sold for "kine-pox."

After publishing *Further Observations* in April and *Continuation of Facts and Observations* in December, 1799, Jenner came to London, and with the help of Lord Egremont managed to defeat Pearson's proposal for a vaccine institute by making similar proposals of his own. He had the satisfaction of being presented to the King by Lord Berkeley, and also to the Prince of Wales. He spent six months in London promoting the cause of the new inoculation; he vaccinated the whole of the 8th Regiment, which operation was complicated by the fact that they were all suffering from scabies and by other difficulties. The sailors of the fleet were all vaccinated about this time, and a gold medal was given to Jenner in commemoration of this event.

The Origin of the Vaccine Inoculation was published in 1801. Jenner was soon afterwards obliged to present to Parliament a petition for a grant of money. Stress was laid on the fact that the new discovery was made known to all, whereas the author could have reaped a harvest of £10,000 a year if he had kept his secret to himself. He had been put to great expense; his postages often came to £1 a day. So great was the call on his time and pocket by those who, in all parts of the world, were anxious to obtain information from him, that he called himself the "Vaccination Clerk of the World." Pearson opposed the petition on the ground that the discovery was not Jenner's, and that he had not played the chief part in making vaccination current coin, but the decision of the House of Commons was unanimous in favour of Jenner, and a grant of £10,000 was made.

In 1803 several friends in London resolved to form a society with Jenner as president, under distinguished patronage. Their object was to vaccinate gratuitously, and to send virus to all parts of the world. Thus came into being the Royal Jennerian Society; Jenner came to London and started a practice in Mayfair, but this proved a failure. His grant was not paid until 1804, and he was regarded as a public servant in consequence of it. He was called upon to vaccinate the poor gratuitously, sometimes as many as 300 a day. He gave up this practice before long, and the Royal Jennerian Society, deprived of his presence, lost touch with his teachings and soon went to pieces through bad management and lack of funds.

In 1806 Jenner made a second petition for money, and after a favourable report on his work from the Royal College of Physicians, £20,000 was granted. Vaccination was commended. "Its truth seems to be as nearly established as the nature of such a question admits. The public may look forward to the end of the ravages, if not of the existence of smallpox."

In 1808 Jenner spent five months in London organizing the National Vaccine Establishment, acting as director. During his unavoidable absence owing to the illness of his son, the officers were appointed by Sir Lucas Pepys, Jenner's nominations being ignored; he, therefore, resigned, but gave the institution the benefit of his advice when needed.

IV.

"At pulchrum est digito monstrari et dicier, Hic est."
PERSIUS.

Jenner's second grant was accompanied by minor grants from various public bodies, and honours poured in from all quarters. Forty-seven diplomas, honours and addresses were awarded to him, and before 1812 he was made an honorary member of almost every medical society in Europe. The freedom of the cities of London, Edinburgh, Glasgow, Dublin and Liverpool was conferred on him, and a service of plate from Gloucestershire was one of his earliest gifts. He appreciated most the praise of the members of his own profession; honorary degrees and fellowships were conferred on him, and most of the English medical societies passed resolutions in his honour. Only one corporation of rank from which a favour was sought refused. The Royal College of Physicians would not have him save by the usual examination—a decision for which it has always withheld any explanation. Jenner, hearing that the examination included a paper in Classics, exclaimed, "I would not do it for a diadem. It would be irksome beyond all measure. I would not do it for John Hunter's museum!"

It is marvellous to see how quickly and ubiquitously vaccination spread over the world in the three years which followed the publication of the *Inquiry*. Outside his own country Jenner's success was complete.

In England, although most medical men and the best in the profession, such as Abernethy and Lettsom, saw that a great discovery had been made, yet the movement was strongly opposed by an influential section of the profession. The earliest and most formidable antagonist of vaccination was Dr. Ingenhousz, of Vienna, an experienced inoculator, who happened to be on a visit to England at the time of the publication of the *Inquiry*. He held that cow-pox might give immunity from smallpox in a few cases, but certainly not in all. He would not hear a word in defence of Jenner's theory of its origin, although Jenner sent his friend Paytherus to talk him round. He disbelieved in spurious smallpox and spurious cow-pox. He spoke handsomely of Jenner, and advised him in a friendly way to collect more facts and secure his ground as he advanced, not to be in a hurry to publish a second time on cow pox. Moreover he declined to enter into controversy; it would appear that he soon began to doubt Jenner's sincerity in the matter of spurious cow-pox.

Jenner felt this antagonism very keenly, and was at a loss what to do; he wrote to Gardner for advice and sympathy. His future peace and his very existence were at stake; he had no lymph to work with; his last experiments had given bad results; he was almost in despair. By 1804 failures had multiplied to an alarming degree, and many of Jenner's friends lost heart, but Jenner expained them all as due to spurious vaccine, and gave expectations of a book with accurate coloured plates to enable his colleagues to distinguish between the true and the spurious pustules. This book never appeared, but in 1809 Jenner published a paper on "Variations and Modifications of the Vaccine Pustule occasioned by the State of the Skin."

In 1811 conspicuous failures of vaccination to protect from smallpox occurred, and notably the case of the Hon. Robert Grosvenor. The state of feeling in London was such that Jenner resolved never more to think *pro bono publico*, and he advised Moore to do the same, "for we are sure to get nothing but abuse for it." Jenner was actually summoned to appear before the House of Lords; this unnerved him and aged him considerably; for weeks he had recourse to brandy and opium to give him appetite and sleep. The meeting was, however, abandoned, to Jenner's great relief. All Jenner's friends wrote to him for advice, and domestic troubles about this time combined to reduce him to melancholia. He refused to take any further part in controversy with objectors: "I know very well the opinion of the wise and great; the foolish and little I don't care a straw for."

The most honoured man in Europe was one of the most unhappy. Jenner was "sick of the life he led in London." The death of his wife in 1815 was the signal for Jenner's retirement from the fast and furious whirl of public life. He never left Berkeley again for more than a few days.

V.

"Spectatum satis, et donatum iam rude."
HORACE.

While his fame continued to spread through the world, Jenner spent his closing years in the seclusion of his native village, doing the things he had liked to do in his boyhood; he wandered over the countryside in search of fossils; he worked in his garden; he marked his specimens with careful fingers. We hear of the strange disorder of his study. Jenner loved the country so much that he was continually joked about it. He was for ever picking up stones and examining them; he made his companions tread warily every time he saw a bird or heard a well-known song. He had a curious sentimental attachment to certain objects. He obtained the hide of the cow that had infected the hand of the dairymaid who furnished the lymph for his classical experiment. Baron saw this hide hanging in a coach-house, and asked what was to be done with it. "Send it to the British Museum," said Jenner. The hide is preserved in the Pathology Department of St. George's Hospital. The horns of the same cow are exhibited in a well-known dispensing establishment in Worcester.

Jenner's paper on the "Migration of Birds" belongs to this period of his life. A charming note describes how moths feed upon the night-flowering primrose.

He vaccinated all the poor gratuitously, and had a special place for the purpose erected in his garden, called the "Temple of Vaccina." Although the epidemic of smallpox in 1818 brought discredit upon Jenner, the good reports received from abroad and published by the National Vaccine Institute, and the efforts of Baron and of Sir Gilbert Blane did much to restore the credit of vaccination. Jenner's paper on the "Effects of Artificial Eruptions" was printed in 1822.

On January 24th, 1823, Jenner saw a patient whom he describes as being "in a state of paralytic debility." The following day he was himself found insensible on a couch, in a condition similar to that of the last patient he ever visited. The faithful Baron was summoned, but in vain. Jenner died on the next day. He was

buried in the chancel of Berkeley Parish Church. This is his epitaph :

"Within this tomb hath found a resting place,
The great physician of the human race,
Immortal Jenner, whose gigantic mind
Brought life and health to more than half mankind."

In forming an estimate of any great man's character there is a *via media* lying between enthusiastic praise and the bitter malice of opponents. Baron was so great a worshipper of Jenner that his statements were often warped by his affection for his friend, and his book is valuable only for the large number of letters which are published in it. On the other hand, those who have been opposed to vaccination and cannot, or will not, see the benefits of it, can hardly find words to express their contempt and loathing of Jenner. This difference of opinion exists even in his own district, where some have heard of him as a contemptible man who appropriated a common notion, full of vanity and selfishness; others regard him as the great benefactor of humanity. In the present century one writer has described him as crafty, vain and petulant, a fool, a liar and a shuffler, an "old man of the sea on the back of the profession"; facts have been distorted and a bad motive found for all his actions. Another authority has described Jenner's detractors as "ignoramuses, fools, knaves and cranks," better left in the obscurity into which Jenner's fame has cast them.

That he was a great man of the type of Hunter no one would assert. A patient and accurate observer, but dilatory and perhaps unmethodical, not possessed of great manual dexterity, but full of perseverance, he was commonly looked on as having "a bee in his bonnet" about cow pox.

He was unsophisticated and guileless, full of candour, and given to outbursts of humility; quite unspoiled by flattery, quick-tempered in answering his critics. He was a good doctor, popular with his colleagues, especially young practitioners, and much beloved by his family and his neighbours. He seems to have lived, while in Berkeley, the happy life of the perfect country doctor.

VI.

"Time is the judge, time has nor friend nor foe.
False fame must wither, and the true must grow."
YOUNG.

For a time it was fashionable to sneer at the claims of Jenner in connection with the introduction of vaccination; it was perhaps forgotten that the same materials were ready to the hands of other observers, but no one seemed to think them worthy of investigation. Jenner not only showed so well how to prevent smallpox that most doctors nowadays have never seen a case of it, but from his discovery followed further advances in the field of protective inoculation, which have added lustre to his fame. If utility to human life be any test of what is noble in labour, Jenner's work may rank with any achievement of man. Simon writes, "The close of the eighteenth century, which had so much to darken it, will be remembered to the end of human history for the greatest good ever yet given by science to the world."

Jenner opened the door to a whole realm of therapeutics, of which we have by no means yet surveyed the whole. Pasteur was born thirty days before Jenner died; their lives overlapped by a month and their life's labours were closely related. It seemed as though the one great worker handed on the torch of science to the other. Pasteur himself acknowledged that the credit of the discovery of the attenuated virus was due, not to himself, but to Jenner. "Sans Pasteur, Lister serait resté inconnu. Sans Jenner,—qui sait,—le grand œuvre de Pasteur serait peut-être resté stérile." These are the words of Sir StClair Thomson, speaking at the Jenner Celebration in Paris in 1923. From the East the chorus of Jenner's praise has not yet diminished. A few years ago a famous Persian statesman, on a visit to the Royal College of Surgeons, asked first to see Jenner's lancets, and spoke feelingly of the manner in which whole Asiatic countries had been rescued from a scourge more terrible in the East than ever it was in Europe.

Thus Jenner's monument is his work; and if in our own country Jenner is in danger of becoming a legendary figure to most of us, it is only a proof of the completeness of his victory over one of the formidable shapes of death. "Often the thoroughness of a reformer's victory is that which most makes silence of his fame."

Jenner's work still goes on. If its consummation be reached, we may, in the words of a modern historian of medicine, expect improvement in health and prolongation of life to a degree greater than any previous ages have seen. "Medicine cannot give immortality, but it should enable us all to live out our full lives. Death coming in due time is shorn of all his terrors when every man shall 'come to his grave in a full age, like as a shock of corn cometh in, in his season.'"

W. S. BAXTER.

SMELLS.

WHEN out of the scents of the countryside, the sweet breezes and pleasant odours of trees and flowers, the smell of wet earth (whose origins in decay are hidden from us), and the vapours of the sea, we enter this strangely beautiful capital of England, shining against the dawn with white stone and spacious streets, and rising to welcome the sunlight undefiled by the dung of cattle, we experience no change, for we have noticed neither. When, however, we come into the houses reserved for those fallen sick in spite of superior sanitation, we do notice something, for it is forced upon us. All about floors and walls and ceilings in passages and rooms the air is rich with—we cannot guess what, but as pigs smell of pigs, so do hospitals of hospitals.

Life is not to me, as it is to a dog or a gazelle, a succession of smells; I am without the sense of smell. And I am happy to risk sudden extinction by coal-gas, and new-laid eggs, and eau-de-Cologne, and even to forgo the detection of situations (a lady assures me they can sometimes be smelled), and the taste of unknown foods, if I may escape also the fouler odours of life; particularly those of situations—how terrible must be the scent of that zenith of stagnations, the contentment of men! I write from imagination and hearsay even of a medical student's dog-like or gazelle-like existence.

The scents of your earliest years I will pass over, because you will not remember them. The odours that embraced us in the womb, at birth, in infancy, may have made a lasting impression on the mind, but it is an unconscious one. Nearer our sphere are the airs of childhood, but this part of your life did not really begin till out of the sweet atmosphere of London you came into the evil vapour of a hospital.

From unknown realms this odour percolates everywhere. The luncheon water tastes of it, and it alters even the smell of dogfish. Fish have unhappy ends, by the holocausts of men. Yet can we say, remembering what you endure, and the extreme sensitivity of fish to smells, that a dogfish is unfortunate in dying before it enters a hospital? I do not wonder few fish care to breathe the air; even the Dipnoi filter it through mud, and the whale cleanses it in salt spray. For not wandering scents such as we know, tossed by the winds, but, in the still deeps, stable odours, rocked only by the lash of a tail, and the swift ravin of a marauder, and slowly swayed by the tides and diffused imperceptibly through the length and breadth of the sea—such a world of smells do fish inhabit. That must be happiness. Yet what we men lose in delight we gain in safety. In this more tenuous atmosphere, where gravity exercises a stronger claim upon us, eruptions may bury us from above, but cannot hurl us with burst lungs to float in decay on the waves of the upper air.

In a high seclusion the water of stagnant ponds is set before us. Decaying weeds and leaves have given it its joys, as they have given also a living liquid to its mysterious inhabitants. Poison to us is the elixir of the young life of the world. In their myriads they excite our wonder and imagination; they exercise our minds in memorizing the arrangement of their transparent interiors, our intelligence in inventing reasons for what must be to them obvious behaviour—that is, without reason—and our artistic and photographic senses in defining their posturings and drawing them. They also make green spots on our clothes.

More memorable of the peace outside cities is the worm, whose earthly smell gives no hint of the rare effluvia to exhale from his incised and septate interior; we almost believe that each annulus has a separate and distinguishable emanation. Those of us that have dissected worms more leisuredly at home, returning to our specimens after a week-end, have learnt enough of his microcosm to last us a lifetime; even that he is sometimes viviparous.

With the ascent of the animal scale, the stages of decay increase in number, and therefore our repertory of smells named in the chemistry laboratory (where every smell must be named, in order that it shall be recognized) increases, and our flow of abusive adjectives is *pari passu* enlarged. The dissociation of the frog is an introduction to all other departments except that of physics. Even in the electrical departments there are ozone, sulphur, rubber and occasionally the smell of burnt flesh. In the physics laboratory many recover their smell, but lose their hearing. Even while it lives, the frog stinks. Male and female are they made, and each has a distinguishing odour, his stronger, hers more persistent. Their eggs also would be found odoriferous if anyone could bear to approach his face near enough to assay them.

The dogfish is known to most, and from the others I will conceal it to the last. If only the ancient world had replaced on its altars the bull, the sheep and the goat, and in its brazen censers the myrrh and cinnamon, with this fish, the cost and labour might have ceased, and still the vapours of sacrifice would have ascended for ever. Fire would have been granted to man without the torments of Prometheus, without the punishments of Pandora, without the fall of Zeus himself. The young gods would have had a weapon stronger than the thunderbolt, that would have made their enemies the giants like children. Walhal would have raised its towers eternally, and Ormazd and Hathor stood for ever in the light, while over Ireland the Sidhe in their wonderful beauty would have roamed and been visible to this day instead of living hidden in the Danaan duns. But it is too late. Evil can preserve, but it cannot create.

No one will know the scent of the rabbit till the smell of the dogfish goes up from earth to heaven. Night and day these scents arise, and the five are one year.

In the dissecting-room we sit down, like feudal lords, to the whole animal. We carve and tear with teeth and hands, till at last each of us, like a dog, retires with his bone into a corner. For eighteen months we gnaw this half-preserved brawn till strange madnesses take hold of us, and some sit and gibber and are rewarded, and others never become articulate, and remain and gnaw for ever. It is in fear of this intoxication that the meat is impregnated with a sauce held to conceal the scent even of the fairy blooms that grow in the vales of our fathers. The flower takes this and that from the soil and the air, and knits them into the odour it gives out. The herb that grows on this soil and the worm that breaks its clods each removes something of its essence till what is left is indistinguishable from the hills around, and on the air is an aroma that is the sole betrayer of the plant's source of life. We are all saprophytes, and vary only in our ability to ignore smells. I am naturally at an advantage over those whose road to salvation lies in ignorance. I do not have to shut my eyes to the pubs and join temperance societies in order to keep sober. I smell by an act of the imagination, and the more I smell the more I wish to smell, because this makes me more sober, and not less. If it did otherwise, I should get drunk.

Histology, like organic and bio-chemistry on another plane, is an investigation of the minute components of smells. The passing of flesh into oblivion owes its completeness to the levity of these vapours, and, but for that tenuity, which enables them to pass the finest mesh of our containers, we could by assembling them in the correct proportions and order create life. The act of dabbing tissue with a coloured chemical is a sacred act, as are all acts that involve our whole attention; and the hue assumed by the tissue is the key to its name, which is vital, because when we have named it we know it. When we have learnt all we can about anything the learning is useless to us till we have given the thing a name. Then, in one moment, is altered the whole course of our life. Our religion, our philosophy, our attitude to the arts, the aspect of science itself, are coloured with the dye under whose direction we have invented a name. Nothing in our world remains as it was before. Mountains become dykes, and dykes mountains; rain falls as gold, and gold spatters as rain; the dry land becomes a swamp, and the sea firm ground; it even alters our relations with our wives.

Therein is the superiority of wisdom to learning. It is evinced again when the student who can recognize an abscess on sight, and is about to incise a popliteal aneurysm, is prevented by someone who merely notices that it is pulsating. After all, it is the student who discovers that it is an aneurysm. If he had not detected this he would have found himself the centre of one of those human cyclones which (I am convinced) occur solely because a number of smells have been released on the world before their time. The whole labour of medicine and surgery is directed to delaying the inevitable exodus of aromas; success in those is judged by success in achieving this, and vast sums are spent in holding back that which little or nothing is expended to make worthy of retaining. Go thou (you will) and do likewise. On that I close. S.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

It was a great pity that the game against the Old Paulines on September 28th had to be scratched, but our policy was justifiable as the ground was quite unfit.

So far we have played three games and lost them all. This appears at first to be rather discouraging, but they have all been matches against very strong sides. On the whole the prospects are very good, and we should have quite a useful side by the time Hospital Cup-Ties come along.

We have been unfortunate in casualties. Darmady hurt his knee against the Old Millhillians and has been unable to play since; this was especially bad luck as he was unable to play in the Cambridge Seniors' match. Nunn also hurt his knee against Richmond after showing great form, and Grace and Prowse both hurt themselves against Bristol.

The forwards show great promise; although rather light they manage to get their share of the ball. The three-quarters, well served by Taylor and Beilby at half, are good in defence, but their kicking is weak.

The junior teams have done extremely well, and on two successive Saturdays all the junior sides have won their matches. The "A" beat Haileybury and the O.M.T.'s "A," both very useful sides, and they should maintain an unbeaten record for some time.

The Freshers' match, like all freshers' games, was scrappy but showed some talent. Pirie, Curtis and Moynagh seemed to be the outstanding lights and should be useful. J. M. J.

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD MILLHILLIANS.

Result: Bart.'s, 5; Old Millhillians, 11.

October 5th, at Winchmore Hill.

We won the toss and chose to play with the wind. At 3.30 Ramsay, the visitors' captain, kicked off. Play then settled down about the half-way line. The game continued quite evenly for the first 15 minutes, after which the O.M.'s began to get the ball more frequently than Bart.'s in the tight scrums. From one of these the ball reached their left wing, who ran along the touch-line as far as our "23," drawing the defence towards him. Here he cross-kicked: the ball bounced twice, and J. S. Anderson, one of their forwards, running at speed gathered it and scored easily under the posts. Carris converted. Ten minutes later Darmady, who was playing a strong game, almost scored, being pulled up two yards from the goal-line. Bart.'s from this time pressed continually. From a drop-out in the O.M.'s "25" the ball was caught by one of our forwards and passed. It went quickly from the right through eight pairs of hands until it reached Prowse, who, drawing his opposite number and puzzling Carris, their right wing, gave a well-timed pass to Powell, who ran with great determination to score a fine try near the corner flag. Capper, despite a troubling cross-wind, kicked an excellent goal.

Immediately following the re-start of play Bart.'s again attacked and Edwards was unlucky not to score. Half-time arrived with the score 5–5. In the first five minutes of the second half Colman, the O.M.'s scrum-half, secured the ball, and ran, untouched, straight through our three-quarter line, but was well tackled by Ryan near the line. Play now settled down in our half, with the O.M.'s getting slightly more of the ball than us. As the result of "feet-up" in the scrum we were penalized and Carris kicked a penalty goal from near the half-way line. Play again settled down in our half, and very shortly after Carris made a mark; he gave the ball to Colman to place for him, our forwards charged before the ball was placed in the mark, and "no charge" was ordered. Carris then took the kick at his own leisure. The ball passed between the uprights but touched Darmady in its flight and no goal was allowed. Our forwards now made some excellent rushes and reached the visitors' "25." Here we had more than our share of the ball and might have scored on two occasions, but things would go wrong at the crucial moment. Five minutes from the end play was carried back to our half. The opposing packs were evenly matched and playing all out. When we heeled Taylor would make well-judged punts to touch. Following a line-out passing between the O.M.'s forwards resulted in Howard's scoring a try far out. Carris failed to convert. Final score, O.M.'s 11, Bart.'s 5.

Team: T. J. Ryan (*back*); A. H. Grace, G. F. Petty, C. B. Prowse, J. D. Powell (*three-quarters*); J. A. Nunn, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, J. R. Jenkins, E. M. Darmady, H. G. Edwards (*forwards*).

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

Result: Bart.'s, 6; Richmond, 21.

October 12th, on the Richmond Athletic Ground.

This was rather a disappointing game, for after the Hospital had hammered at the Richmond defence for the first twenty minutes of the game, during which time we had far the greater part of the attack, nothing came of such an enterprising start, and Richmond for the rest of the game did most of the attacking. Nunn scored a very good try, for after securing the ball he kicked over the Richmond line, and following up, beat about three Richmond men to touch down quite near the posts. A few minutes later Nunn again secured the ball and gave Prowse a well-timed pass, who managed to score a splendid try fairly far out. Both kicks at goal, one by Ryan and the other by Capper, failed.

The pack played together well, especially in the tight, though people were rather too fond of not getting in properly in the loose. Our chief failing is in the line-outs. The tackling was good on the whole but there were too many missed passes. The three-quarters, after starting so well and showing great possibilities in attack, were chiefly on the defence; they still need a lot of practice together. Taylor played well at half, and his well-timed punts to touch gained us much ground on occasions. Ryan at full back was fairly safe; his kicking needs more length, but no doubt this will come after a little practice. Richmond proved to be a fairly useful side, but they missed many chances.

Team: T. J. Ryan (*back*); A. H. Grace, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, H. G. Edwards (*forwards*).

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

Result: Bart.'s, 6; Bristol, 22.

October 19th, on the Memorial Ground, Bristol.

This was a most enjoyable game, and the Hospital showed much better form than against Richmond. Bristol turned out a very strong side, including T. W. Brown, A. W. Lillicrap and J. S. Tucker.

Bristol were the first to score, Sherman securing a pass from Jones and scoring far out. The kick by Burland hit the posts. Grace scored a fine try for Bart.'s soon after, the kick by Capper failing. Sherman scored Bristol's second try, which was converted with a splendid goal by Burland. Just before half-time Sherman scored his third try. Everett scored a try for Bristol on resuming after half-time. This was a disgraceful piece of work, as he was allowed to run through our defence after three Bart.'s men had tried to tackle him. It, however, gave us a lesson in how to run all out for the line. Powell scored a magnificent try for the Hospital soon after; Capper did not convert. Bristol obtained further tries by Everett and Lillicrap, Burland converting one of them. Bart.'s played very well on the whole. The forwards were not quite as good as against Richmond but they packed well in the tight. The tackling on two or three occasions was very weak. Lewis came into the side instead of Darmady, who was unable to play on account of a knee injury. The three-quarters defended well, and it was very bad luck that both Grace and Prowse were injured. Powell played extremely well, and he was unlucky in not scoring a second try when he was brought down a few feet from the line. Burrows tackled well and made some good openings. The kicking was poor and showed up very badly against the fine Bristol kicking. Beilby showed better form at stand-off half and Ryan played a steady game.

Team: T. J. Ryan (*back*); A. H. Grace, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

ASSOCIATION FOOTBALL CLUB.

THE Association Football Club opened its season with an away match against Aldenham School 1st XI on September 28th. Though not at full strength the team played keen football and succeeded in winning by 3 goals to 1.

A trial match was held on October 6th, and very satisfactory form was displayed by most of those tried. As a result of this game the 1st XI which played at Woolwich on October 12th against R.M.A. included three freshmen, and their high standard of play was particularly gratifying. The team played excellently to win this match by 3 goals to 1, and the marked degree of team spirit and the absence of too much individualistic play augurs well for another successful season.

Results.

September 28th: 1st XI *v.* Aldenham School 1st XI, won, 3—1.
October 12th: 1st XI *v.* R.M.A. Woolwich 1st XI, won, 3—1.
October 12th: 2nd XI *v.* Old Stationers, lost, 2—5.
October 16th: "A" XI *v.* East London College, lost, 2—3.

REVIEWS.

ESSENTIALS OF GENERAL PHYSIOLOGY. By ERIC PONDER. (New York: Longmans, Green & Co., 1929.) Pp. vii + 491. Price 15s. net.

The characteristic of general physiology is its concern with the nature of the mechanisms underlying the various phenomena connected with the vital processes. It includes all living material, and demands that these vital processes should be transcribed in known physical and chemical terms. With this broader definition it abandons the restricted outlook obtained when the phrase "cellular physiology" was used. This introduction to the subject is intended for the use of students at the commencement of their physiological studies, who have learnt the elements only of chemistry and physics. To this end the first five chapters deal with physico-chemical subjects, thereby forming the basis of the later part of the book, which deals with the various vital processes. The mechanisms of these processes are presented in a manner which can be readily followed, although it would seem that in some places essentials have given place to a real treatise on the subject. The book is free from bias, as regards any theories which as yet are not proved. It is well printed and produced. It can hardly, however, be recommended as a suitable purchase for those at the commencement of their studies in physiology for medical purposes: it would rather appear to be intended for those who mean to study physiology more fully, and for them it is an excellent introduction.

LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY. By L. BATHE RAWLING, M.B., B.C., F.R.C.S. Seventh Edition. (London: H. K. Lewis & Co., Ltd., 1929.) Illustrated. Pp. viii + 97. Price 7s. 6d. net.

Changes in the landmarks of the human body are evident only to the geologically minded, whose seconds are centuries. Since no new system of surface markings has been devised, and since the newness of this edition resides in a few illustrations, it may be assumed, correctly, that the book is now of its kind perfect. Thus ends work begun at this hospital by Luther Holden in 1866. In the first of his essays on "Medical and Surgical Landmarks" in the second volume of the *Hospital Reports*, he writes: "The following observations are not made with the idea of exhausting the subject, but rather to induce in students the habit of looking at the living body

with anatomical eyes, and with eyes too at their finger's ends." The essays, published in book form, went through four editions between 1876 and 1888.

There the matter rested until the present author, in 1904, feeling the "urgent need of a handy book which describes and illustrates the more important landmarks and surface markings of the human body," filled the "gap in the series of text-books." The two confessions printed together show something of a change in medical teaching, which the reading of the two texts shows even more clearly. Which method, if indeed either, is the better can only be judged by the kind of doctor produced.

Of the value of this book, a necessity for the medical student from his first contact with human anatomy, there can be no two opinions; and Mr. Rawling is to be congratulated on having seen into the world during twenty-five years a week of editions.

THE BRITISH JOURNAL OF UROLOGY. (Constable & Co., Ltd.) Published Quarterly. 20s. per annum.

As each special branch of surgery increases in importance and the number of its adherents, so does the literature increase and thus the demand for new journals arises; hence the appearance this year for the first time of the *British Journal of Urology*. With such editors as Mr. Frank Kidd and Mr. Winsbury White, and with the imposing list of those on the Editorial Committee, this new journal is certain to "enjoy a long and useful life," to quote from the letter of greeting from Mr. Hurry Fenwick, one of the most famous of all urologists. We are glad to see the names of a number of physicians on the Editorial Committee, so that the medical and bio-chemical side of urology may not be lost amid the galaxy of surgical urology.

In addition to a number of original articles there appear several sections in the journal which we hope will continue to appear quarterly. Amongst these must be mentioned especially the Abstracts from Current Literature, the literature covered being very widespread, no less than 80 articles on urology being abstracted in the March number. The Index Medicus, Urological Hints for Practitioners and Bio-Chemical Notes are also very valuable, and if regularly continued will help greatly to spread the journal far outside any small circle of urological specialists.

The excellent example set by the editors of including a Time-table of the Work of Urological Clinics in London and the Provinces might well be followed by other editors. Amongst seven original articles, all of which reach a high standard, those by Duncan Morison, F.R.C.S.(Ed.), on "Animal Experimental Work to show the Routes of Absorption in Hydronephrosis," and the one by Dr. Maurice Meltzer, of New York, on "Surgical Aspects of Polycystic Disease of the Kidney," seem of special interest. We hope that the number of notes on interesting cases will increase as the journal grows older.

We wish the *British Journal of Urology* a long but calm journey as it goes out to all countries where urology is advancing.

CHANGES OF ADDRESS.

DICKS, H. V., 154A, Adelaide Road, Hampstead, N.W. 3. (Tel. Primrose 2660), and 10, Harley Street, W. 1. (Tel. Langham 1220.)

MILLS, W. T., Chiddingfold, Surrey. (Tel. Chiddingfold 5.)

SKELDING, H., Manor House, Diptford, S. Brent, Devon.

TOMLINSON, J. H., 2, Victoria Villas, Whitley Bay, Northumberland.

APPOINTMENTS.

DICKS, H. V., M.B., M.R.C.P., appointed Physician to the Tavistock Square Clinic for Functional Nervous Disorders. (November, 1928.)

MILES, A. A., B.Chir.(Cantab.), M.R.C.P., appointed Demonstrator of Bacteriology, London School of Hygiene and Tropical Medicine.

BIRTHS.

BLACKWELL.—On October 10th, 1929, at Maison Bruges, Don Road, Jersey, to Mary Georgina, wife of Dr. A. S. Blackwell—a daughter.

COOPER.—On September 29th, 1929, at The Georgian House, Chipstead, to Sally (*née* Court), wife of A. Basil Cooper, M.B.—a daughter.

GILDING.—On September 5th, 1929, to Violet (*née* Hazlitt-Brett), wife of Dr. H. P. Gilding, 97, Oakwood Road, N.W. 11—the gift of a daughter.

HOLMES.—On August 28th, 1929, at a nursing home, London, to Barbara Elizabeth (*née* Hopkins), wife of Eric Gordon Holmes—a daughter.

HOLMES-WATKINS.—On October 7th, 1929, at "Eskdale," King's Lynn, to Vyse, wife of Dr. E. Holmes-Watkins—a daughter.

LYNN.—On August 25th, 1929, at 9, Lancaster Road, to Marjorie, wife of Lieut-Col. G. K. Lynn, D.S.O., I.M.S.—a second son.

MACKIE.—On October 20th, 1929, to Mary Mackie, Utterby House, Louth, wife of Col. F. P. Mackie, I.M.S.—a son.

MALTBY.—On August 24th, 1929, to Marjorie, wife of Dr. H. Wingate Maltby, of 56, Rectory Road, N. 16—a daughter.

McLAGGAN.—On September 29th, 1929, to Elsa V. McLaggan, M.B., B.S. (*née* Adams), wife of J. D. McLaggan, F.R.C.S., of 15, Wimpole Street, W. 1—a son.

REICHWALD.—On October 20th, 1929, at Timber Hill, Ashtead, Surrey, to Katharine Civil (*née* Rouquette), wife of Dr. M. B. Reichwald—a son.

VICK.—On October 5th, 1929, at St. Clere's Hall, Danbury, to Reginald and Mary Vick—a daughter.

MARRIAGES.

DARNES—NEWMAN. On October 16th, 1929, at St. Philip's Church, Kensington, Warren Alston Barnes, M.B., B.Ch., elder son of Mr. and Mrs. R. S. Barnes, of Addiscombe, Surrey, to Helen Newman, M.B., B.S., elder daughter of the Rev. and Mrs. Herbert Newman, of Stone, near Ashford.

CLARKSON—GRANT.—On September 26th, 1929, at Christ Church, Lancaster Gate, by the Rev. Norman Manning, Rector of Bideford, Lieut.-Col. T. H. F. Clarkson to Evelyn Augusta, widow of Lieut.-Col. Ian Hope Grant.

HARRIS—GOLDSMITH.—On September 27th, 1929, at Christ Church, Lancaster Gate, Charles F. Harris, M.D., M.R.C.P., son of Mr. and Mrs. G. F. Harris, of 249, St. James's Court, London, to Edith Nadejda, daughter of Mr. and Mrs. J. E. Goldsmith, of 63, Lancaster Gate, London.

INGLEBY-MACKENZIE—TINDAL-ATKINSON.—On October 7th, 1929, in London, Surgeon-Commander Kenneth Alexander Ingleby-Mackenzie, B.A., M.B., B.Ch.(Oxon.), Royal Navy, elder and only surviving son of Mr. and Mrs. Ingleby-Mackenzie, of Lansdowne House, Ryde, Isle of Wight, to Violetta Maria, younger daughter of His Honour the late Judge Longstaffe and of Lady Tindal-Atkinson, of St. Ermin's, Westminster.

OKELL—DUTTON.—On October 2nd, 1929, at St. John's Church, Hartford, Cheshire, by the Rev. E. S. Oliver, vicar, and the Rev. J. R. Spencer, vicar of St. Chad's, Over, Dr. Robert Okell, younger son of Dr. Okell, J.P., and the late Mrs. Okell, of Over Lodge, Winsford, to Hilda Margaret, younger daughter of George W. D. Dutton, J.P., and Mrs. Dutton, of Hillingley, Northwich.

DEATHS.

CAPON.—On August 1st, 1929, at the French Hospital, New York, Dr. Herbert Vawdrey Capon, of Pine View, Sonning Common, Oxon., aged 42.

CHAMBERS.—On September 20th, 1929, at West House, Worthing, Dr. Herbert William James, husband of Frances Mary Chambers.

LEE.—On October 15th, 1929, at "Sainsfoins," Little Shelford, Cambridge, Crichton Stirling Lee, M.R.C.S., L.R.C.P., aged 50.

SMITH.—On October 22nd, 1929, at Trevean, St. Austell, Cornwall (the residence of his brother), Ernest George Smith, M.R.C.S., L.R.C.P., late of 33, Ford Park Road, Plymouth.

VERRALL.—On October 4th, 1929, at East Lodge, Leatherhead, Sir Thomas Jenner Verrall, M.R.C.S., L.R.C.P., LL.D.

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, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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. 1. Telephone: City 0510.*

St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Mon., Dec. 2.—Special Subject: Clinical Lecture by Mr. Elmslie.
Rugby Match *v.* R.N.E. (Keyham). Away.

Tues., ,, 3.—Prof. Fraser and Prof. Gask on duty.

Thurs., ,, 5.—Association Match *v.* Lancing College. Away.

Fri., ,, 6.—Dr. Morley Fletcher and Sir Holburt Waring on duty.

Sat., ,, 7.—Rugby Match *v.* Bath. Away.
Association Match *v.* Selwyn College, Cambridge. Home.
Hockey Match *v.* Staff College. Away.

Mon., ,, 9.—Special Subject: Clinical Lecture by Mr. Scott.

Tues., ,, 10.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.

Wed., ,, 11.—Rugby Match *v.* R.M.A. (Woolwich). Home.
Hockey Match *v.* Epsom. Home.

Thurs., ,, 12.—Association Match *v.* St. John's College, Cambridge. Home.

Fri., ,, 13.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.

Sat., ,, 14.—Rugby Match *v.* Moseley. Home.
Hockey Match *v.* Hendon. Home.

Tues., ,, 17.—Dr. Langdon Brown and Mr. Harold Wilson on duty.

Thurs., ,, 19.—**Last day for receiving matter for the January issue of the Journal.**

Fri., ,, 20.—Prof. Fraser and Prof. Gask on duty.

Tues., ,, 24.—Dr. Morley Fletcher and Sir Holburt Waring on duty.

Wed., ,, 25.—**Christmas Day.**

Fri., ,, 27.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.

Tues., ,, 31.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.

EDITORIAL.

AS we go to press, news comes that will be welcome to all connected with St. Bartholomew's. H.R.H. The Prince of Wales, K.G., President, is to visit the Hospital on the afternoon of Wednesday, December 4th, upon the occasion of the inauguration of the Reconstruction Appeal.

* * *

We announce with great regret the retirement of Mr. A. A. Miles from the editorship, after three years on the staff of the Journal. The main work of editing a hospital journal, which he performed with singular skill, remains of necessity behind the scenes. We would only draw attention to his success in keeping alive in these columns the *Round-the-Fountain* spirit—a difficult feat in these serious times. In his writings he always left the reader chuckling at the neatness of his exits; his exit from the editorial chair, despite the glorious achievements synchronous with it, is the sad exception. We hope that he will not utterly forsake the cultivation of his Comic Muse for that of the Schizomycetes.

* * *

The Dean has provided the following enlightening figures with regard to the entry of students in October, 1929:

Full-time students 131
(An increase of 8 on October, 1928)
Part-time students entering to special courses 68

The proportion of Cambridge graduates is higher than that of last year. Those who complain that medicine is an overcrowded profession may take comfort from the thought that it is not as overcrowded as it will be.

* * *

The Amateur Dramatic Society has chosen for its winter production in the middle of January *The Mask and the Face*, by Chiarelli, in C. B. Fernald's translation. The Society has made an ambitious choice, for we understand that the play presents great technical difficulties and calls for a very high standard of dramatic talent. It is hoped that old Bart.'s men, especially old members of the A.D.S., will avail themselves of the general invitation to be present, and will apply for tickets to the Secretary, Mr. C. K. Vartan, at the Hospital.

* * *

Congratulations to Dr. Wilfred Shaw on winning the Raymond Horton Smith Prize for his M.D. thesis at Cambridge.

OBITUARY.

MR. R. A. LYONS.

MR. R. A. LYONS, who had but recently retired from the Contributions Department, died in this Hospital on October 28th, 1929, from pneumonia.

An Irishman, he was at one time an officer in the 2nd Life Guards. In the course of his work he met many St. Bartholomew's men, amongst whom he was a well-known and popular figure. It was a great pleasure to work with him on "Fleet Street Week for Bart.'s," and he was highly esteemed by the newspaper men who do so much to help the Hospital.

For his kindliness and charm Mr. Lyons will long be remembered.

ACKNOWLEDGMENTS.

The British Journal of Nursing—Charing Cross Hospital Journal—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East African Medical Journal—King's College Hospital Gazette—The London Hospital Gazette—Long Island Medical Journal—The Medical Review—The Middlesex Hospital Journal—New Troy—The Nursing Times—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecine—St. George's Hospital Gazette—The St. Thomas's Hospital Gazette—The Student—Sydney University Medical Journal.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

SOME ABDOMINAL CONDITIONS—(*contd.*).

(1) In the routine examination of the abdomen the same procedure should be followed as in examination of the thorax—inspection, palpation, percussion and auscultation. Of these methods the first often receives much too scant attention, whilst the last is generally omitted altogether. Time and care spent upon inspection are never lost, and valuable information, which is not available by any other method, is often gained. The abdomen should be inspected from the head and from the foot of the bed, as well as from the side, and with the observer's eye upon a level with the abdomen as well as above it.

(2) Despite the fact that the liver lies mainly on the right side, and that the "lie" of the hollow viscera is essentially asymmetrical, the shape of the healthy abdomen, regarded as a bilateral structure, is quite symmetrical. Even the slightest deviation from symmetry should therefore be noted. Whether the significance of this be serious or trivial is a consideration which should be left until the whole examination is complete.

(3) Examples of data, and their significance, obtained by auscultation of the abdomen are the following: The discovery of friction over a tumour in the left hypochondrium, suggesting perisplenitis; the presence of a bruit over a large hypernephroma, suggesting that the tumour has large blood-vessels connected with it, and that its removal would thereby entail grave risk.

(4) In the estimation of free fluid in the peritoneal cavity the method of "*ballottement*" is sometimes more convincing than the examination for "fluid thrill." This is particularly so when there is present also some solid organ, such as an enlarged liver, over which this special method of palpation may be employed.

(5) Abdominal *pain* must always be carefully distinguished from abdominal *tenderness*, and a separate note should be made under each heading. *Pain* is independent of the observer's examination; *tenderness* is a painful sensation elicited during palpation.

(6) Abdominal tumours in anomalous situations, and possessing unusual features, especially if the patients present little or no evidence of visceral disease—consider the possibility of cysts, such as of the pancreas, of the omentum and of the liver.

(7) In "cystic disease of the kidneys" small cysts are not infrequently found in the liver during post-mortem examination. Rarely, one of these liver cysts may give signs and symptoms during life. To remember these facts may lead to a diagnosis of the main disease by discovering that one or both kidneys are enlarged or (and) that the patient presents the general features, cardio-vascular and metabolic, of the condition.

(8) Bearing in mind that the gall-bladder in chronic cholecystitis is frequently contracted and adherent, it is not surprising that it is a common experience not to be able to feel the organ, even in the presence of an exacerbation of the inflammation. The absence of signs of a gall-bladder tumour is therefore not only no evidence against the diagnosis, this fact is quite compatible with it.

(9) Tuberculous peritonitis is much more often diagnosed, and diagnosed correctly, in the absence of direct evidence of tuberculosis than in its presence. For isolation of the tubercle bacillus from the liquid effusion (if this be present) is rarely possible, and, since the disease is more often than not confined to the abdomen, "signs of tuberculosis elsewhere" are not usually forthcoming.

(10) "Tumours" that can be felt in the abdomen in a case of tuberculous peritonitis are of varied nature. They may be (1) "indurations" caused by thickening of the peritoneum by the plastic inflammation, (2) enlarged (caseous) lymph-nodes, (3) sacculated collections of fluid, (4) the inflamed (tuberculous) appendix, (5) tubo-ovarian "abscess," (6) coils of tympanitic bowel, and (7) fæcal masses.

CHOLECYSTOGRAPHY.

ALTHOUGH several years have elapsed since the introduction of cholecystography as a test for the functional activity of the gall-bladder, its value is still a matter of dispute. Inquiries are made with regard to its safety and its reliability, and there are not a few who feel they will never be able to trust a test in which a positive result is based upon a "negative" skiagram. It is with a view to answering such inquiries that the following analysis has been made. The information has been obtained by correlating the result of cholecystography with the findings at operation in the cases which have been under the care of the Surgical Professorial Unit since May, 1926.

The test has been carried out only when clinical examination failed to establish the diagnosis of disease of the gall-bladder, and therefore the figures are small. While any conclusion based upon a small group of cases is to be accepted with reserve, yet there does not seem to be any reason to suppose the impression created by the study of this group to be misleading.

When this method of investigation was first used in the Surgical Unit the oral method of administration of dye was giving rise to considerable difficulty. Nausea, vomiting, diarrhœa, headache and faintness frequently followed; and only too often a large but unknown proportion of the dye passed unabsorbed down the intestine. Results of the test following the oral method were so unreliable that it was decided to ensure the absorption of the dye by injecting it intravenously, and so eliminate the greatest source of error. We have had no cause to alter our technique throughout the present series; and although it has been described in full elsewhere (1), a brief outline may be permitted here.

A preliminary X-ray examination is made for gall-stones or other abnormal shadows in the right upper quadrant of the abdomen. A meal which contains a good proportion of fat is given at 6 a.m., and after that no food is allowed for twelve hours. At 9.30 a.m. the dye is injected, and skiagrams are taken at 1.30 p.m. and 5.30 p.m. At 6 p.m. the patient has the usual evening meal, and, if a shadow of the gall-bladder has been visible, a further skiagram is taken after breakfast at 9.30 a.m. on the following day. If the test is to be relied upon it is very important that no aperient be given on the day preceding it, and that no drugs or food be given between the administration of the dye and the taking of the second skiagram eight hours afterwards. Under such conditions a normal gall-bladder will fill with dye, and concentration of the contents will take place. The evening and morning meals should cause it to empty, and no shadow should appear in the skiagram twenty-four hours after injection.

The fluid to be injected is a freshly prepared 10% solution of sodium tetra-iodo-phenolphthalein, the purity of which can be trusted. We have used from 3 to 3·5 grm. of the salt, depending upon the body-weight of the patient.

The needle, fitted with a short piece of rubber tubing, is introduced into the vein, and as it is of the first importance that none of the dye shall escape into the subcutaneous tissue, 5 c.c. of normal saline is run in to make sure of the position of the needle. The dye is

then run in very slowly, never faster than 2 c.c. per minute, and with occasional pauses of two or three minutes in the course of the injection. This is followed immediately by 10 c.c. of normal saline to wash all the dye out of the needle and minimize the risk of thrombosis of the vein.

As a prophylactic against a general reaction the patient is kept lying flat, with one pillow under the head, during the injection and for an hour or so afterwards. Since a few patients have noticed a chilly feeling in the extremities, a hot water bottle and an extra blanket are provided.

This routine was evolved as a result of early experiences with toxic samples of the dye; and although we have met with no serious reactions in the past three and a half years, we prefer to take these precautions rather than run the risk of upsetting a patient who might have an idiosyncrasy to the dye. Using this method the patient is always perfectly under control, and should a complaint of any suspicious symptoms be made—for example, flushing, shivering, feeling of constriction around the chest, or cardiac irregularity—a pause of five or ten minutes may be made in the injection. If the symptoms return when the injection is recommenced the procedure should be abandoned. This difficulty has been encountered once in the course of sixty injections, and in this instance it was considered advisable to stop after 2 grm. had been given.

In the present series there has been one case of mild cellulitis of the antecubital fossa, which did not call for treatment, and one case of thrombosis of the cephalic vein. Nausea and headache each occurred once, and a slight shivering feeling, "as though something was creeping over the body," has been noted on two occasions. Several of the patients suffering from disease of the gall-bladder have noticed immediately after the injection a feeling of discomfort in the right hypochondrium, which was indefinite in nature and of short duration. There have been no other "reactions"; and the once prevalent impression that there was less risk attached to laparotomy than to dye injection can have been founded merely upon imperfections in technique.

The interpretation of the skiagrams demands a knowledge of the possible variations in the position and shape of the shadow produced by dye in a healthy gall-bladder. A series of observations carried out by Francis Davies (2) gives valuable information in regard to normal "cholecystography," and he showed that the position of the gall-bladder varies considerably according to the type of bodily "habitus" of the individual. A careful study of a number of normal and abnormal skiagrams leads one to believe that the vague pyriform outline frequently seen lying parallel to the eleventh rib well away from the spine, which is sometimes reported on half-heartedly as "possibly a diseased gall-bladder," lies in a position which the gall-bladder never occupies. The shadow is produced by the lower edge of the liver.

Difficulty does not arise when a perfect shadow, appearing and disappearing under appropriate conditions, or the complete absence of a shadow or "negative shadows" of gall-stones in the dye are reported. The most difficult skiagrams to interpret are those in which the gall-bladder shadow is not as dense as it ought to be four hours after the injection, and at the eight-hour period concentration is unsatisfactory. There is a certain amount of variation among healthy persons in regard to the activity of the gall-bladder. It must also be remembered that if the lesser degrees of impairment of filling or concentrating power are to be diagnosed with certainty the radiographic conditions must be strictly comparable, and this demands the close and efficient co-operation of the radiographer. This point is emphasized, since it is to be hoped that the method may prove useful in the diagnosis of uncomplicated cholecystitis.

In our series there were 19 cases in which no shadow of the gall-bladder was visible. In 17 of these there were gall-stones in the gall-bladder; and in the other 2 the gall-bladder was shrunken and atrophic, and gall-stones were found in the common bile-duct.

There were 5 cases in which a faint shadow, with failure to concentrate, was reported, indicative of cholecystitis. Three proved to be cases of gall-stones, one of cholecystitis, and in one the gall-bladder appeared normal, but a duodenal ulcer was found. In this case it was discovered afterwards that castor oil had been given on the night before the test was performed.

In 3 cases "negative shadows" of gall-stones in the shadow of the dye were reported, and in all the diagnosis was confirmed.

Three reports stated that the shadow was distorted, and at operation adhesions constricting the gall-bladder were found.

In rather over 20 cases the gall-bladder shadow has appeared to be normal, and in 2 of these the abdomen had to be opened on account of other symptoms. One patient was suffering from torsion of part of the great omentum, and the other from pancreatitis, but in both the gall-bladder looked and felt healthy. Several of the patients whose skiagrams were normal have been followed up, but the repeated examinations have not thrown any further suspicion upon the gall-bladder.

One case was of great interest, and showed the importance of the twenty-four-hour skiagram. Although the gall-bladder filled and concentrated well enough to be passed as within normal limits, yet a dense shadow was still visible after two meals had been taken. The clinical history was extremely suggestive of biliary colic, and the unusual feature in the cholecystogram caused us to urge exploration. About 200 gall-stones were found in a thin-walled gall-bladder which showed no obvious signs of cholecystitis. It is possible that certain of the stones exerted a kind of ball-valve action at the entrance to the cystic duct.

The results may be summarized in the following table:

Skiagram.	Operation findings.					
	Gall-stones in gall-bladder.	Atrophic gall-bladder.	Cholecystitis.	Adhesions.	Normal gall-bladder.	Total.
No shadow	17	2	..	..	..	19
Poor shadow; poor concentration	3	..	1	..	1	5
"Negative shadows" of gall-stones	3	..	..	..	..	3
Distorted shadow	..	..	..	3	..	3
Normal shadow	..	..	..	..	2	2
Failure to empty	1	..	..	..	..	1
Total	24	2	1	3	3	33

Thus the answer to the original inquiries is that in our experience the intravenous administration of dye is a safe procedure, and the information yielded by the test has been reliable in so far as the cases operated upon are concerned. It is possible that certain of the gall-bladders passed as normal may have been the seat of early disease, but we have no evidence that this is so. A striking point is that every time a shadow was not seen operation revealed gross disease of the gall-bladder. Even our small numbers should encourage those who distrust a "negative" skiagram.

This note would be incomplete without a reference to cholecystography in the presence of jaundice. Although we had been given to understand that the injection was dangerous and the results misleading, we desired to try to verify these statements. We found that the injection could be given even to patients with extreme hepatic insufficiency without ill-effects; but the test is completely valueless, and should never be advised if jaundice be present.

REFERENCES.

(1) *St. Bartholomew's Hospital Reports*, 1927, lx, p. 147.
(2) *Brit. Med. Journ.*, 1927, i, p. 1138.

J. P. Ross.
(*From the Surgical Professorial Unit.*)

TWO CASES OF HEMIPLEGIA RESULTING FROM CORTICAL LESIONS.

AN essential step in dealing with any malady afflicting the central nervous system is the localization of the lesion or lesions; and to ensure accuracy of such localization, a knowledge of the anatomy and physiology of the nervous system is essential. Therefore any case which demonstrates the value of a careful examination based on anatomical and physiological foundations should be of interest. We accordingly feel that the two cases about to be described have a value in demonstrating the necessity of the utmost care in the examination of patients suffering from a "stroke," and more so because there is a common conception that the site of the lesion is most generally in the region of the internal capsule of the brain.

The two cases were admitted during the summer months to the wards under the care of Prof. Fraser, and we are desirous of taking this opportunity of thanking him for permission to publish the following details.

S. M—, a man, æt. 45, was admitted with a history of having had a "stroke." The onset was characterized by a sudden feeling of "an electric shock" in the left arm and leg, and was unattended by a complete loss of consciousness. After an initial period of cerebral shock he began slowly but surely to recover, and on examination now shows the following signs in the central nervous system: The highest cerebral functions appear normal, except possibly for some slight loss of memory; in the cranial nerves there is a general constriction of the fields of vision in both eyes; the pupils are unequal, the left being larger than the right, but both react to light briskly and also on accommodation. He is able to follow an object with his eyes in all directions equally well; however, if commanded to turn his eyes in various directions, he is unable to deviate both eyes to the left as far as to the right; further, he is unable to hold the eyes deviated to the left as long as to the right—the eyes tend to swing towards the central axis. At rest there is considerable flattening of the folds of the face on the left side, and when asked to perform voluntary movements, there is marked weakness of the movements of the muscles of the left half of the face; for instance, on showing his teeth, the right corner of the mouth is more drawn than the left, and on sustained movement the left naso-labial fold gradually disappears; also, on closing the eyes, the eyelashes on the left side are less deeply buried than on the right side. If he be allowed to keep the eyes closed for any length of time, the left eyelids gradually open slightly so as to show the white of the sclerotic. When asked to protrude his tongue,

the tip of the tongue may come out in the mid-line or very slightly to the left, and if the tongue is kept protruded, the tip gradually deviates to the left. The voluntary movement of the left arm is greatly diminished in power and range; a scrutiny of the movements reveals more power and range at the shoulder and elbow, with less power and range at the wrist, and especially of the fingers. The movement of the left side of the chest is possibly less than the right side. The left leg is weak when compared with the right leg, but in comparison with the left arm is much stronger and more agile. The sensory functions are also profoundly disturbed on the left half of the body. Crude sensations, such as pain, temperature and touch, he appreciates on the left side; if the tests for these sensory functions are constantly repeated, it is found that the degree of stimulus necessary to produce a conscious feeling varies; it may need to be of greater amplitude than on the right half of the body, or again it frequently is of the same low amplitude as on the healthy half of the body. When tested for the localization of touch he is grossly inaccurate on the left side; he is unable to appreciate accurately on the left side between the stimulation by one point and the stimulation by two points simultaneously applied. He is grossly inaccurate in recognizing the position in space of the left hand and arm. And, lastly, he is quite unable to recognize objects when they are placed in his left hand. The reflexes confirm the results of these examinations by being brisker on the left side than on the right, by the left abdominal reflexes being less brisk than the right, and by the left plantar response being extensor in type.

This patient exhibits, therefore, a hemiplegic motor weakness, the movements of the hand being most involved, those at the wrist, elbow, shoulder and leg being less so in the order given. Also there is considerable weakness of the left facial movements, the left tongue movements, and left conjugate movements of the eyes. At what level in the neuraxis is the source of this disturbance? The distribution of the motor disturbance can only be explained by a lesion at the level of the cortex; if the lesion had been in the internal capsule, he should have exhibited a greater weakness in the shoulder than in the hand, when the face, tongue and eye movements are so much involved.

On the sensory side there is no loss to crude sensations, but there is evidence of some inattention to these stimuli, as shown by the variability of response to different degrees of stimulation. Sensation demanding the integration of the highest centres is grossly involved, namely the sensations related to planes of dimensions as evidenced by astereognosis, by the defect to compass points and by the failure to localize touch accurately. Thus, his sensory disturbance is explicable only on a basis of a lesion at the cortical level.

We therefore suggest that this man has a vascular lesion at the cortical motor and sensory level in the right cerebral hemisphere. These areas are supplied by two branches of the middle cerebral artery, namely the second and third cortical branches. We conclude that this man suffers from a lesion of the second and third cortical branches of the right middle cerebral artery.

The second case is also that of a man, A. L. St J. J—, æt. 52, who on admission gave a history of a stroke unaccompanied by a complete loss of consciousness. After recovering from the initial shock he appears now to have reached a stationary condition. On examination the following signs of involvement of the central nervous system are apparent. He lacks in spontaneous speech and says little more than "yes" or "no"; occasionally he may utter a phrase, but this is rare; more commonly he grunts some unintelligible noise. He is unable to repeat the alphabet or go through the simple mathematical tables; he is unable to repeat anything that is said to him, or to read what he sees printed. He is unable to make any intelligible patterns of written cyphers spontaneously or to dictation; nor is he able to copy such cyphers. He will, however, perform spoken and written commands, such as "Shake your fist," "Close your eyes," etc. More complicated verbal commands he is unable to execute, and shows much emotional reaction. On account of these difficulties his co-operation in the examination is limited, and consequently many of the finer tests for dysfunction are inapplicable. In the cranial nerves there is no hemianopia; the right pupil is slightly larger than the left, but both react briskly to light and on accommodation. He is able to follow an object with his eyes in all directions, but exhibits a disinclination to turn his eyes or keep them deviated to the right. The facial movements on the right side are weak; at rest the right side of the face is flatter than the left; when trying to say anything he uses the left side of the face more than the right. The left eyelashes are buried more deeply than the right when the eyes are tightly closed. On being asked to protrude his tongue, at times he does so correctly and at other times he fails to respond to the command; but it is noticeable that he licks his lips in a natural fashion. The right sterno-mastoid and trapezius muscles are definitely weak, hardly any movement being appreciable in the latter. The right arm is devoid of any voluntary movement at the finger, wrist, elbow or shoulder-joints. The right half of his chest moves slightly less than the left side. The right leg is weaker than the left, but he is able to move it at the hip, knee- and ankle-joints, the movements at the ankle-joint being strongest and of most facility.

In the sensory system he appreciates the prick of a pin and the touch of cotton-wool, as evidenced by his facial expression. Tests for more integrated sensory function were impossible. The reflex activity substantiated the above observations, the right deep reflexes being brisker than the left, the right abdominal reflexes being absent, and the right plantar response being of extensor type.

The patient therefore exhibits a marked aphasia on the executive side with little to no involvement of the sensory side. He has a hemiplegic distribution of motor disturbance with the leg least involved, arm most and also the face to a marked degree; the conjugate movements of the eyes are also affected. Further, he has at times difficulty in protruding his tongue voluntarily, though he can do it reflexly; this suggests an apraxia of the tongue movements. Crude sensations are not grossly disturbed.

The motor aphasia is only explicable by a lesion of the cortex or subcortex anterior to the central sulcus. In a lesion of an internal capsule, the fibres from the motor speech centres to the opposite hemisphere by way of the corpus callosum take on the function of speech, and hence a lesion of a single capsule does not produce a permanent aphasia. The motor disturbance is also explicable by a lesion in such a region. The question therefore arises as to whether the lesion is cortical or sub-cortical. The comparative absence of involvement of the leg suggests that the cortical or subcortical area supplying the leg has been free from severe damage; and as it is known that the cortical leg area has a different arterial supply to that of the arm and face, it appears justifiable to assume that the lesion in this case may be a lesion of the artery supplying the cortical motor areas for the eyes, face, tongue and arm. Is the aphasia explicable by a lesion of such an artery? This is unlikely, but a lesion of another cortical artery arising from the same parent artery would cause motor aphasia. We accordingly suggest that this man has suffered from a vascular lesion involving the first and second cortical branches of the left middle cerebral artery. We have no definite evidence as to the function of the cortex supplied by the third branch, but as there is no gross sensory aphasia the fourth branch is unlikely to have been affected.

We apologize for taking up the valuable space of the JOURNAL with the records of two cases of hemiplegia, but we desire to plead for the necessity of greater care in the topographical diagnosis of lesions of the central nervous system, especially in so-called cases of stroke. And in pleading so we utilize the records of two cases of hemiplegia admitted to the wards within a comparatively short time of each other, and in which the lesions were not, as is commonly held, in the capsule, but in the cortex.

F. A. RICHARDS.
E. ARNOLD CARMICHAEL.

TWO CASES OF MEGACOLON.

IN 1886 Hirschsprung, of Copenhagen, described two fatal cases of constipation associated with dilatation and hypertrophy of the colon. Although the condition of megacolon is usually coupled with the name of Hirschsprung, two earlier cases had already been described by Von Ammon. The condition is also sometimes referred to as idiopathic dilatation of the colon. Of the two cases I am about to describe the first came to autopsy and was a much more acute illness than the second case, and both of them were admitted to Addenbrooke's Hospital, Cambridge, during the time I was a house surgeon there.

CASE I.—A farm labourer, æt. 39, was admitted on May 5th, 1929, on account of increasing abdominal distension and constipation.

History.—The patient had apparently been in normal health until a week before admission, when his abdomen was first noticed to be enlarging. The enlargement was progressive up to the date of admission. He stated that he had always experienced considerable difficulty in keeping his bowels acting regularly, and that latterly he had been more constipated than usual. He said that he had had his bowels open on the morning of admission after taking some medicine, but with a very poor result.

He had not vomited, but had lost his appetite.

Condition on admission.—On admission he was complaining of pain all over the abdomen. The patient was a thin, well-built man with an anxious expression. Temperature 97°, pulse 108, respirations 24. The tongue was heavily furred and fœtor oris marked. The heart was displaced upwards, the apex-beat being situated in the fourth left intercostal space. The lungs appeared to be normal. The abdomen was enormously distended, the maximum girth being 43 inches and the distension being symmetrical. The skin of the abdominal wall was smooth and shiny and the umbilicus was flush with the surface. There was no visible peristalsis and the abdomen was immobile on respiration. On palpation the whole abdomen was tense and elastic—no viscera or abnormal swellings could be felt. The percussion note was everywhere tympanitic, including the flanks; there was no fluid thrill. There was no tenderness or rigidity. Rectal examination revealed a somewhat roomy rectum containing some semi-solid fæcal material. The tone of the anal sphincter appeared normal, and there was no obstruction within reach of the finger. During examination the patient was frequently passing flatus and eructating. There was a large left inguinal hernia which, the patient stated, had been present for years. It could be reduced, but with some difficulty.

Operation.—Laparotomy was advised, and at 2.30 p.m. on the day of admission operation was performed. A paramedian incision was made and the peritoneal cavity opened. It was then seen that the whole of the large bowel was enormously distended, particularly the sigmoid loop. A rectal tube was passed well up into the sigmoid, but neither fæces nor flatus were passed. An attempt was then made to close the abdomen, but owing to the huge bulk of the large gut a loop had to be left out as in a transverse colostomy. The patient was returned to the ward. It was then decided that an attempt to

reduce the distension should be made and at 4 p.m. strychnine gr. $\frac{1}{100}$ was given. At 6 p.m. pituitrin 1 c.c. and eserine sulphate gr. $\frac{1}{120}$ were given and repeated at 10 p.m. At this time the distension was still enormous and respiration becoming very embarrassed. At 11 p.m. the loop of large intestine that had been left out at operation perforated and large quantities of gas and semi-fluid fæces escaped. This caused considerable relief by reducing the difficulty in respiration, but the size of the abdomen did not appear to have been materially decreased.

At 1.45 a.m. (May 6th) the patient was complaining of considerable generalized abdominal pain, and morphia gr. $\frac{1}{4}$ was given. At 11 a.m. the patient was almost moribund, but free from pain. The abdomen was still distended and respiration difficult. The patient remained in this condition until 7 p.m., when he died.

Autopsy.—Alimentary tract: Œsophagus normal; stomach somewhat dilated; small intestine normal throughout, not collapsed, but empty. Appendix normal. Cæcum and ascending colon: Slightly distended, about 5 in. in diameter.

Transverse and ascending colon about 6 in. in diameter. Sigmoid colon enormously distended, about 8 in. in diameter, the loop occupying the greater part of the abdominal cavity and lying in front of the other contents of the abdomen.

The pelvic colon shared in this dilatation, but the rectum did not appear to be unduly large, though decidedly roomy. The pelvic colon entirely filled the true pelvis, the bladder being pushed up above the symphysis pubis. The colon had pressed upon both ureters, which were dilated to about the size of a lead pencil. Nothing else of note was discovered.

CASE 2.—A married woman, æt. 53, was admitted on August 19th, 1929, complaining of gradual enlargement of the abdomen.

History.—Ten days before admission the patient first noticed a swelling of the abdomen accompanied by an aching pain "all over." The swelling, she stated, had not increased since first noticed. She wondered if she might be pregnant. The appetite was usually poor, but had been worse since the onset of the present symptoms. There had been no vomiting and no nausea. She stated that she had always had difficulty with her bowels all her life. Constipation had been worse for the last ten days. Nothing else of note.

Condition on admission.—A stout, healthy-looking woman. Temperature 98°, pulse 108, respirations 26. Tongue somewhat furred. Chest natural. Abdomen was uniformly distended, the umbilicus being flush with the surface. No dilated veins were visible. Skin tense and shiny. No bulging in the flanks. No visible peristalsis. Maximum girth was 36½ in. On palpation the abdomen was soft and elastic, no rigidity and no tenderness. No viscera or abnormal swellings were palpable, and there was no fluid thrill. On percussion the note was everywhere resonant, including the flanks.

Rectal examination showed the anal sphincter to be normal in tone, the rectum empty and not enlarged, and no obstruction could be felt.

On admission a soap-and-water enema was given with a large result, partly of formed scybala. This was repeated daily and afforded considerable relief, but the size of the abdomen did not diminish.

A barium enema was given on August 24th, which revealed a uniformly distended large intestine. No obstruction was demonstrated. The patient was discharged on August 27th *in statu quo*.

NOTES.

Hirschsprung's disease, megacolon, or idiopathic dilatation of the colon, is supposed to be more common in young children than in adults, being considered by some authorities to be a congenital neuro-muscular defect.

In 1907 Tuffier collected a series of 88 cases, 61 of which occurred in individuals over the age of 19. Of the others in this series one case was a seven months old fœtus, and 21 were children in the first year of life.

Cases have also been recorded in old age and one in a man over seventy years of age. It has been suggested that those cases occurring in elderly subjects are really survivors of the more common group of young children.

Usual symptoms are great abdominal distension and a tympanitic percussion note, both due to large quantities of gas. Peristalsis and coils of dilated gut are sometimes visible. Pain and vomiting are usually absent. There may be respiratory distress owing to pressure on the diaphragm and palpitations due to upward displacement of the heart.

There is usually a past history of bowel trouble. The constipation is not usually serious and yields to purges, or more often only to enemata.

Occasionally there may be diarrhœa just before death, due, no doubt, to an ulceration in the colon set up by the stagnating fæcal contents, and cases have been known where the ulceration went on to perforation and death.

Causation.—It was generally considered that this disease was due to a congenital neuro-muscular defect, which frequently lay dormant until adult life was reached. Hurst points out that in all cases the musculature of the bowel is definitely hypertrophied, and that hypertrophy is only produced as a result of the increased work required to overcome some obstruction, although usually no definite obstruction is found at autopsy. Hurst considers that there is an obstruction either at the anal sphincter or at the pelvi-rectal junction, and draws an analogy between this condition and achalasia of the cardia.

Morbid anatomy.—The site of the dilatation is usually the sigmoid loop of the colon, which may be so distended as to pass accross the abdominal cavity, and by insinuating itself between the liver and costal margin, cause the hepatic dullness to be completely obliterated. Both muscular layers of the gut are usually hypertrophied, the circular fibres being the more markedly so. According to Hurst, the lower limit of the dilatation is in half the cases at the pelvi-rectal flexure, and in the remainder at the anal sphincter. Stercoral ulcers are sometimes found in the mucous membrane.

Treatment is thoroughly unsatisfactory, and medical treatment is without avail. According to some authorities excision of the affected part of the colon is the only satisfactory method. This, however, has a very high rate of mortality. Hurst advocates the daily passage of a rectal tube with a thorough colon wash-out, and in those cases of pelvi-rectal achalasia he suggests that an anastomosis between ileum and rectum might be attempted.

I wish to record my thanks to Mr. W. H. Bowen for permission to publish these cases.

W. R. FORRESTER-WOOD.

THE ADVENTURE OF THE ANATOMY ATTENDANT.

(With apologies to Sir Arthur Conan Doyle.)

"THE medical profession, my dear Watson," said Holmes to me one evening, "is extraordinarily short-sighted in many ways."

He was paying one of his rare visits to my house, and after dinner my wife had retired and left us to chat over the fire. I was smoking a cigar, but he, as usual, would not be separated from his beloved pipe, and lay sprawling in an armchair behind a huge cloud of smoke.

"We are perhaps the most criticized profession," I replied, "and it is always interesting to hear fresh arguments against us. Why do you say this?"

"For this reason: there are many scientists who are capable, by reason of their learning, of adding something valuable to the store of clinical medicine, but are prevented by the petty restrictions of the General Medical Union from conducting a practice. I have often made observations which would have been of considerable value, but were refused by your two leading medical journals, *The Scalpel* and *The Consultant*, because I was not a qualified medical practitioner. I have therefore taken a step which will surprise you. I have joined your own hospital of St. Debora's and become a registered medical student!"

"You are joking!" I cried.

"Not at all; I called upon the Dean, who tells me I may become a perpetual student in return for a modest fee, which, I may add, includes the Students' Union. There is a large common room where all the leading daily papers are provided, and there is, moreover, an excellent sports ground at Simone Mount only two hours' journey by fast train."

"But surely," I protested, "the course will take you a long time, which you cannot spare from your criminal work?"

"I have fortunately been excused the first examination on the strength of my researches into the electrical responses of the pituitary body of the adult kangaroo, so I can start my anatomy and physiology forthwith. I hope you will come down with me to-morrow and introduce me to the work."

"Certainly I will," I replied, "but I cannot help feeling that you are making a mistake."

The conversation drifted to other matters, and it was not until the early morning that we parted.

The next day, according to my promise, I accompanied him to the Dean of the hospital, to whom he parted with a large cheque—not without some trouble, for I may say that with all his seeming carelessness Holmes is a keen business man on occasions. I left him safely installed in the dissecting-room, seated on a high stool, oblivious to his fellows and surveying the body with knitted brows, concentrating all his faculties, as is his wont, upon the work before him.

An epidemic of measles, to which was shortly added one of influenza, kept me well occupied, and, as is not uncommon among medical practitioners, I fell a victim to the latter complaint myself, so that it was not for some seven weeks that I saw Holmes again. I was spending the evening with him at Baker Street, and after one of those unaccountable silences of his, he looked at me with an amused smile and said:

"I suppose you have met Saunders, the assistant anatomy attendant at St. Debora's?"

"I know him slightly," I replied, "although he was not there in my student days. He was appointed about seven years ago. I have been told that he is firmly addicted to the bottle, and indeed one of the most unpleasant recollections I have is of seeing him in an attack of *delirium tremens*. He had sunk into a drunken sleep in the small room where the bodies are prepared for dissection, and his awakening in those surroundings initiated an attack which I have never seen equalled. Next day after that attack of "'orrors," as he called it, he swore to forsake the bottle, but I am afraid his resolve soon gave way and he is as bad as ever."

Holmes's upper lip curled in a forbearing smile.

"It is only natural, my dear Watson, that you, a clinician of no mean ability, should have concentrated upon his physical disability, and that I, with a different eye, I admit, should have detected in a fortnight what you would never have discovered in ten years."

"What do you mean?" I asked.

"I mean that the arch-criminal Professor Larkin and your alcoholic anatomy attendant are the same person."

"You astonish me!"

"His pseudo-alcoholic tendencies are merely a guise intended to throw dust in the eyes of the unobservant, and I am afraid, Watson, that they appear to have been successful in deceiving you."

We were silent for a few moments. I was the first to speak:

"What are your plans?" I asked.

"It is now eight-thirty," he replied. "This evening at six o'clock I presented Larkin with a bottle of whisky of the crudest Irish brand I could buy, with which he retired to his little den, and I did not leave until I saw him half-way through it. He will now be asleep on the floor and I propose to walk in later on and catch him unawares."

"A good idea," I remarked; "when do we start?"

"In view of the fact that you are a medical man and your *alma mater* is involved, I am afraid I must leave you behind," said Holmes. "Should your name be mentioned in connection with this, you might be struck off the register—who knows? I shall arrive at the hospital at midnight, and in less than half an hour I hope to have the alcoholic professor under lock and key. You shall hear of it to-morrow."

The recent exhibition of pictures at the Paris Salon had been a particularly notable one, and Holmes, who is an artist of considerable merit, fell to discussing them with a keenness and insight which aroused my admiration, accustomed as I was to his versatility; the evening sped on and I rose to go shortly before eleven.

As I bade him *au revoir* his eyes shone as he said, "To-morrow I can snap my fingers in the face of officialdom, after I have rooted out the core of Europe's greatest criminal organization. Imagine their faces at the Yard when I arrive in a cab and deposit the drunken figure of Larkin with my compliments!"

On my way home I could not help a feeling of disappointment that after sharing the perils of many a dangerous adventure with Holmes I should be denied the pleasure of joining in his greatest triumph. I suddenly determined at least to witness it, although I might take no part in it, for Holmes is as unyielding as a rock, and would strongly resent any manner of opposition to his wishes. Making my way rapidly to the hospital I crossed the quadrangle and climbed up the fire-escape to the roof, which I knew well. The skylight over the attendant's room showed a dull glow and I carefully wormed my way towards it. Lying flat on my stomach I peered through the glass. Saunders I knew was a hardened drinker and already he was recovering from the fumes of his whisky. He was a powerfully built man, eminently fitted for his work of dealing with bodies of all sizes. He was sitting on the floor, the empty bottle beside him, muttering angrily at some imaginary assailant and fingering a large black eye, probably sustained by a fall during his evening's debauch.

I realized at once the danger that Holmes was in—should I hasten back and stop him? A moment's reflection negatived this, as I knew his anger would be extreme at my unexpected interference. I moved on to a large sky-light which illuminated the dissecting-room. This was in darkness, and I lay there with my face against the glass, in a fever of anxiety, awaiting Holmes's arrival.

The familiar sounds of a great hospital at night came through the darkness. The night superintendent's cough as she sat beneath a shelter in the quadrangle waiting for the house surgeon to finish his round sounded pathetically patient. Somewhere a telephone bell rang insistently, and down Goldfair Street the sound of lumbering footsteps, breaking periodically into a shambling trot, betrayed the district clerk going forth on his errand of mercy.

Shortly after, midnight boomed from the cathedral and I knew that Holmes would soon be at hand. Locked doors as a rule detained him but a short time, for he was an adept with his skeleton keys.

At last the brilliant gleam of an electric torch lit up the dissecting-room, and I knew he had arrived. Swiftly he made his way towards the attendant's room, but in his eagerness he must have tripped over a stool, for the torch suddenly lunged wildly and disappeared, together with the crash of falling furniture, which rang through the darkness. Instantly the room was flooded with light, and showed to my startled eyes a picture I shall never forget. Saunders, with a murderous expression of drunken malevolence, was standing near the electric light switches and glaring at Holmes, who, disguised as a surgeon in morning dress and white spats, was sitting on the floor near an overturned table, with his nose bleeding in a steady stream down his upper lip on to his white shirt. It must have dawned on Saunders that his visitor meant him no good, yet I knew that Holmes, with his fine courage, would never abandon his attempt at arrest, but rather fight on equal terms with his opponent.

The first move was made by the attendant, who, with a strategy which surprised me, leaped for the spiral staircase in the corner, ran up with incredible speed and arrived in the gallery which runs all around the dissecting-room. As yet no word had been spoken between them. Holmes, realizing the disadvantages of their relative positions, began to move, but was met by a perfect fusillade of bones, which Saunders hurled from the gallery with unerring aim. A scapula caught Holmes fairly on the side of the head, and he retired again beneath a table to consider his position.

It appeared that the efforts of my friend to reach his assailant would be unavailing, but his infinite resource came once more to his aid. Near the clock was a large life-sized plaster model of the human figure, used for demonstrations. It was apparently his idea to clamber by means of this on to the gallery railing before Saunders could run round and prevent him, for Holmes cautiously raised himself on all fours and carefully measured the distance with his eye. Unfortunately he partly lost the shelter afforded by the table and a skull shot from the gallery and struck him with terrific force. This provided the necessary solution to his hesitation, for with a yell of pain he sprang through the air like an ape.

I knew he was an admirable athlete; he was equally at home on the bowling-green and the billiard table. Only sea-sickness and an unexpected encounter with a crab had prevented him from swimming the Channel in his younger days. But of all his athletic achievements I have seen nothing finer than that leap. With coat-tails flying, his feet tucked well under the seat of his striped trousers he landed squarely upon the shoulders of the model and clung there, hugging its head to his chest with both arms. Another second and he would be in the gallery.

But as luck would have it the force of his jump proved his undoing, for the model rocked perilously, and before Holmes could leap away, both came to the floor with a crash. He strove to rise, but a femur whistled through the air like a boomerang and caught him a tremendous blow on the occiput. He gave one short cough and lay still.

As I lay on the roof my hair rose in horror as I saw the villainous Saunders creep downstairs towards his victim. I was helpless, for it would take me at least five minutes to find my way from the roof down to the dissecting-room in the darkness.

Holmes was already beginning to revive, but Saunders seized him, and holding his neck in a vice-like grip, he produced a pair of clippers from his pocket and cropped his hair as short as a convict's. Then, grasping his heels, he dragged him across the floor to one of the long zinc-lined tanks containing bodies for dissection. Opening the lid he unceremoniously thrust my friend inside, closed it and placed a heavy table on the top, after which he switched out the lights and disappeared into the darkness.

I waited until his footsteps had died away and then made my way as rapidly as I could to the dissecting-room. In a few seconds I had liberated Holmes and dragged him out struggling feebly, his fashionable clothes saturated with preservative and smelling pungently. I propped him up against the tank, swiftly collected the heap of hair from the floor, and went out into the surgery. I approached a porter, and in a few words explained that a student was asleep in the dissecting-room, having wandered there automatically after a celebration. The porter, with ten shillings transferred to his palm, readily undertook to see the misguided fellow home to the address I gave, and I made my way homewards, tired but satisfied with my work.

The following morning at breakfast a summons to the telephone revealed Mrs. Hudson's anxious voice: "Oh! Dr. Watson," she said, "do please come round and see Mr. Holmes—he came home early this morning in a terrible state like what I never dreamed he would have done, and he's still in bed and very irritable."

"Very well," I replied, "I will come in a few minutes."

I went round shortly after and the tremulous landlady showed me upstairs. Holmes was sitting up in bed, his head covered with a huge night-cap, which covered both his ears and his eyebrows. By his side was a bottle of whisky, a soda siphon and a glass.

"Well, Watson," he said somewhat sharply, "you are early. I never expected you, and in fact I am barely well enough to see anyone."

"That is why I came," I replied, "firstly because I heard you were ill, secondly to rejoice with you over the capture of Professor Larkin."

Holmes coughed. "Larkin must wait," he said. "I have been seized with such an acute attack of gout that my plans for his capture are all upset."

"But you are not usually subject to gout," I objected; "is there no other cause for it?"

"I can offer none," he retorted shortly.

"Gout," I remarked, "is often characterized by nodules on the ears," and with a sudden movement I snatched the night-cap off his head. Holmes made a grab to prevent it, but he was too late, and he flushed a deep crimson as his head was bared, cropped like a criminal's, and disfigured at the back with a pair of bumps the size of hen's eggs.

I drew back a pace and looked at him severely.

"I know you students are a trifle irresponsible,' I said, "but it seems to me a foolhardy prank to allow one of your colleagues to crop your hair like that in midwinter. I was early in the dissecting-room this morning, and amongst a pile of upturned furniture on the floor I found a heap of hair from which this lock is taken. I immediately recognized it as yours. Moreover I had a late call last night, and in passing down Baker Street on my way home I saw you lifted out of a cab and laid on the pavement in a condition in which I am happy to say I have never seen you before and I hope I shall never see you again. Far be it from me to preach, but before I left school for Cambridge my dear Headmaster sent for me and warned me against drink and women. It is largely owing to keeping his advice that I hold my present place in my profession," and as I spoke to Holmes I gently transferred his bottle of whisky to my own pocket, where it could tempt him no longer.

"Your gout, my dear Holmes," I concluded as I made for the door, "needs no other treatment but my Headmaster's advice—good-bye."

Holmes made one or two ineffectual attempts to speak, but his tongue failed him, and with a hand which trembled with emotion he poured himself out another glass of soda-water.

F. W. J. W.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

The 1st XV, after losing to Cambridge University on October 23rd by 18—0, have shown admirable form and have not been beaten since. In beating Coventry and Moseley and drawing with Northampton they have accomplished a noteworthy feat. The Club has been unfortunate in the matter of injuries, no fewer than eight backs being out of action at the same time. J. T. Rowe dislocated his shoulder against Cambridge and will be unable to play again this season; A. H. Grace, T. E. Burrows, C. D. Prowse, R. M. Marshall, J. A. Nunn, C. W. John and W. H. D. Trubshaw were all unable to play at the beginning of the month, but the majority are again fit and have started playing again. During this period the vacancies in the 1st XV three-quarter line were ably filled by the "A" players.

Several members of the Club have been called upon to represent their counties: J. T. C. Taylor has so far turned out with great success for the *Eastern Counties*, and has reproduced for them some of the form which he has shown for the Hospital; G. F. Petty played for *Cornwall* against Devon; R. N. Williams has turned into a wing forward for *Gloucestershire*, and T. E. Burrows played for *Sussex* against the Eastern Counties. In the United Hospitals team *v.* Edinburgh University, Bart.'s were well represented, having more members of the team than any other hospital: C. R. Jenkins, R. N. Williams, C. B. Prowse, J. T. C. Taylor and F. J. Beilby all turned out, while W. M. Capper was chosen, but was unable to play on account of a damaged shoulder.

The Club has now so many members that it has become necessary to run a seventh team. G. A. Ransome has been appointed secretary.

The junior teams have shown great enthusiasm in turning out so far, and, as will be seen by the Club records, are enjoying a very successful season. J. M. J.

St. Bartholomew's Hospital Rugby Football Club: Season 1929 30.

Team Record up to and including November 21st.

	Played.	Won.	Drawn.	Lost.	Pts. for.	Pts. agst.
1st XV	8	3	1	4	60	85
"A" XV	8	6	1	1	126	49
Extra "A" XV	9	6	1	2	143	81
"B" XV	8	4	0	4	128	65
"C" XV	7	5	0	2	134	03
Extra "C" XV	5	4	0	1	71	33
"D" XV	2	1	1	0	24	6
Total	47	29	4	14	686	382

St. Bartholomew's Hospital *v.* Cambridge University.

Result: Bart.'s, 6; Cambridge University, 18.

October 23rd, at Winchmore Hill.

Bart.'s were a singularly unlucky side to be beaten as they were by Cambridge; the final score of three goals and one try (18 pts.) to two tries (6 pts.) gave only the faintest reflection of the course of the play. This annual fixture is invariably played early in the 'Varsity term, but not, as a rule, too early for one or two reasonable deductions to be drawn from the result, and the hard, well-packed scrummaging of the Bart.'s forwards, buttressed by close marking and tackling, nearly had Cambridge a beaten side. The loss of Guy Morgan owing to an injured wrist was not nearly enough to explain the score of 0—0 at half-time, neither was an injury to one of Bowcott's hands sufficient to explain why the Hospital opened the scoring, and why also, having to all intents and purposes given away a try under the posts, we scored again and led by 6—5. Up to this point, and indeed even after J. T. Rowe had to go off owing to a dislocated shoulder, Cambridge looked a very moderate team, in spite of an obvious advantage in weight in the pack and a no less obvious advantage in first-class players in the back division; and it was not until the Bart.'s forwards began to weaken as the result of C. R. Jenkins's withdrawal from the pack to fill the gap on the right wing that Cambridge at last gained ascendancy. Then, as against the Harlequins, the 'Varsity pack joined effectively in the assault. There were not many outstanding events during the first half apart from the injury to Guy Morgan, still, it should be noted that the comparatively light Bart.'s pack stood up well to their opponents, both inside and outside the scrummage, while the backs tackled their men after the manner of Hospital cup-ties.

W. D. B. Hopkins, though not well served by his forwards, managed to open up the game a fair number of times for the 'Varsity, but J. T. C. Taylor proved to be a continual source of worry to him, and managed to break away from him several times. N. E. Browning, the 'Varsity full-back, was none too happy in facing the Hospital pack, and one forward rush, led by J. R. Jenkins, nearly produced a try. W. M. Capper took a penalty kick which just failed to be converted, and soon afterwards T. E. Burrows nearly dropped a goal.

From a breakaway by Taylor, C. R. Jenkins managed to open the scoring with a try for Bart.'s, which was not converted. Almost directly afterwards T. J. Ryan had a kick charged down, and N. A. York scored a try for the 'Varsity which was converted by F. H. Waters. Even this setback did not discourage us and Taylor scored our second try, by means of a slip-away from the scrummage which was quite reminiscent of A. T. Young at his best. After Bart.'s had lost Rowe, and after Bowcott had been moved to full-back with Browning filling the stand-off position, further tries were added for the 'Varsity by N. A. York, F. M. Heywood and P. W. P. Brook.

Team: T. J. Ryan (*back*); J. T. Rowe, T. E. Burrows, G. F. Petty, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

Cambridge University: N. E. Browning (*back*); R. W. Smeddle, T. H. Tilling, W. G. Morgan, F. M. Heywood (*three-quarters*); H. M. Bowcott, W. D. B. Hopkins (*halves*); F. H. Waters, J. J. A. Embleton, P. W. P. Brook, C. L. Ashford, S. M. Saunders-Jacobs, C. H. Williams, R. J. A. Kaulbach and N. A. York (*forwards*).

St. Bartholomew's Hospital *v.* Coventry.

Result: Bart.'s, 8; Coventry, 3.

October 26th, at Winchmore Hill.

Bart.'s were without R. N. Williams, C. B. Prowse and T. E. Burrows, while Coventry had Coulson absent. The first half was very evenly contested, neither side scoring. The Hospital forwards showed excellent form and gained possession of the ball time and again. Taylor was the main factor in the Bart.'s success, and being well served by his pack, opened up the game with rare dash and cleverness. The three-quarters, although not spectacular, were always very sound. R. M. Kirkwood and J. D. Powell scored for Bart.'s, W. M. Capper converting the former try with a beautiful kick. P. Clarke scored an unconverted try for Coventry. The closing stages of the match were played at a terrific pace, Coventry attacking, and it was only through the fine defence of the whole Bart.'s side that our line was not crossed again.

Team: T. J. Ryan (*back*); G. F. Petty, R. M. Kirkwood, A. E. Pirie, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis, A. T. Blair (*forwards*).

St. Bartholomew's Hospital *v.* Moseley.

Result: Bart.'s, 8; Moseley, 0.

November 2nd, at Moseley.

Following our win against Coventry, it was expected that we should repeat our success and add Moseley to our credit. C. B. Prowse and T. E. Burrows were still on the injured list, and A. H. Pirie and R. M. Kirkwood again filled the vacancies. The weather was sultry, and it was the first muddy game of the season. Soon after the kick off Bart.'s nearly scored, Petty cross-kicking for Jackson to pick up, but he was brought down a few inches from the Moseley line by Knott, the home full-back. Powell scored a try soon afterwards from a movement started by Taylor; Capper converted. Petty then scored for the Hospital. The second half produced no further score; the forwards were evenly matched, Moseley having the better of it in the tight, but Bart.'s showed more speed in the loose. The three quarters gave quite a display of bright football. Taylor was again in evidence and gained much ground by his short punts to touch. T. J. Ryan played a sound game at full-back, but had little to do in the second half.

Team. T. J. Ryan (*back*); G. F. Petty, A. H. Pirie, R. M. Kirkwood, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

St. Bartholomew's Hospital *v.* Northampton.

Result: Bart.'s, 10; Northampton, 10.

November 9th, at Winchmore Hill.

G. F. Petty and R. N. Williams were playing for their counties, R. M. Marshall and A. T. Blair coming into the side to fill their places. Northampton had a very strong side, the only change from the selected side being J. Bentley in the place of J. Millward, the visitors' scrum half. The game was very evenly contested. The Northampton pack showed excellent form, both in the tight and in the loose, but the Hospital forwards managed to get their share of the ball; this was especially important, as we held the advantage in the back division. Beilby scored a clever try for Bart.'s, which Capper converted. Northampton replied with a penalty kick by Haslemere. Soon after the opening of the second half Briggs scored a try, which Capper converted. This was closely followed by Weston scoring an unconverted try for the visitors. Up to this stage of the game it looked as if we were going to repeat our success against Coventry and Moseley and add Northampton as the third Midland side to our credit. The final stages of the game were fought out very hard, with Northampton trying to pull the score round in their favour and Bart.'s determined not to lose the lead. The climax arrived a few minutes before "no-side," when Haslemere from 40 yards' range dropped a magnificent goal, thus drawing the game. The last few minutes resulted in Bart.'s again reaching the visitors' half, and through some magnificent movements on the part of the backs nearly scored, but the Northampton defence was sound and the game ended in a draw.

Team: T. J. Ryan (*back*); R. M. Marshall, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); G. D. S. Briggs, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, B. S. Lewis, A. T. Blair, D. P. McCoy (*forwards*).

St. Bartholomew's Hospital *v.* London Irish.

Result: Bart.'s, 11; London Irish, 0.

November 16th, at Motspur Park.

Bart.'s turned out a full side, but the weather conditions were atrocious, the game being played in rain and sleet. The Hospital backs showed great skill in handling the ball in the opening stages of the game, but conditions soon became too bad for them to do much in the way of open football and the game developed into a forward struggle. It was during the opening play that Bart.'s did all their scoring. G. F. Petty scored far out from a movement started by Taylor. Soon afterwards Taylor cut through on his own and scored the second try, neither try being converted. Finally after a fine dash, again by Taylor, who passed to C. R. Jenkins, the Hospital obtained their third try. This was converted by the scorer. In the first half the Bart.'s forwards dominated the play and obtained the ball every time in the tight; in the open, although rather inclined to kick too far ahead, they combined to bring off some fine forward rushes.

In the second half the Irish forwards began to get together better and we did not have everything quite our own way as in the first half. T. J. C. Taylor again gave of his best form, and all the scoring was the result of movements by him. The backs played well considering the adverse conditions, and T. J. Ryan at full-back showed up well against his opposite number.

Team: T. J. Ryan (*back*); G. F. Petty, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, T. J. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

HOCKEY CLUB.

St. Bartholomew's Hospital *v.* Beckenham II.

Played at Winchmore Hill on October 12th. For the first time for several years the Hospital were beaten in their match with Beckenham II by 3 goals to *nil*. Our opponents were faster and quicker and more accurate than we were, and deserved the three goals they scored. Our halves, and in particular Hunt, gave the forwards many opportunities, but lack of control of the ball and combination were the chief reason why we failed to score.

Team: H. L. Hodgkinson (*goal*); P. M. Wright, F. C. H. White (*backs*); J. H. Hunt, W. F. Church, V. C. Snell (*halves*); A. E. Williams, J. W. C. Symonds, E. W. Burstal, L. F. Jameson-Evans, E. J. Neill (*forwards*).

St. Bartholomew's Hospital *v.* Woolwich Garrison.

Played at Woolwich on October 19th. In this match White, who had played back all the previous season, was brought into the forward line, and Iliff was put at left back in the place of White. The experiment worked well, for the forwards played with better combination and more dash, and our defence was able to keep our opponents out of the circle. The halves did plenty of good work, and gave the forwards every opportunity to get used to the new combination. Iliff played a good game at back, and with Wrigh we should have a sound pair of backs. The goals were scored by the forwards, who each scored one. Our opponents, who played a very strenuous game, well deserved their one goal; the forwards in particular were good, and looked like scoring on several occasions.

The Hospital won by 5 goals to 1.

Team: H. L. Hodgkinson (*goal*); P. M. Wright, A. D. Iliff (*backs*); M. S. Fordham, W. F. Church, J. H. Hunt (*halves*); A. E. Williams, J. W. C. Symonds, F. C. H. White, L. P. Jameson-Evans, E. J. Neill (*forwards*).

St. Bartholomew's Hospital *v.* Radlett.

Played at Radlett on October 26th. A hard but rather scrappy game resulted in a win for the Hospital by 4 goals to *nil*. The first half was well contested, but in the second half the ball seldom was in our half of the field. The forwards worked hard and did well to score four goals considering the uneven surface of the ground. The score would have been considerably greater had it not been for the good goal keeping of our opponents: many well-aimed shots were stopped and cleared.

Team: H. L. Hodgkinson (*goal*); P. M. Wright, A. D. Iliff (*backs*); J. H. Hunt, W. F. Church, M. S. Fordham (*halves*); R. T. Davidson, F. C. Roles, F. C. H. White, A. T. Pagan, E. J. Neill (*forwards*).

St. Bartholomew's Hospital *v.* Trinity College, Cambridge.

Played at Winchmore Hill on Saturday, November 2nd; resulted in a win for the Hospital by 4 goals to 2. Our opponents started off with a forward rush and were with difficulty stopped from scoring. The attack was resumed, and their forwards, running through the defence, scored. This was soon followed by another goal. Our forwards, who had up till now not been combining well, got together, and through Jameson-Evans and Youngman scored two goals by half-time. With the hill in our favour our forwards worked well, and with good support from the halves managed to score two more goals through Davidson and Youngman. Our opponents pressed hard, but were unable to add to their score. The game was a fast and strenuous one, and we did well to win after having been two goals down.

Team: H. L. Hodgkinson (*goal*); P. M. Wright, A. D. Iliff (*backs*); J. H. Hunt, W. F. Church, M. S. Fordham (*halves*); R. T. Davidson, A. Youngman, F. C. H. White, L. P. Jameson-Evans, E. J. Neill (*forwards*).

St. Bartholomew's Hospital *v.* Reading University.

Played at Winchmore Hill on Saturday, November 9th. After a very handsome win against University College Hospital last week Reading came to Winchmore and we expected a hard game. From the bully-off our forwards took the ball to our opponents' circle, but were unable to score. Following this the play was fairly evenly distributed to the two halves of the field until, following a good forward movement, Jameson-Evans scored a goal. Up to this the play had been rather ragged, but now the forwards seemed encouraged and our opponents' defence was severely tested. Our opponents pressed, but were unsuccessful. Jameson-Evans scored our second goal just before half-time. In the second half we had the advantage of the hill and this was made use of by White, who ran through and scored. The play stayed more or less in the middle of the field until just near the end Neill scored after beating two or three of the defence.

Neill played a good game, sending across many excellent centres. The defence worked very hard and much good work was done by our opponents scored their one goal, which was well deserved, after a determined forward attack, the result being 4—1 in our favour.

Team: H. L. Hodgkinson (*goal*); P. M. Wright, A. D. Iliff (*backs*); J. H. Hunt, M. S. Fordham, K. W. D. Hartley (*halves*); R. T. Davidson, A. Youngman, F. C. H. White, L. P. Jameson-Evans, E. J. Neill (*forwards*).

ASSOCIATION FOOTBALL CLUB.

The 1st XI have been extremely unfortunate in having several players either on the injured list or absent owing to illness. It is especially regrettable that Keane, our captain, is unavailable this term owing to illness in his home circle. He is not only the mainstay of the side, but also its inspiration. Under the circumstances the team have no reason to be despondent with the results to date, and there is still every likelihood of our Cup team for next term being superior to that which played in the Final at Wembley last season.

Results.

October 26th: 1st XI *v.* Caius College, Cambridge, home; won, 5—0.
November 2nd: 1st XI *v.* Keble College, Oxford, away; lost, 2—3.
November 9th: 1st XI *v.* Caius College, Cambridge, away; lost, 3—5.
November 16th: 1st XI *v.* Old Mercers, home; lost, 2—5.
November 23rd: 1st XI *v.* University College, away; won, 3—2.

UNITED HOSPITALS HARE AND HOUNDS.

THE Five Miles Club Handicap was run at Hayes on October 23rd under ideal conditions. T. L. Timms (St. Thomas's) was the winner, and considerable talent was shown by some of the new members of the Club.

Three matches have been run so far. The first, against University College and Hospital on October 30th, at Perivale, resulted in an easy victory for the Hospitals. H. C. Harley (St. Mary's) and H. B. C. Sandiford (St. Thomas's) were first and second respectively.

The second match was against the Thames Hare and Hounds on November 9th. H. C. Harley, representing the Thames, retained their 7-Mile Challenge Cup by winning in 40 min. 35 sec. The first Hospitals man home was R. C. Somerset (K.C.H.), who was third. The Thames won by 34 points to 41.

The match against Westminster Bank on November 13th at Hayes was won by the Bank. The race was very keen and the plough soft.

All Bart.'s men who are at all interested in cross-country running should come down to Hayes and go on one of the practice runs. Particulars and fixture list are posted in the Abernethian Room.

CORRESPONDENCE.

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

DEAR SIR,—The Council of the Students' Union have received the resignation of Mr. A. A. Miles with regret, and desire to thank him for the conscientious manner in which he carried out his work as Editor of the JOURNAL.

Yours faithfully,

A. H. GRACE,
G. D. S. BRIGGS,
Hon. Secs., Students' Union.

St. Bartholomew's Hospital,
London, E.C. 1;
November 22nd, 1929.

THE TREATMENT OF MEASLES.

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

DEAR SIR,—In the last issue of the JOURNAL (September, 1929, XXXVI, p. 202) which recently arrived I noted your desire to hear about the treatment of measles. I enclose herewith the details, which I hope you will find beneficial.

I regret that I misinterpreted the statement that fresh air was the best treatment for influenza.

Yours sincerely,

G. E. MURRAY.

Johannesburg;
October 16th, 1929.

In February, 1924, I was requested to go to see a child who had been ill for four days and was very feverish.

On inspection the measles rash was just coming out, the temperature was 104° F. and the child was restless and miserable. I decided to prescribe something to reduce the fever: pyramidon occurred to me. I ordered the proportional dose for age; I instructed the mother to give one powder that morning, another midday, one that night, and a fourth first thing the following morning. When I went to see him he said, "Can't I get up and go and play; I am quite well." On examination there was no rash and temperature was normal; subsequently there was no cough or other complication. It naturally occurred to me that a mistake had been made in diagnosis, but I determined to remember it.

A short time afterwards there were thirty cases of measles among the children at Nazareth House, which gave the opportunity of testing the treatment. In two days they were all playing out in the grounds, not one developed cough or other complication, and there was no further infection.

Subsequently there has been no failure in treating individual cases.

It makes an enormous difference to the patients: instead of being in bed for the best part of a fortnight they are well in two or three days. In the *British Medical Journal* of July 12th, 1924, I saw a short paragraph that Dr. Locwenthal had made a similar discovery: consequently I decided not to publish it as it was already known.

A few months ago there were twelve children in the same institution who clinically had scarlet fever, with typical rash and considerable temperature. They were given the same treatment. In two days rash and temperature had disappeared, there was no peeling, except in one case, who had been ill for four days before she was seen, and no complications. I went up to the Institute for Medical Research and asked if it was possible to prove that the cases were scarlatina, but was informed that it was impossible.

The arrangement was arrived at that should any fresh cases occur the necessary investigation would be undertaken before treatment was commenced.

G. E. MURRAY.

REVIEWS.

MOVABLE KIDNEY, ITS ÆTIOLOGY, PATHOLOGY, DIAGNOSIS, SYMPTOMS AND TREATMENT. By WILLIAM BILLINGTON, M.S.(Lond.), Ch.M.(Birm), F.R.C.S., Professor of Surgery, University of Birmingham. Second Edition. (London: Cassell & Co., Ltd., 1929). Pp. ix + 177. Price 12*s.* 6*d.* net.

When a surgical procedure falls into disfavour owing to extravagant claims made on its behalf as a therapeutic method, it is inevitably a slow and tedious process for it to become re-established as a method having justifiable indications. If nephropexy is at present in disfavour it is for two reasons: firstly, its employment in the past has been too indiscriminate, and secondly, many of the so-called nephropexies have been technical failures when judged by clinical and radiological standards. In consequence the operation is one which in most quarters is rarely carried out, and even when carried out the surgeon is invariably full of misgiving as to the probable result. So much so is this the case that it appears almost necessary to go to Birmingham to get a kidney fixed at all—a state of affairs which has prompted a cynic to remark that in that city the industry of nephropexy was second only in importance to the manufacture of screws.

The present volume is the second edition of a work which appeared nineteen years ago, and embodies the author's experience of twenty-five years of about 2,000 nephropexies. Full accounts of the pathology, symptomatology and treatment of movable kidney are given, with especial reference to the technique employed by the writer in his operation of nephropexy. Although as a general rule pyelography is not employed in the investigation of straightforward cases, it is invaluable in the doubtful ones, and should then be carried out both in the horizontal and vertical positions, the latter being of great importance. Success or partial success is claimed in about 70% of the cases, but the value of these figures is difficult to assess, since in the majority of cases appendicectomy was carried out at the same time.

The book is not intended for students, but is to be recommended to all interested in urology. The author is certainly an enthusiast for nephropexy, but if his work serves only to bring about a more rational outlook among surgeons on the subject of movable kidney it will have performed a most useful service.

THE AFTER-TREATMENT OF OPERATIONS. By P. LOCKHART-MUMMERY, F.R.C.S. Fifth edition. (London: Baillière, Tindall & Cox, 1929.) Pp. ix + 281. Illustrated. Price 7*s.* 6*d.* net.

After-treatment of operations may be a science or it may be an art, but it is liable to degenerate into a routine handed down from house surgeon to house-surgeon. Mr. Lockhart-Mummery's admirable little book, now in its fifth edition, gives a very sound and comprehensive account of modern methods with regard to the after-care of the various types of operation, with special reference to the common complications. An interesting addition is Dr. Dukes's method of preventing infection from an inlying catheter. Mr Gabriel gives a concise account of blood transfusion, though the tube and cannula arrangement suggested for the citrate method is unsatisfactory in patients who are very collapsed. A diagram of the Keynes apparatus would have been helpful.

Criticism of so useful a work is out of place, but a curious misprint occurs in several references to Milton's solution, the strength of which is stated to be "31 to the pint." Details of the diet suitable for cases of gastro-enterostomy or partial gastrectomy for chronic ulceration would be useful.

The book can be strongly recommended to past, present and future house-surgeons and physicians.

TEXT-BOOK OF PATHOLOGY. By ROBERT MUIR, M.A., M.D., Sc.D., LL.D., F.R.S. Second Edition. (London: Edward Arnold & Co., 1929.) Pp. 872. 501 illustrations. Price 35*s.*

The second edition of Muir's "Pathology" contains about a hundred pages more matter than the first, of which some are taken up by some seventy new figures. The book has been revised with little increase in bulk and a great increase in value. The new figures are mainly histological photo-micrographs, especially in the expanded tumour sections, *e.g.* of the thyroid and breast, and in diseases of the spinal cord.

There are new articles upon thrombo-angeitis obliterans, capillary hyperæmia and anoxæmia, and cyanosis, decompensation, glanders, rabies, Schilder's encephalitis and sickle-celled anæmia; while leprosy has an expanded section, and Raynaud's disease is treated fully under arterial disease.

The section upon the spread of carcinoma and the ætiology of tumours has been largely re-written, and the work of Gye and Barnard is discussed.

The treatise on inflammation is modified to admit the later conceptions of the reticulo-endothelial system, and the pernicious anæmia, lymphadenoma and Gaucher's disease articles are brought up to date, while on the more physiological side, McNee's work on the liver and a discussion of renal sufficiency test receive their due.

The whole edition is worthy to follow its predecessor as a sound, readable and sufficiently detailed text-book of orthodox pathology. We can recommend it without reservation.

ESSENTIALS OF MEDICAL ELECTRICITY. By E. P. CUMBERBATCH, B.M., D.M.R.E., M.R.C.P. Sixth edition, revised and enlarged (London: Henry Kimpton, 1929.) Pp. xvi, + 443. Illustrated. Price 10*s.* 6*d.* net.

It is eight years since the last edition of this excellent book appeared. The plan of the present edition is like that of its predecessor, but the book has been increased considerably in size. A new chapter has been added on the treatment of pelvic and prostatic infections by diathermy. Unfortunately, this section has not got quite sufficient detail, and those desiring to use this treatment should refer to the fuller account given by the author in his book on diathermy. The section dealing with the galvanic current has been rewritten with the introduction of a new nomenclature, which will make the subject easier to follow. A paragraph has been added on chronaxie, but the preceding part on condenser discharge testing does not make use of it, the condensers being charged to an arbitrary voltage instead of twice the rheobase. There are valuable additions on the significance of the various types of electrical reactions, and several new diseases appear in the list of those likely to benefit from electrical treatment.

The book is easy to follow, and contains all the necessary information for those taking the D.M.R.E. It should be invaluable to all those wishing to practise electrotherapy, and is a very useful guide to those wishing to know the scope and possibilities of electricity in medicine and surgery.

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

APPLETON, A. B., M.A., M.D., M.R.C.S., L.R.C.P. *Laboratory Guide to Vertebrate Dissection.* Cambridge University Press, 1929.

ARKWRIGHT, J. A., M.D., F.R.C.P., F.R.S. Bradshaw Lecture on "The Virulence of the Micro-organism in Infective Disease." Delivered before the Royal College of Physicians of London on November 5th, 1929. *Lancet*, November 9th, 1929.

BARRIS, J. D., F.R.C.P., F.R.C.S. "Chronic Cervicitis (Leucorrhœa)." *British Medical Journal*, October 12th, 1929.

BEATTIE, W. J. H. M., M.A., B.Chir., M.R.C.S. "Suppurative Pericarditis as a Complication of Acute Osteomyelitis." *Clinical Journal*, October 30th, 1929.

BERTWISTLE, A. P., M.B., Ch.B., F.R.C.S.(Edin.). "Motorist's Heel." *British Medical Journal*, November 9th, 1929.

BOURNE, GEOFFREY, M.D., F.R.C.P. "Some Clinical Aspects of Cardiac Pain." *Clinical Journal*, October 9th, 1929.

CHANDLER, F. G., M.D., F.R.C.P. "Conditions Simulating Pulmonary Tuberculosis." *British Medical Journal*, Oct. 19th, 1929.

CLARK, FRANCIS, M.D., M.R.C.P. "Leprosy Treatment in Wei-hei-wai, N. China." *Leprosy Notes*, October, 1929.

COCHRANE, R. G., M.D., M.R.C.P., D.T.M. & H. "The Position of Iodides in the Treatment of Leprosy." *Leprosy Notes*, October, 1929.

COCKAYNE, E. A., D.M., F.R.C.P. "Life's Endless Chain." *Lancet*, October 5th, 1929.

COLT, G. H., M.B., B.Ch., F.R.C.S. "Pain as a Guiding Symptom in the Injection Treatment of Varicose Veins." *British Medical Journal*, November 9th, 1929.

CROOK, ERIC A., M.Ch.(Oxon.), F.R.C.S. *Aids to Orthopædic Surgery.* London: Bailliere, Tindall & Cox, 1929.

CUMBERBATCH, ELKIN P., M.A., B.M.(Oxon.), D.M.R.E.(Camb.), M.R.C.P. *Essentials of Medical Electricity.* Sixth Edition. London: Henry Kimpton, 1929.

CUNNINGHAM, L., M.B., M.R.C.P. (and DAINOW, M. M., M.D.). "The Importance of the Liver in Chemotherapy." *Lancet*, September 28th, 1929.

DIVE, Major G. H., D.S.O., R.A.M.C. "A Case of Cysticercosis (*Cysticercus cellulosæ*)." *Journal of the Royal Army Medical Corps*, November, 1929.

GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S. "The Radium Problem.—I. Introductory." *British Journal of Surgery*, October, 1929.

GROVES, ERNEST W. HEY, M.S., M.D., B.Sc., F.R.C.S. "The Borderland between Surgery and Gynæcology." *Bristol Medico-Chirurgical Journal*, Autumn No., November, 1929.

HADFIELD, GEOFFREY, M.D., M.R.C.P. "The Association between Angioma of the Cerebellum, Polycystic Pancreas and Renal Adenoma (Lindau's Syndrome)." *Bristol Medico-Chirurgical Journal*, Autumn No., November, 1929.

HANNAN, JOHN H., M.A., M.D., B.Ch. "Ovarian Transplantation." *Journal of Obstetrics and Gynæcology, British Empire*, Autumn No., 1929.

HANSCHELL, H. M., D.Sc., M.R.C.S., D.T.M. & H. "The Problems of Venereal Disease in the Mercantile Marine." *British Journal of Venereal Diseases*, July, 1929.

HARTRIDGE, H., M.A., M.D., Sc.D., F.R.S. "The Central Nervous System and Sense Organs." *Starling's Principles of Human Physiology*, 5th edition. London: J. & A. Churchill, 1930.

HEALD, C. B., C.B.E., M.D., M.R.C.P. "Electrical Treatment in Acute Conditions." *Lancet*, November 9th, 1929.

HERNAMAN-JOHNSON, F., M.D.(Aberd.), D.M.R.E.(Camb.). "The Present Position of X-Ray Therapy in Malignant Disease." *British Medical Journal*, October 5th, 1929.

HERRINGHAM, Sir WILMOT P., K.C.M.G., C.B., F.R.C.P. Harveian Oration entitled "Circumstances in the Life and Times of William Harvey." *Lancet*, November 2nd, 1929.

HORDER, Sir THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "Medical Notes." *Clinical Journal*, October 2nd, 1929.

——— "More Medical Notes." *Clinical Journal*, October 9th, 1929, and November 13th, 1929.

——— "Treatment of Pleuritic Effusions." *British Medical Journal*, October 5th, 1929.

HOWELL, B. WHITCHURCH, F.R.C.S. "The Treatment of Torticollis." *British Medical Journal*, October 19th, 1929.

HUME, J. BASIL, F.R.C.S. "The Causation of Multiple Exostoses." *British Journal of Surgery*, October, 1929.
LEGGE, Sir THOMAS MORISON, C.B.E., M.D. Shaw Lectures on "Thirty Years' Experience of Industrial Maladies," delivered before the Royal Society of Arts, February and March, 1929.
——— "Beauty in the Factory," *Strand Magazine*, October, 1929.
LEITCH J. NEIL, M.D., M.R.C.S., L.R.C.P., D.T.M.&H. *The Use of Standard Treatments in the Campaign against Disease in the Tropics.* With an Introduction by Dr. G. CARMICHAEL LOW. London: H. K. Lewis & Co., 1929.

EXAMINATIONS, ETC.

University of Cambridge.

The following degree has been conferred:
M.B., B.Chir.—Gray, R. A. P.

University of Durham.

The following degree has been conferred:
M.D.—Rivaz, P. M.

Conjoint Examination Board.

First Examination, October, 1929.

Anatomy.—Chester-Williams, T. L., Lawn, J. A. E., Morgan, G. R.
Physiology.—Brownlees, T. J. K., Lawn, J. A. E., Lewis, B. S., Morgan, G. R., Oxley, W. M.
Pharmacology and Materia Medica.—Adams, F. P., Bamford, H. C., Robertson, H. D., Simmons, H.

Final Examination.

The following have completed the examination for the Diplomas of M.R.C.S., L.R.C.P.:
Davies, T., Edward, J. A., Edwards, H. G., Fisher, J. F., Graetz, G. H. A., Gurney, A. H., Hopton, J., Kramer, N., de Labilliere, C. D. D., Phelps, I. E., Pomarantz, F., Pope, E. S., Smith, J. O., Stephens, J. E. S., Taylor, J. M., Whitehurst, T. H. N.

Royal College of Physicians.

The following have been elected *Members* of the Royal College of Physicians: Malk, M., Miles, A. A.

Royal College of Surgeons.

The following candidate was successful at the examination held at *Toronto* for the *Primary Fellowship* in August, 1929: Olver, L. R.

Royal College of Physicians of Edinburgh.

The following has been elected a *Fellow* of the Royal College of Physicians of Edinburgh: Bose, A. N.

Royal College of Surgeons of Edinburgh.

The following has been admitted a *Fellow* of the Royal College of Surgeons of Edinburgh: Pearson, L. V.

Royal College of Physicians and Surgeons.

D.O.M.S.

The Diploma has been conferred on: Briggs, W. A.

CHANGES OF ADDRESS.

FIDDIAN, E. A., Milford, 5, The Goffs, Eastbourne.
GELL, H. W., Wicksted, near Leamington, Warwickshire.
GODLIFFE, R. V., St. Ives, Worcester Park, Surrey.
HAMILTON, Lt.-Col. W. G., I.M.S., Warwick Bench House, Guildford, Surrey.
KLABER, R., 88, Harley Street, W. 1. (Tel. Langham 1874.)
MAITLAND, C. R., 34, Victoria Road, Southwick, Sussex.
MELLOWS, P. B. P., Town Hall, Stonehouse, Plymouth.
SAUNDERS, W. E. R., 7, Holmlands Park, Chester-le-Street, co. Durham.
SELWYN CLARKE, P. S., Chief Health Officer, Kuala Lumpur, Federated Malay States.
SHAH, Major J. M., I.M.S., c/o Lloyds Bank Ltd., 6, Pall Mall, S.W. 1.
SHERRARD, N., Fairseat, Beccles, Suffolk. (Tel. Beccles 57.)

APPOINTMENTS.

BALLINGER, O. D., B.M., B.Ch.(Oxon.), appointed Honorary Assistant Physician to the Royal Infirmary, Bradford.
CASTLEDEN, L. I. M., M.B., B.S.(Lond.), appointed Assistant Medical Officer to Highgate Hospital, Dartmouth Park Hill.
MELLOWS, P. B. P., L.M.S.S.A., appointed Assistant Medical Officer of Health and Medical Inspector of Aliens, City and Port of Plymouth.
SAUNDERS, W. E. R., M.R.C.S., L.R.C.P., D.P.H., appointed Medical Officer of Health for the Chester-le-Street Urban District Council, and District Tuberculosis Officer for the Durham County Council.
SELWYN-CLARKE, P. S., M.D., M.R.C.P., D.P.H., appointed Chief Health Officer, Federated Malay States.

BIRTHS.

COCHRANE.—On October 29th, 1929, at Northampton, to Gwen (*née* Asplin), wife of Dr. T. S. Cochrane, of Dartford—a son (John Graeme).
HOLMES.—On November 4th, 1929, at 54, Hoghton Street, Southport, to Phyllis (*née* Stansfeld), wife of John Holmes, M.B., M.R.C.P.—a son.
HORSBURGH.—On November 3rd, 1929, at Lyndhurst, Manor Court Road, Nuneaton, to Dr. and Mrs. P. G. Horsburgh—a son.
SCOTT BROWN.—On October 25th, 1929, at The Vine, Sevenoaks, to Peggy (*née* Bannerman), wife of W. G. Scott Brown, F.R.C.S.E.—a son.
STARKEY.—On October 23rd, 1929, at 2, Spring Grove Gardens, Richmond, to Squadron Leader and Mrs. H. S. Crichton Starkey—a son.

MARRIAGE.

LLOYD—HUNT.—On October 23rd, 1929, at the Parish Church, Curry Rivel, Somerset, William Jeaffreson, second son of Mr. and Mrs. C. O. Lloyd, of Newport, Mon., to Hazel Lumsden, only daughter of Mrs. and the late Mr. F. L. Hunt, of Hillards, Curry Rivel.

DEATHS.

GRAY.—On November 19th, 1929, at "Little Haven," Ealing, of heart failure, John Alfred Gray, M.B.(Lond.), in his 72nd year.
KENDREW.—On October 23rd, 1929, in a nursing home, London, Alexander John Kendrew, M.C., M.B., White House, Mile End, Colchester.
MARTIN.—On November 8th, 1929, at the Clock House, Abingdon, Paulin Martin, L.S.A.(Lond.), M.R.C.S., only son of the late John Frisney Martin, Surgeon, of the Clock House, Abingdon, aged 87.
WHITEFORD.—On November 13th, 1929, Charles Hamilton Whiteford, M.R.C.S., L.R.C.P., of Sussex Terrace, Plymouth.

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, E.C. 1.*
The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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.1. Telephone: City 0510.*

St. Bartholomew's Hospital Journal.

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

VOL. XXXVII.—No. 4.] JANUARY 1ST, 1930. PRICE NINEPENCE.

CALENDAR.

Fri., Jan. 3.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Sat., ,, 4.—Rugby Match *v.* Harlequins. Home.
Hockey Match *v.* Shoeburyness Garrison. Away.
Tues., ,, 7.—Prof. Fraser and Prof. Gask on duty.
Fri., ,, 10.—Sir Percival Hartley and Sir Holburt Waring on duty.
Sat., ,, 11.—Rugby Match *v.* Old Hailcyburians. Home.
Association Match *v.* Old Wykehamists. Home.
Hockey Match *v.* Old Uppinghamians. Home.
Mon., ,, 13.—Special Subject: Clinical Lecture by Dr. Cumberbatch.
Tues., ,, 14.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Fri., ,, 17.—Dr. Langdon Brown and Sir Charles Gordon-Watson on duty.
Medicine: Clinical Lecture by Dr. Langdon Brown.
Sat., ,, 18.—Rugby Match *v.* Gloucester. Away.
Association Match *v.* Old Westminsters. Home.
Hockey Match *v.* University of Reading. Away.
Mon., ,, 20.—Special Subject: Clinical Lecture by Mr. Elmslie.

Last day for receiving matter for the February issue of the Journal.

Tues., ,, 21.—Dr. C. M. Hinds Howell (acting) and Mr. Harold Wilson on duty.
Thurs., ,, 23.—**Abernethian Society: Clinical Evening at 5.30 p.m.**
Fri., ,, 24.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Dr. Langdon Brown.
Sat., ,, 25.—Rugby Match *v.* Pontypool. Home.
Association Match *v.* St. John's College, Cambridge. Away.
Hockey Match *v.* St. Albans. Away.
Mon., ,, 27.—Special Subject: Clinical Lecture by Mr. Rose.
Tues., ,, 28.—Sir Percival Hartley and Sir Holburt Waring on duty.
Fri., ,, 31.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.

EDITORIAL.

THE PRINCE'S VISIT.

ON Wednesday, December 4th, at 4.45 p.m., H.R.H. The Prince of Wales visited the Hospital to inaugurate the Reconstruction Appeal. We reprint elsewhere a report at length of the speeches and addresses with which the occasion was graced. Nevertheless nothing, not even the Prince's sincerity, the Lord Mayor's optimism, the Archdeacon's fervour, nor the dramatic lighting of the beacon light, was so impressive as the scene from the windows of the Great Hall, while the procession crossed the Square through the living hedge of nurses and students, in the white light of the photographers' flares, and to the resounding music of the cheering. At this moment the occasion touched reality, the reality of Bart.'s loyalty to its President, its appreciation of his visit, and its faith in the virtue of his example.

Through the glare of publicity that "press stunts" and advertisements have directed upon the Hospital, it is difficult to visualize the reality that has called it forth. We imagine that the Hospital, dipping her hand into coffers which have served her for eight hundred years, can never find an end to her resources. We forget that, with the increasing value of her possessions, demands grow ever more urgent. A larger population, wider fields of treatment, more expensive apparatus, accommodation for the new sciences which have grown up under the shield of Minerva Medica, have made the situation so grave, that in accordance with the procedure proper to medicine puzzled, the Hospital has been put into the hands of the specialists—of men whose business is to collect money. Whatever hard work and ingenuity can do to unloose charity is being done; and we cannot but congratulate the authorities upon their choice.

In November we published a *précis* of the plans for which the money was required. They are not luxuries; they are necessities. Each of us must play his part in helping to see that these plans can be carried out. The organizers have sent an appeal to Bart.'s men from which we quote: "We need all the help of all Bart.'s men. For good or for ill the appeal is launched. Given the goodwill, the support, and the courage needed to stay the full course, there is little fear as to the results. Let us hope that Bart.'s may not find any serious difficulties in getting all she needs."

* * *

DR. H. MORLEY FLETCHER.

With very real regret we have to record the retirement of Dr. Morley Fletcher from the Visiting Staff of the Hospital. His private patients will have the benefit of his increased leisure, but for St. Bartholomew's there is no consolation.

A correspondent writes: To his colleagues and juniors it must seem almost incredible that a man so obviously in the prime of life can have reached retiring age. It has long been a charming paradox at Bart.'s that our Senior Physician has appeared to be one of the younger men about the place, yet we are told that Dr. Fletcher has been on the Staff of the Hospital in some capacity for nearly forty years: the uninitiated would be justified in assuming that he began as an *enfant prodige!*

We may console ourselves in knowing that Bart.'s is not really to lose him; he merely ascends now to what is really the highest position a hospital can offer—its Consulting Staff. We hope and believe that he will continue to give us the benefit of his advice and experience at Medical Consultations, and that the Hospital will gain a most active Consulting Physician.

Dr. Fletcher's interests in the work of Bart.'s have been, and are, so many that it is impossible even to enumerate them here. He has been Chairman of the Medical Council, Vice-President and Treasurer of the College, and Chairman of the Reconstruction Committee, to mention but a few of them. Recently he has been a member of the Building Committee, and so has played his part in launching the Bart.'s of the future.

His interest in sport is proverbial. He has been President of the Athletic Club for many years, and of the Hockey Club since its foundation; certainly nobody has had a more active share in promoting the games of the Hospital.

He will be sorely missed from our Visiting Staff, but he carries with him into his retirement the sincere good wishes of hundreds of past and present students who have enjoyed the privilege of working with and under him.

PRESENTATION TO MR. ECCLES.

It must have been felt on all sides that the retirement of Mr. McAdam Eccles from the Chairmanship of the Publication Committee after twenty-five years demanded some more tangible acknowledgment than a printed expression of regret. Such, at least, was the opinion of the Publication Committee and of those editors of the JOURNAL who served under Mr. Eccles' chairmanship. A silver clock has accordingly been sent to him, in the hope that it will bring him pleasant memories when he looks at it, and with this inscription: "W. McAdam Eccles from the Publication Committee and the Editors of 'St. Bartholomew's Hospital Journal,' 1904–1929."

* * *

Prof. J. Barcroft is to deliver the Mid-Sessional Address before the Abernethian Society on Thursday, February 6th, at 8.30 p.m. For title he has taken a quotation from Claude Bernard—"La fixité du milieu intérieur est la condition de la vie."

* * *

The Forty-Ninth Annual Dinner of the Cambridge Graduates' Club was held at the May Fair Hotel on Wednesday, November 20th, and met with its accustomed success. Dr. H. Morley Fletcher, who presided, delivered his "Swan Song." He was glad to report thirty-six new members. Among the guests, he was especially pleased to welcome Lord Stanmore. He ended by contrasting the conditions at Bart.'s in his own early days with those of the present time and of the near future, when the New Block would be opened. "The Guests" was proposed by Dr. Langdon Brown, and Lord Stanmore and Dr. Thursfield replied. The health of the chairman was proposed by Sir Percival Hartley.

* * *

The results of the last Examination for the Final Fellowship reflect great credit upon the Hospital. Out of the forty-two successful candidates no less than thirteen were Bart.'s men. Congratulations to all concerned.

* * *

The dates of the Amateur Dramatic Society's performances of *The Mask and the Face* have now been fixed for Tuesday, February 4th, until Friday, February 7th inclusive.

* * *

Congratulations to R. N. Williams and J. T. C. Taylor on the distinctions they have gained in the Rugger world.

OBITUARIES.

MR. PAULIN MARTIN.

MR. PAULIN MARTIN was born at Highworth, Wiltshire, in 1842. His father was Dr. John Martin, who went to Abingdon, Berkshire, to practise in 1847. Paulin Martin was educated at Radley College, and entered St. Bartholomew's in 1858. His midwifery tutor was Robert Greenhalgh, M.D.; he learnt his medicine from Dr. R. Martin, F.R.C.P., and his surgery from Sir Wm. Lawrence.

His father died in 1846, when Paulin Martin took over the Abingdon practice, which he worked single-handed for 45 years, until his eldest son joined him. Together they carried on the large country practice until his son's death in 1926—sixty-four years of good, hard work. In 1874 he married Mary, daughter of Dr. A. Iles, of Fairford, Gloucestershire.

His profession absorbed him and left little time for leisure, but what time could be spared was devoted to literature and archæology. While at Radley he started his now famous collection of old books—a hobby which he never dropped. He specialized in Shakespeare, early printed books, and Bibles. Rare books could be bought without great expense in those days, and the rarest and best were not out of reach if one knew, as Dr. Martin did, what were the best. He searched and bought carefully and assiduously, and entirely without thought of any future monetary profit. Apart from the regret, softened by his age and failing memory, of selling some of his library, his chief emotion seemed to be surprise that the folios he had bought for a hundred pounds or so should be eagerly bought for five thousand. The gap in the book-shelves seemed at once to be filled by editions only a little less rare, and now at his death there are scores of treasures which show the care and skill of a great collector. Nothing gave him greater pleasure than thrusting a first folio or a first *Compleat Angler* into the hands of anyone who showed the least interest in them. He was delighted when Lord and Lady Oxford, who came to consult him when he was eighty, recognized his first folio from the date on the binding.

He formed a collection of fossils and antiquities from the neighbourhood of Abingdon, which was an early Neolithic settlement. The doors of his house were propped open in summer with cannon-balls from the Civil War, and an ancient tilting helmet shared the wall of his study with portraits of Shakespeare and Chaucer.

His practice extended for many miles round Abingdon. He generally drove himself, his round often being between 30 and 40 miles over stony roads in a dogcart or, in very bad weather, in a brougham. He did his own dispensing, often having fifty bottles of medicine to make up at the end of the round. He did a great deal of midwifery—70 or 80 cases in the year mostly at a guinea a case—though later (in 1880) he gave up the guinea ones and charged two guineas. A human touch comes in one of his letters: "There is nothing so worrying as having a message from a grinning ignorant ass of a husband asking one to 'keep in the way'—destroying all sleep and comfort." A good sample of an ordinary day in the eighties was one of visits to thirteen villages in the neighbourhood, besides those in Abingdon, entailing a round of 37 miles—not too long in these days of motors and good roads, but in those days of stony unrolled ways with iron-bound wheels, even a pair of horses could not make the journey anything but slow and tiring. In between his journeys he dispensed the usual "endless bottles of physic," and finished the day at 10 p.m. with a guinea midwifery case—and so to bed with no more than a fleeting glance at his beloved folios.

§

MR. JOHN SADLER CURGENVEN.

It is with deep regret that we have to announce the death of John Sadler Curgenven, M.R.C.S., L.R.C.P., L.S.A., which took place very suddenly from an attack of angina pectoris at his house in Chiddingfold on November 25th.

He succeeded his father, Mr. John Brendon Curgenven, in practice at 12, Craven Hill Gardens, in 1890, and continued therein with great success till he retired in order to join the R.A.M.C. during the war. He was an accomplished practitioner, a man of fine character and great personal charm. He leaves a widow and a daughter and a wide circle of relations and former patients to mourn him.

ACKNOWLEDGMENTS.

The British Journal of Nursing—Cambridge University Medical Society Magazine—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The London Hospital Gazette—The Magazine of the London Royal Free Hospital School of Medicine for Women—The Medical Review—The Middlesex Hospital Journal—New Troy—The Nursing Times—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecine—The St. Thomas's Hospital Gazette—The Student—Sydney University Medical Journal—University of Toronto Medical Journal—University College Hospital Magazine.

INAUGURATION OF SPECIAL APPEAL FOR THE RECONSTRUCTION OF THE HOSPITAL

BY

HIS ROYAL HIGHNESS THE PRINCE OF WALES, K.G.

(President of the Hospital),

IN THE GREAT HALL,

WEDNESDAY, DECEMBER 4th, 1929.

HIS ROYAL HIGHNESS having taken his seat on the platform, the following Address was read, in the unavoidable absence of Lord Stanmore, by Mr. Henry Hopkinson :

May it please your Royal Highness,

We desire to express to your Royal Highness our gratification at your presence here to-day ; we feel it to be another indication of the unfailing interest which your Royal Highness, as President, has shown in the welfare and progress of this ancient Institution, both in its work of healing the sick and in its no less important functions as a training school of medical practitioners and nurses.

St. Bartholomew's has carried on an unbroken record of service through eight centuries and thirty-seven reigns and, while it is proud of its past and jealous for its traditions, it recognizes that it can maintain these traditions only by keeping in the van of progress of scientific developments. To the attainment of this end the provision of modern buildings and equipment is essential.

As a first step in this direction a new Surgical Block, providing 250 beds and five Operation Theatres, is in course of erection, and it is earnestly hoped that funds will be forthcoming to enable the Governors not only to meet their liabilities in respect of this building, but to proceed with the next stage in the scheme for the general reconstruction of the Hospital.

It is an interesting coincidence that it is exactly 200 years since an appeal was made to the Citizens of London for funds for the erection of the still existing Ward Blocks, which form the Hospital Quadrangle, and one of the main purposes of the present Appeal is to enable the Governors to modernize these buildings.

The large sum for which the Appeal is made, however, is not exclusively for the reconstruction of Hospital buildings. Special contributions are invited towards the provision of adequate accommodation for new Laboratories and modern scientific equipment, essential alike in connection with the treatment of the patients of the Hospital and for the efficient training of the men who will subsequently carry on the healing art in all parts of the Empire.

We are confident that your Royal Highness's keen appreciation of the necessarily intimate association of the treatment of the sick and the education of medical practitioners will ensure your approval and warm support of our Joint Appeal on behalf of the Hospital and the Medical College.

His Royal Highness in reply said :

" It was eight hundred years ago on this very spot that the ancient Hospital of St. Bartholomew was given, by Henry the First, that Charter of Foundation which marked an epoch in the history of medicine and in the life of the British people by starting Bart.'s on its mission for the mastery and prevention of disease—a mission pursued with unabated zeal and energy to this day.

" It is a work of service to the nation and humanity which contributes, perhaps, more than any other to the very foundation of our national character—the aim of ' keeping fit.'

" The ideal of Bart.'s is that of a real Temple of Health —because this Hospital exists to transform C3 men into A1 men, and in continuing its pioneer and leadership work to this end, to make Great Britain a nation of fit men and women.

" It was this ideal that flourished three thousand years ago, in Greece, when physical fitness, which is perfect health for the whole race, was clearly conceived as a supreme duty of citizenship, an object even of worship, established and honoured in those marvellous old Temples of Health, some of which still stand for us to see—waiting till our imagination should rise to grasp the purpose for which in the distant past they were designed.

" Since those days science has performed many miracles with the loyal aid and support of such great medical institutions as Bart.'s, and by the discoveries of such men as Harvey, for 34 years her chief physician. Science has immensely increased our knowledge of disease and our power to fight it. We have advanced far beyond the primitive, but not unwise, medical methods of the classic times. For this we owe more than can ever be repaid to the unselfish labours of research and to the devoted service of our hospitals.

" But have we done as much, with our greater opportunities, as the Greeks with their little knowledge ?

" It seems we are only just beginning to recognize the immense economic value of health, and its necessity for the welfare and happiness of the race.

" It is not the doctors who have grudged self-sacrifice. It is not the hospitals who have faltered in the work. It is public consciousness and encouragement, the hearty goodwill and co-operation of the people that the hospitals are seeking in sufficient volume for their needs. Often, indeed, has individual generosity done big things for special occasions ; often, indeed, have the poor themselves responded whole-heartedly to a special call.

" Our great hospitals are struggling to secure sufficient support for ordinary maintenance expenses. Handicapped as many of them are, they cannot even provide adequate facilities for the new generations of doctors to acquire highly efficient knowledge ; for patients to be given the full benefit of all the latest apparatus and equipment ; for the most up-to-date treatment which modern hospital construction could provide.

" Properly encouraged, adequately supported and generously endowed—and there are men to-day, we know, ready to meet the needs of a great purpose frankly presented to them—the research work of our hospitals *can* and *will* prolong the life of mankind.

" Nothing really vital has been, or can be, accomplished without imagination, without carrying our vision over immediate obstacles. We need to look, as Bart.'s is looking, to the years ahead of us ; to a goal which it is not for us to dismiss as impossible.

" To-day, perhaps, marks yet another epoch in the history of this ancient institution. For we are here to release a signal—that Bart.'s has begun her great forward movement towards a Temple of Health : a signal that expresses an aim and an ideal justifying the whole-hearted sympathy of all.

" It is an SOS signal that none may ever forget Bart.'s need ; a light to remind us, at each flash, of the fight for life facing one or more of our fellow-creatures ; of the care and the cures that Bart.'s, despite all handicaps, is at this and at every moment administering in her wards, her laboratories and her operation theatres ; cures that her doctors will perform whatever our response. Above all, it should remind us of the miracles they could perform with so much greater effect and to such far greater purpose, with our encouragement, understanding and support."

Photo : Central Press.]

The Lord Mayor (Sir William Waterlow), in supporting the Appeal, gave an assurance that the citizens of London would respond. The name of the first Lord Mayor, Henry FitzAylwin, was inscribed on the walls of the Hospital, and his successors had all been associated with that grand institution. The present buildings, which had been erected in the days of the sedan-chair and candle illumination, needed to be brought up to date.

Photo: Keystone View.

Bart.'s was especially associated with the history and the traditions of the Corporation and the Livery Guilds, and he was sure that these various elements would wish to be closely identified with the reconstruction. In conclusion he was glad to be able to read a list of a number of donations which had already been promised.

The company then standing, the Venerable the Archdeacon of London said the following prayer:

O Eternal God, by Whose Providence this Hospital has ministered down the ages to the relief of suffering; we thank Thee for Rahere our Founder, and for all other our Benefactors whose charity in the past has made possible for us the opportunities of the present.

Make us worthy of the heritage that is ours. Direct and prosper all that we now design to further the work which Thou hast committed into our hands.

Bring to fruition all that we plan and purpose: that so, by Thy Blessing, Love and Science may do yet greater works to the setting forth of Thy glory, and the relief of the necessities of others; through Jesus Christ our Lord. Amen.

The Grace of Our Lord Jesus Christ, and the Love of God, and the fellowship of the Holy Ghost, be with us and remain with us always. Amen.

The Prince then pressed the button which released the revolving light on the roof of the New Surgical Block, and at the same time a model of the light, which had been placed on the table before him.

His Royal Highness, who had graciously consented to be admitted a Perpetual Student of St. Bartholomew's Hospital Medical College, was formally admitted by Dr. H. Morley Fletcher. This he said was the highest honour in our keeping, and one that had only been given four times. The names of the four Perpetual Students were: Prof. Hugh Cabot, Dr. Harvey Cushing, Lord Moynihan and Prof. Grey Turner. The Medical College was deeply sensible of the honour done to it by His Royal Highness in having his name upon its rolls. Dr. Morley Fletcher then asked the Dean to read the declaration, which is signed by all students of the College.

His Royal Highness left the Hall and proceeded to the Library, where tea was served.

Thus was the Appeal inaugurated.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

ON THINNESS AND FATNESS.

(1) In any case of loss of weight in which the cause is obscure, the first consideration should concern the food swallowed—whether this be sufficient to maintain nutrition. The second consideration should be directed towards the question whether or no the food leaves the body, by vomiting or by diarrhœa, before it can be properly digested and assimilated. The investigation should then proceed in such a way as to eliminate the following factors: Microbic infection (especially tuberculosis), neoplasm (especially of the alimentary tract), metabolic defects (especially diabetes and pancreatic deficiency), endocrine imbalance (especially hyperthyroidism) and nerve diseases.

(2) Loss of weight may be the first complaint in Graves's disease, and unless the observer be sensitive to the facies presented in the early stages of exophthalmic goitre, or unless the possibility of this disease be thought of, as it should be in all wasting of obscure nature, the diagnosis may go overlooked for some time. The patient most likely to give rise to this difficulty is a man in the later years of life, for in this case neither the sex nor the age of itself suggests the existence of Graves's disease.

(3) If, in a young woman who is emaciated, tuberculosis, diabetes and Graves's disease can be excluded, the probable cause of the trouble is "anorexia nervosa" or some allied psychosis.

(4) In both diabetes mellitus and exophthalmic goitre the prognosis is better in the "fat type" of the disease than in the "thin type."

(5) Many fat patients profess themselves small eaters. Though it is true that some of them do eat very little, all should be suspect until the evidence is indisputable.

(6) It is too often assumed that fat patients who are short of breath have fatty hearts. The satisfactory response made by many such patients to general measures of treatment, and to graduated physical exercise, gives strong support to this statement.

(7) The diagnosis of "fatty heart," as against certain other forms of myocardial disease, is not possible.

(8) Localized deposits of fat are sometimes mistaken for other and more serious things. In the neck they

may be mistaken for an enlarged thyroid and also for enlarged lymph-nodes. In the abdomen they may be mistaken for tumours (and especially for cysts) and for ascites. These errors are more likely to occur if the fat has appeared rather quickly, as is not infrequent at the menopause.

(9) It is not only in Dercum's disease that fatty deposits are painful and tender. This is not infrequently so in "fibrositic" or "gouty" subjects who become fat. As is the case in adiposis dolorosa proper, the patients are generally women.

(10) Rapid loss of weight sometimes renders conspicuous lipomata, the existence of which was previously unknown. A lipoma on the back of the chest, brought to light in this manner, has been mistaken for a pointing empyema.

(11) A fatty liver is perhaps more often overlooked than is any other considerable enlargement of this organ. The reasons are these: The texture is not so firm as to make palpation easy; the organ is not tender; and the observer, if he be not aware that a fatty liver may be very large and yet give no symptoms, may fail to palpate the abdomen sufficiently low down to feel the free border of the viscus.

SOME NORMAL "ABNORMALITIES" IN INFANCY.

A PHYSICIAN who has to deal with very young infants is kept well in his place. It is rare for him to meet a mother who does not spend most of an interview in giving him advice on the care of babies in health and disease. Any suggestion he may put forward is subjected to a searching criticism, annotated with liberal quotations from folk-lore and the views of friends and relations. The suggestion is often rejected with scorn, the amount of scorn being in inverse ratio to the number of children produced by that mother. Under these circumstances it is good to have a few cards up the sleeve to restore one's self-confidence. One such card is a knowledge of those conditions in babies which alarm their mothers, but which in fact have no serious significance whatever. There follows a brief account of some of the symptoms complained of from time to time by mothers, and about which they can be confidently reassured.

Such variations from the normal fall naturally into two groups. The first is formed by those conditions which are in themselves unimportant, but which have to be distinguished from allied abnormalities of a more serious nature. The most obvious example of this group is the caput succedaneum. In the process of birth nearly every baby gets a greater or less degree of œdema over the presenting part. When this is the head, a soft patch can be felt, which involves all the layers of the scalp and which is not limited by the sutures. It is to be distinguished from a cephalhæmatoma. In the latter case the whole scalp is lifted from the bone by the effused blood, and the swelling is usually limited by the surrounding sutures to one bone of the vault. In most cases a caput succedaneum disappears within a few days of birth; very occasionally it persists for two or three weeks and gives rise to alarm. Even when this is the case its disappearance is eventually complete, and no harm is to be anticipated. Allied to the caput succedaneum is another less frequently described abnormality. This consists of an effusion of blood into those parts subjected to pressure in the birth canal. Such effusions usually appear in the skin over the eyelids, over the forehead above the bridge of the nose, over the occiput or over the nape of the neck. Unlike the caput succedaneum, they are not present immediately after birth, but become apparent in the course of two or three days. They may last for five or six weeks. When first these effusions appear they are not unlike nævi, for which they are commonly mistaken by the mothers. On close inspection, however, it is clear that the discoloration is produced by blood poured out into the tissues and not contained in vessels. Another source of complaint is the mild jaundice that is present in about five babies out of ten. This symptom usually becomes evident within two or three days of birth and is gone by the tenth day. There are fairly wide variations in its time of onset and in its duration. It is understandable that if the jaundice appears later than usual or lasts longer or is more intense, a mother may well become uneasy. In spite of its frequency, the authorities are not very clear in their minds why it occurs at all and, as is usual in such circumstances, there are two schools of thought. One holds that it is the result of hæmolysis, in the course of which the high fœtal red cell-count diminishes to that of the normal baby; the other maintains that it is due to the liver being slow to meet the requirements of extra-uterine life and a consequent reabsorption of bile-pigments into the blood-stream. One very reputable text-book supports both hypotheses in the same paragraph, though perhaps unintentionally. Anyway, the transitory jaundice is common enough to be regarded as a normal phenomenon, and the babies who have it suffer no disadvantage. It is necessary, however, to distinguish it from the graver forms of jaundice to which infants are liable. When the colour is deep or the condition long-lasting, this is not always easy. The observations that the child is thriving, that the spleen is not palpable, that the liver is not enlarged and that there is no umbilical sepsis can be taken into account in forming an opinion.

The conditions in the second group are simpler. They are distinct from any abnormalities of a serious nature; once they are recognized, no process of differential diagnosis has to be gone through. Described on paper, they appear trivial, but to the eyes of a mother possessed of a new baby, any one of them may assume undue importance. Such, for example, are the small white spots so often to be seen over a baby's nose. These are not raised above the surface and are less than half a millimetre in diameter. When present, they are scattered fairly densely over the middle and lower part of the nose and, sometimes, over the adjacent parts of the cheeks. The spots are to be seen when the child is born and disappear in about four weeks, leaving the skin perfectly normal. It seems probable that the sebaceous glands are not in full working order at birth, and that collections of their retained secretion give rise to this appearance in the skin. Over a rather longer period of time "milk-blisters" may be present on the lips and call for comment. It is not surprising that the name "blisters" is used. The epithelium along nearly the whole length of the opposed parts of the lips seems raised from the surface and has a transparent bluish look. This altered appearance never extends quite to the junction of the red lip and the skin, but stops short by about a sixteenth of an inch. It is popularly supposed that the infant raises blisters on its lips by powerful sucking at the nipple. In point of fact there is no blister fluid under the puffy epithelium, nor is the latter shed. The condition will probably prove to be a by-product of the process of differentiating the lining of the mouth from the skin outside. A similar developmental explanation can be offered for another minor variation in the mouth. Many babies have a diamond-shaped white patch in the mid-line at the junction of the soft and hard palates. Its longest axis, from before backwards, does not exceed a quarter of an inch. For three weeks or so from birth the patch remains a yellowish white and then gradually assumes a pinker colour. It seems reasonable to look on it as the last phase of the union of the lateral processes which meet to form the palate. Some enthusiastic parents, however, prefer to regard it as a form of thrush, and therefore scrub it vigorously, to the great discomfort of their offspring. Again, the enlargement of the breasts, which most newly born babies have, often calls for an explanation. The fœtal circulation presumably carries the same hormones as those present in the mother's blood; consequently the mechanism which prepares the mother's breasts for lactation has a similar effect on those of the fœtus. Boy or girl babies are equally affected. An increase of mammary gland tissue, rather than of fat, accounts for the size of the breasts. Drops of milk can be squeezed from the nipples. The condition tends to become more noticeable if a baby rapidly loses weight soon after it is born, so that the fat under the skin round the breasts disappears, leaving the glands standing out. The enlargement lasts for a variable time, usually only two or three weeks, but sometimes for as long as three months. The fact that a baby's breasts may be large at birth has a rather wider publicity than some of the other peculiarities of babyhood. Quite a respectable amount of folk-medicine has become attached to it. Nevertheless, some women are still unaware of it, and view with suspicion its occurrence in their babies. The only other source of complaint that can be referred to in this short account concerns the shape of a baby's legs. Owing to the relative shortness of the tibiæ and to the high proportion of subcutaneous fat to muscle, the legs look bent with the convexity outwards, as compared to those of a normal adult. It needs only to run the finger down the bone to perceive that there is in fact no real bowing. This deceptive appearance is always being rediscovered by parents, who fear that their baby has rickets. The bone changes in this latter disorder do not appear before the age of six months, except under very unusual circumstances. The parents can be convinced of the normality of their own child by looking at the legs of a few other children of the same age.

It has often been pointed out, and with truth, that babies are under considerable disadvantages compared to the young of other animals, as, for instance, puppies. The babies cannot move about to get their food, nor can they survive unless they are kept wrapped up in clothes. Although they are mammals, they lead almost as obscure an existence as young marsupials. As a result, the general public is unused to seeing more than the tip of a tiny baby's nose, and there is little common knowledge about the normal variations in infants in the earliest weeks of their lives. There are no established standards for babies, and the individual mother has to compare her baby with the more fully grown animal—a procedure which is sometimes very misleading. It is on this account that she may be in real need of advice; to restore her peace of mind, it is only necessary to have a working acquaintance with the minor "abnormalities" of infancy, of which some instances have been outlined here.

CHARLES F. HARRIS.

SOME OBSERVATIONS ON THE CONDITION OF THE APPENDIX IN CASES OF ACUTE APPENDICITIS.

THE following notes, based upon 30 consecutive cases of acute appendicitis, are written, not with the idea of showing any originality of thought, but rather to emphasize some points suggested by Mr. W. H. Bowen, M.S., F.R.C.S., in the ætiology of acute appendicitis.

His views on this subject are set out in the *Guy's Hospital Reports* of January, 1929, in a paper entitled "Notes on the Etiology of Appendicitis." The writer suggests in his paper that there are three main conditions which, if upset, impair the health of the appendix. These conditions are:

(1) Impairment of nutrition.

(2) Impairment of activity of the musculature of the walls of the appendix.

(3) Blockage of the lumen.

Tabulated Series of 30 Consecutive Cases of Acute Appendicitis.

Case No.	Age.	Sex.	Duration of history.	T.	P./R.	Gangrene.	Stercolith.	Other remarks.
1	3	M.	30 hours	103°	152/32	Yes	Yes	Free fluid present; appendix retrocæcal; distal third mainly involved.
2	5	M.	36 ,,	101·4°	140/40	No	No	Free pus present in peritoneal cavity; appendix retrocæcal and acutely inflamed throughout
3	7	M.	2½ days	99·2°	118/24	Yes	Yes 2	No free fluid; appendix retrocæcal; distal third involved.
4	10	M.	2 ,,	100°	104/32	,,	Yes	Appendix encircled by omentum; no free fluid; distal two-thirds involved; swollen lymphoid follicles at cæcal end almost blocking lumen.
5	11	M.	24 hours	100·6°	120/28	Diffuse gangrene of mucous membrane	No	Intense injection throughout all coats. Lumen contained inspissated fæcal material.
6	18	M.	2 days	100·6°	96/20	Yes	Yes	Clear free fluid present; distal third involved; coated with recent lymph.
7	18	F.	20 hours	100°	84/28	No	No	No naked-eye pathological changes.
8	18	M.	18 ,,	100·2°	86/20	Yes	Yes	Distal third involved; recent lymph present.
9	21	F.	8 ,,	100·6°	88/22	,,	No	Appendix enlarged, recent lymph; mucous membrane gangrenous; lumen contained inspissated fæces.
10	21	M.	6 ,,	101°	100/26	No	,,	Early acute catarrh.
11	22	M.	12 ,,	100·4°	100/24	,,	,,	Free sero-purulent fluid; small hæmorrhages in mucous membrane; lumen empty.
12	23	F.	24 ,,	..	..	,,	,,	Walls thickened; lumen constricted in middle of its length; distal end contained pus. History of previous attacks.
13	24	M.	24 ,,	102·8°	114/24	Yes	Yes	Free purulent fluid; appendix perforated; 2 fæcoliths free in peritoneal cavity; a third fæcolith blocking the lumen proximal to perforation.
14	25	M.	2 days	..	..	No	No	Acute catarrh; appendix embedded in omentum.
15	27	M.	48 hours	100°	84/24	,,	,,	Distal third intensely injected; lumen obliterated at junction of middle and distal thirds; distal end contained a small collection of non-odorous pus.
16	28	F.	24 ,,	100·4°	136/24	,,	,,	Sero-purulent free fluid; acute catarrhal inflammation.
17	29	F.	20 ,,	101·6°	100/24	,,	,,	Acute catarrhal inflammation; no free fluid.
18	29	F.	36 ,,	100°	132/22	,,	,,	,, ,, ,, ,, ,,
19	30	M.	30 ,,	100·8°	80/24	Yes	..	Malodorous purulent free fluid; intense injection of whole appendix with two small areas of gangrene; no stercolith, but pus and inspissated fæces in lumen.
20	40	M.	24 ,,	99·6°	80/24	No	,,	Clear free fluid; adhesion producing kink; slight inflammation distal to kink.
21	43	M.	24 ,,	99·8°	116/26	,,	,,	Enlarged appendix; acute catarrh; recent lymph.
22	45	F.	48 ,,	101·8°	110/28	Yes	Yes	Sero-purulent free fluid; gangrene in distal third, followed by pelvic and sub-diaphragmatic abscesses.
23	48	M.	12 ,,	97·4°	65/20	No	No	Appendix kinked; distal portion inflamed.
24	48	F.	15 ,,	100·6°	108/20	,,	,,	Acute catarrhal inflammation; recent lymph.
25	53	F.	48 ..	100·6°	84/24	Yes	Yes	Short appendix ¾ in. long and ½ in. in diameter; large stercolith involving whole lumen.
26	54	M.	5 days	100·8°	96/20	,,	No	Free mal-odorous purulent fluid; appendix retrocæcal; many patches of gangrene; lumen containing inspissated stercoraceous material.
27	56	M.	52 hours	100·6°	100/26	No	,,	Clear free fluid; acute catarrh; retrocæcal, and bound down by omentum.
28	56	F.	7 days	102·6°	116/26	,,	,,	Localized abscess of mal-odorous pus; appendix completely sloughed.
29	69	M.	56 hours	99°	98/24	,,	,,	Appendix swollen; œdematous and pale; walls thickened.
30	16	F.	60 ,,	102°	120/28	,,	,,	Acute catarrhal inflammation; purulent, non-odorous free fluid.

It is these three factors which I desire to emphasize in the notes.

(1) *Impairment of nutrition.*—Anatomical considerations play a very large and important part in the site of the lesion of the appendix. Whilst in many cases the whole length of the appendix is involved in catarrhal inflammatory changes, there are many cases of acute appendicitis in which only a portion of the appendix bears the brunt of the infection. The artery to the appendix runs along the free border of the mesappendix, sending off branches as it proceeds distally. The mesentery, however, stops short before the tip of the appendix is reached, and the terminal ramifications of the appendicular artery lie along the appendix itself. It is therefore easily understood that the terminal portion of the appendix is the most vulnerable, for its supply of nutrition may easily be upset by slight œdema of the appendix walls or by pressure of contents of the lumen, whereas the vessels of the proximal two-thirds are away from such upsetting influences.

It will be seen from the tabulated series below that out of the 30 cases here considered, 14 showed a generalized acute catarrhal inflammation, in one the anatomy of the appendix could not be demonstrated owing to abscess-formation and destruction of the whole appendix, and in one no gross pathological change could be shown to the naked eye. Of the remaining 14 cases, however, the lesion was confined to the distal third in 11 cases and the distal two-thirds in 3 cases; that is to say, that the terminal third was involved alone in 78·5% of cases; in no case was the proximal third involved unless the whole organ was inflamed.

(2) and (3) *Impairment of musculature and the blockage of the lumen.*—I propose to deal with these together. A sluggish musculature brings about the stagnation of the contents of the lumen and the accumulation of soft fæces. The appendix, being a part of the large bowel, is concerned, amongst other things, in transforming the soft fluid fæcal material discharged from the small gut into semi-solid fæces. Hence the stagnated fæcal material becomes inspissated, and finally—if the process is not abruptly terminated by surgical interference—becomes transformed into the fæcolith or stercolith. The stercolith, once formed, may fill and block the lumen of the appendix, and by pressure on the appendicular walls produce gangrene and necrosis, leading even to perforation. That the stercolith is a very potent factor in the production of gangrene is well brought out in W. H. Bowen's series, in which in 80% of cases with gangrene a stercolith was present, and in 93% of cases with catarrh there was no stercolith. In the series here tabulated in 70% of cases with gangrene a stercolith was present, and in no case of acute catarrh was there a concretion.

That there are other causes of blockage of the lumen is obvious, and kinks and adhesions are frequently cited. Enlargement of the lymphoid follicles at the cæcal end of the appendix and fibrosis following a previous attack of appendicitis may also produce a block. Case 4 of this series is a well-marked illustration of follicular enlargement. Case 12 illustrates constriction of lumen from old attacks.

In the above list the duration of history is taken as the length of time from onset of symptoms to time of operation.

Other observations gathered from the above series are:

(*a*) In 13 cases there was a definite history of some degree of constipation; in 7 of diarrhœa; in 10 there was no history of irregularity in the action of the bowels.

(*b*) In 16 cases there was no free fluid present in the peritoneal cavity; in 5 there was clear straw-coloured fluid; in 4 sero-purulent fluid; in 5 purulent fluid.

(*c*) In 8 cases abdominal pain was first noticed in the epigastrium; in 11 in the umbilical region; in 5 all over the abdomen; in 5 in the right iliac fossa; in 1 (Case 10) there was no definite abdominal pain.

(*d*) In 20 cases there was a history of vomiting (in one self-induced); in 10 nausea, but no vomiting.

In conclusion I would again like to point out that I make no claim to originality, and that I am fully conscious of the small number of cases taken. However, I shall be more than satisfied if these few remarks arouse a fresh interest in this common complaint amongst those who, like myself, have but recently become qualified.

I wish to record my thanks to Mr. W. H. Bowen for permission to publish these notes.

W. R. FORRESTER-WOOD.

A CURIOUS CASE OF HÆMATEMESIS.

H—SON (*alias* F. H—), a well-nourished woman, æt. 27, was admitted to Mary Ward on August 20th, 1929, giving the following history:

Whilst travelling to London by train she was suddenly seized with severe abdominal pain, vomited up a large quantity of blood, and collapsed. Three years previously she had suffered with epigastric pain, coming on immediately after taking food. Between the years 1926–1928, whilst domiciled in Canada, she had been operated on seven times for "lumps in the stomach."

On examination she was found to be excessively blanched. Temperature 97° F., pulse 110, respirations 15. There was no obvious blood in the nares or throat. Transfusion scars on either arm, and *seven* operation scars, carefully arranged all over the abdominal wall, testified to a past that few could have endured and still lived to tell the tale. On palpation the abdominal wall was felt to be rigid, although there was some relaxation after exerting continuous pressure, and the abdomen moved fairly well on respiration. There was no liver-dullness and the patient was complaining of severe pain. The blood-count was: Red blood-cells 2,140,000, white blood-cells 11,200, hæmoglobin 13%, giving a colour index of 0·3.

She was transfused with 600 c.c. citrated blood and put on to continuous rectal glucose saline.

Severe abdominal pain persisted and she continued to vomit small quantities of bright blood, in spite of the administration of morphia gr. $\frac{5}{6}$ and heroin gr. $\frac{1}{6}$ in the course of the first twenty-four hours following admission. Not unnaturally she remained quiet for several hours after receiving such heroic dosing, but on the evening of the second day she was again writhing in agony and vomiting blood. During the second twenty-four hours she was given heroin gr. $\frac{5}{8}$ and morphia gr. $\frac{1}{4}$. Meanwhile she had shot temperatures of 104° and 105° F., although the pulse remained between 90 and 100. On the third day she passed a large quantity of tomato skins, but the motion contained no blood. Two subsequent examinations of the stools for occult blood showed a negative result. After the fourth day she rapidly improved on a Lenhartz diet, although she still had occasional small hæmatemeses. On the ninth day after admission she was sitting up reading the newspaper. Her hæmoglobin had risen to 30%.

The correct interpretation of this case was arrived at after a consideration of the following points:

It at once became apparent that the account she gave of herself was not *bonâ fide*. Research on the part of the Police Force showed that she had visited many institutions in this country, and a letter kindly sent to us from one of these reads:

"She was admitted to this hospital on October 27th, 1928, with a copious hæmatemesis. Her history is completely unintelligible. She has been operated on in almost every country in the world, and six months previous to admission here was treated for gastric ulcer at the ——— hospital. [This hospital has denied any knowledge of the patient.] She remained here till March 15th, 1929, during which time she had many hæmatemeses. She could vomit half a pint of blood or more without any ill-effect, and she repeatedly ran temperatures of 107°–109° F. She was treated on a Lenhartz diet and given every known hæmostatic. The hæmoglobin estimation on admission was 20%. All investigations, including a barium meal, drew a blank. On October 28th, 1928, one of the surgeons opened her abdomen and spent two hours vainly trying to separate adhesions. She was transfused once."

No doubt the other six scars could each tell a similar tale.

A brooch, which she had collected from her locker whilst apparently "*in extremis*," was found under her pillow, and this recalled the fact that her first request on being admitted to the ward was for a pin, for the purpose of fixing her handkerchief to her clothing. The request was, needless to say, politely but firmly refused. Her goose was finally cooked by the mercury rising to 110°.

A second and more careful examination of the upper respiratory passages led to the detection of a large and obviously self-inflicted crater far back on the nasal septum.

She remained with us for thirty days in all before being discharged well in body, but apparently unrepentant in spirit.

I am indebted to Dr. Langdon Brown for permission to report on this case; and also to the Nursing Staff, whose close supervision afforded the necessary clues.

E. G. RECORDON.

A RARE TUMOUR OF THE SPERMATIC CORD.

THE following case, though extremely rare, merits some attention owing to its interesting nature.

W. S—, æt. 53, labourer, was admitted to Stanley Ward complaining of an "irreducible rupture." His story is that twenty years ago he noticed a small "rupture" in the left groin, which was easily reducible and gave no trouble. Seven years ago he commenced more strenuous work, and soon noticed that the rupture was getting bigger and that he was unable to reduce it. Since then the rupture had increased steadily in size and had never been reduced. He had no inconvenience and wore no appliance.

On examination he was a healthy man, with no point of interest except the local condition. The right half of the scrotum with the right testicle and cord was normal. In the left half of the scrotum was a swelling 8 in. long by 6 in. by 6 in., the long axis being vertical. The shape was ovoid. At the lower pole was a smaller swelling—the left testicle. The neck of the scrotum could not be gripped above the swelling, which was continuous into the inguinal canal. The surface of the swelling was smooth. Fluctuation was not obtained, and the swelling was not translucent. There was no impulse on coughing. The skin over the swelling was normal, and not attached. The left testicle was felt apart from the swelling and normal. The spermatic cord could be felt external to and somewhat behind the swelling. Pre-operative diagnosis, irreducible hernia.

At operation, after incision of the usual coverings of the spermatic cord, a large cystic swelling was found, with a thin, whitish wall. It was found not to communicate with the abdominal cavity. The swelling burst, and material resembling fine oatmeal porridge escaped under fair pressure. The cyst-wall was easily removed by blunt dissection, except at the upper pole of the tunica vaginalis, to which it was somewhat adherent, but with which it did not communicate. No hernial sac was found. The inguinal canal was widely distended and so left. The wound was partially closed with tube drainage, and the patient was discharged in twelve days with the wound practically healed.

The cyst wall was rough externally, but quite smooth internally. A microscopic section showed a layer of stratified squamous cells, with a definite basal layer. There would seem no doubt that this was a dermoid cyst originally situated in the inguinal canal, but displaced into the scrotum owing to its size. It would also appear that this was a dermoid cyst of the spermatic cord, and not merely an inclusion dermoid of the scrotum.

This form of dermoid cyst is not mentioned in any of the books on general and surgical pathology which were consulted, but Bland-Sutton says: "Dermoid cysts have been described in relation with the inguinal canal. The only record which can be relied on is that of H. J. Paterson."

Paterson's case is also interesting. A man, æt. 35, had for five years had a swelling, thought to be hernial in origin, in the inguinal region. So like a hernia was this swelling that when it became painful attempts were made to reduce it under an anæsthetic. The swelling was elastic, oval, 3 in. in length, with long axis in line of inguinal canal. At operation an opaque whitish swelling was found deep to the external oblique muscle. When the swelling was incised, thick pultaceous material escaped. The swelling was in a closed sac not communicating with the abdominal cavity and was fairly easily dissected out. No hernial sac was seen and no hernia developed subsequently. A single hair was seen inside the cyst. Microscopic section of the wall proved it to be epidermis, showing stratum corneum et granulosum et Malpighii and a cutis vera.

At the time that he described the case Paterson had heard of no other case and has heard of no other similar case since. He thought the origin of the sac was due to antenatal inclusion of epidermis in the medium fusion with displacement into the inguinal canal.

Pearce Gould describes a somewhat similar case. A man for fourteen years had worn a truss for a rupture in the left groin. This rupture commenced to grow bigger, and, the truss no longer fitting, the patient came to hospital. On examination a swelling was found in the left inguinal canal and just extending into the scrotum. The spermatic cord was anterior and external to the tumour. The tumour was about the size and shape of a hen's egg, smooth, tense and fluctuating. At operation a cyst was found deep to the various layers of the cord and just outside the peritoneum. It had a thin smooth wall, and contained sebaceous matter and a few dark hairs. The inguinal canal was widely distended but there was no hernial sac, nor did a hernia appear later.

It will be seen that the three cases (no more could be traced) have several points in common:

(*a*) The patient for some years had a "rupture" giving no trouble.

(*b*) Pre-operative diagnosis in each case was irreducible inguinal hernia.

(*c*) In two of the cases the coverings of the cord had to be incised.

(*d*) In no case was a hernial sac discovered.

I am indebted to Mr. Paterson for permission to publish notes of this case, and to Prof. G. E. Gask for permission to publish the notes of the case from Stanley Ward.

REFERENCES.

BLAND-SUTTON, Sir J.—*Tumours*, 7th ed., London, 1922, p. 533.

PATERSON, H. J.—*Trans. Path. Soc.*, 1903, vol. liv, pp. 147 *et seq.*

Lancet, November 4th, 1893, ii, p. 1126.—Report of Mr. Pearce Gould's case.

I. W. MATHESON.

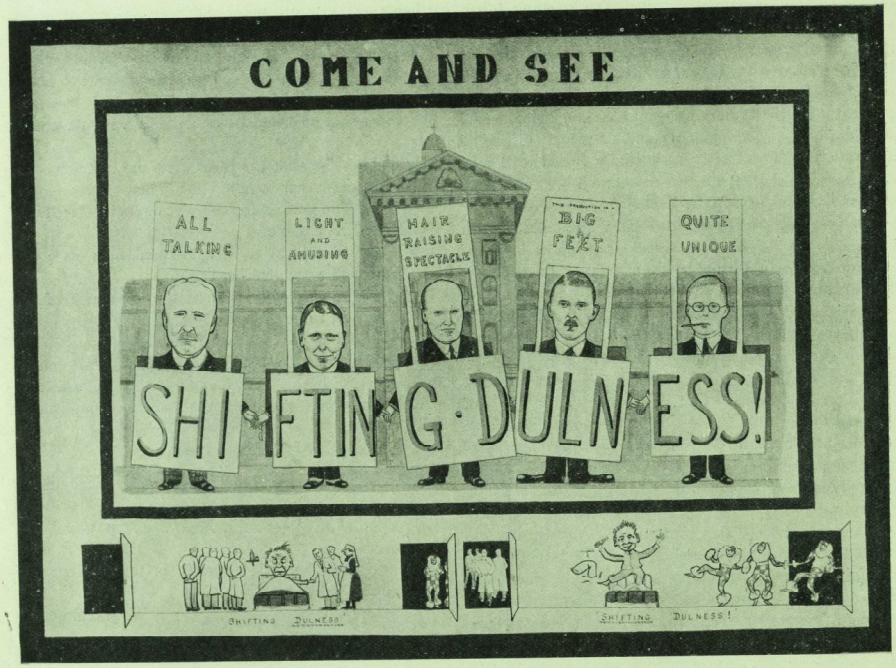
ROUND THE SHOWS.

[We had just settled down to write learnedly a review of the Christmas shows when the following letter arrived by special messenger. Finding in it a spontaneity, a freshness of outlook and a disregard for syntax, to which we could never hope to attain on Boxing Day, we threw our laborious notes on to the blazing Yule log, and, having made such spelling corrections as the sense demanded, we sent the letter to the printers.—ED.]

DEAR SELINA,

Did you have a merry Xmas I did. I didn't eat much Dinner as I had so many teas at Barts. Albert —thats my new young man the one I wrote about last

week—works there and he asked me to go, and see the Xmas shows, they were good. We had to see some people called RSQ first because Albert said they lived at the Hospital so they got jolly sooner in the afternoon than the others. They were all pierrots and they began to sing, but the man at the piano kept changing the tune. They were sick of eating bad breakfasts but the housekeeper seemed to expect it, and didn't mind. The waitress looked like our Cissie not much SA. I like Mrs. Buggins at the pictures watching a real Tom Mix, with a hero and villain and father with a black beard and horses and setting the ranch afire and everything and lots of kissing. Then there was a scene and singing about patients being brought into the wards and nurses *do* go on so at Barts. Albert said the heroine was very pretty, and I said she wasn't, and Albert said it was only a man dressed up, and I said anyway it was time to go to another show.



can't write all the turns as we saw ten shows and there were five in each which makes fifty. They had a comic with a little hat and some dancers, and a play about two women who wanted the same man and I blushed being with Albert, but it was only the butler they wanted. Anyway Albert said he liked a good colour. I always thought doctors were clever, but there is a lot they don't know. Please ask Fred what the blacksmith said when the hard heavy hammer hit his thumb.

Well then we went to *Mary's little lambs*. I thought they would be kids but it wasn't half a grown-up show

So we went to the *Watsonames*. They were some more pierrots, and they sang about students who are a bad lot. Seems they come late and go early and muck up the wards, but I thought the Xmas decorations looked nice. Then two pierrots did a nigger talk and after that they did an operation and took out Sir Somebody's whatsoname and I laughed so much that Albert said we ought to go on to see the *Canaries*. They were really Chinamen, and a fat man sang *Mean to Me* in ever such a nice voice. Albert said he hoped I'd never make him sing that

and a man with funny white hair came in with some young doctors, and he said nasty things to them, but they rather liked it. Seems there is a man like that called the old man, any way he was a very good doctor and he operated and pulled tonsils and bones and things out of a baby's neck without any bother.

So we went to the *Batheing Roberts* who sang *Daisy* and a bicycle made for two. Back to the naughty nineties Albert said, and Dad would tell me about what that meant. Then there was some more operating. Seems the operating is a great joke at Barts. A Frenchman and a parson and an old man like grandad only deaf were helping a doctor to show an American a new operation. When they finished, they had cut the American's ear off by mistake, only nobody saw him change places with the patient. So they all sang about making *whoopee* and when I asked Albert what that was he said if I waited there long enough that night I'd see all right.

Albert said the *Focal Septet* was well produced, he's so clever. They sang a song about a man whose wife was on a diet, and a doctor came in to look at a patient and he asked a lot of silly questions in such a silly voice, I thought it was stupid. But Albert told me it was very clever and one of the doctors was quite like that, so I laughed too. There was a handsome conjurer and Uncle Ben and a man with a big nose as good as the Coliseum. They started a machine to read people's thoughts, but Albert ran out so I had to follow, which was a pity.

Then we saw Uncle Garge and a man from Australia and James and John and Little Eric singing about themselves and *Shifting Dulness*. Another conjurer made a bonfire and a cake out of a poor man's hat. There was a lady from Paris who sang so high up, she was a funny shape. Albert says singers always are, he's so musical. Carnera's brother Secundo lifted 250 pounds, and then the conjurer turned the weight into cardboard. They showed us a patient like a bean pole grow fat on medicine, there's a chance for Cissie still. They brought in Eric the performing bull, but I had my new red on so we went to the *Labour Party*.

They were the nicest, two of them couldn't stand up They had a pair of ghosts and a monkey and two real sea lions, anyway they sounded real only we couldn't see them because of the crowd. Then they put up some scenery and one of them sang about the cane brake and Ohio and he made such lovely big eyes that we all clapped like anything and he sang it again.

Then we saw the *Pink Polyps*, who showed a film they bought in Hollywood all about college boys who

played cards and drank. I am glad Albert didn't go to college, the villain put some hooch into the hero's cocktail. They rode on horseback through the audience firing guns at each other, and I was so frightened Albert had to hold my hand. Then another man lifted weights, but they were only balloons and they all put on noses and sang about a patient called Izzy.

When we got to *Percy's Performing Pediculi*, they were doing a real panto. I thought it was about a

fireman, but Albert said he was a gladiator. Anyway he kept kissing a lady in a night dress called Hernia until she knocked his hat off I loved it. There was a Gypsy princess and an elephant, and everything but Albert said it was time to go home, so we didn't see if the fireman got his Hernia in the end.

Well this is a long letter and Albert and I are going to be married, as he asked me going home. You were right about the top of a bus in this weather.

Your grateful friend,

MILLICENT.

ABERNETHIAN SOCIETY.

A MEETING of the Society was held in the Medical and Surgical Theatre on Thursday, October 24th, at 8.30 p.m., the President, Mr. Hutchinson, in the chair. Sir Leonard Rogers delivered the Inaugural Address on "Climate and Disease: Forecasting Epidemics in Connection with Smallpox, Cholera and Plague."

Variations in the incidence of infectious diseases have always aroused medical interest. The influence of climate has been difficult to study owing to the lack of accurate data. India, however, possesses vital statistics on a uniform basis, extending over many decades, and meteorological records of the remarkable variations in rainfall and humidity, which occur in different portions of the country. After three years' study of the sixty years' literature, the lecturer was able to define to some extent the relationship between the incidence of disease and variations in climate. The first subject studied on these lines was leprosy, and from the beginning the Indian *Atlas of Meteorology* was invaluable. The incidence of leprosy with its special distribution in India was found to be explained by a comparison with the rainfall, for the high leprosy rates occurred in the high rainfall areas. Of more interest in England was tuberculosis—a disease which presents many points of resemblance to leprosy. In this case the key was exposure to rain-bearing currents. This bore out the teaching of Dr. Gordon, of Exeter, that those places protected from the humid rainy winds by the contour of the hills had far lower tubercle rates than those exposed to them. In spite of this many English sanatoria have been placed facing rainy winds! Pneumonia has a well-defined seasonal incidence in the four coldest months, and in this case it is the dry atmosphere which favours the disease.

In the case of smallpox no relationship could be traced between the mean monthly temperature or the relative humidity, and the incidence. The absolute humidity curves, however, gave the key. Deficient monsoon rain with the relatively low absolute humidity for the monsoon season is liable to be followed by smallpox. The meteorological reports in this country show a similar association, the most widespread epidemics following closely on a low absolute humidity. The value of forecasts based on these observations is, however, more reliable in extensive countries such as India, where the rainy seasons are definite.

The last and most important disease dealt with was cholera. The lecturer discussed the original theories of Cornish and Bryden, and showed how he had reached the conclusion that cholera was endemic in certain areas and only epidemic in others, the main factors that produce epidemics being a previous deficient rainfall, a favourable absolute humidity, and the occurrence of large pilgrimages. This last point is of great importance, for although much attention is now paid to the sanitation of the Hardwar and the Allahabad Kumbh fairs, the main cause of the epidemics is the passage of the pilgrims through the endemic areas when meteorological conditions are favourable to the spread of the disease. It is only by understanding the factors and by dealing with them that progress can be made against the great scourge of cholera. The lecture was illustrated by lantern slides.

The vote of thanks was proposed by Dr. Hamill and seconded by Mr. W. R. Bett.

The Society held a clinical evening in the Abernethian Room on Thursday, November 14th, at 5.30 p.m., the President, Mr. A. P. M. Page, in the chair. The minutes of the previous meeting were read and signed. Mr. K. E. M. Fawcett showed a case of bronzed diabetes (hæmochromatosis) for alternative diagnosis and treatment, and Mr. J. M. Jackson showed a case of intestinal parasites (*Tænia saginata*) for advice as to treatment. A lively discussion followed each case, in which there joined Messrs. Matheson, Ravcu, Darke, Hayward, Coltart, Buckland, Masina, MacVine, Franklin and Bett.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

We extend our hearty congratulations from all members of the Rugby Club to R. N. Williams on his selection to play for the colours pack in the English Rugby Trials at Northampton.

Also to J. T. C. Taylor on being chosen as a reserve in the second English Trial to be held at Gloucester on December 21st.

The 1st XV, after giving the London Welsh such a fine struggle, have been showing varied form. In losing to the Devonport Services and Moseley they were certainly surprised, if not unlucky.

There will have to be an improvement in present form if the Hospital Cup is going to return to its rightful owners. J. M. J.

1ST XV RESULTS.

November 23rd: *v.* London Welsh, home; lost 0—8.
November 30th: *v.* Devonport Services, away; lost, 3—14.
December 2nd: *v* R.N.E.C. (Keyham), away; won, 20—0.
December 7th: *v.* Bath, away; scratched, ground unfit.
December 11th: *v.* R.M.A. (Woolwich), home; won, 23—6.
December 14th: *v.* Moseley, home; lost, 6—8.

ST. BARTHOLOMEW'S HOSPITAL RUGBY FOOTBALL CLUB: SEASON 1929–30.

Team Record up to and including December 14th, 1929.

	Played.	Won.	Drawn.	Lost.	Points. For.	Points. Against.
1st XV	13	5	1	7	112	121
"A" XV	12	10	1	1	231	70
Extra "A" XV	12	8	1	3	174	125
"B" XV	11	6	..	5	212	81
"C" XV	9	5	..	4	146	87
Extra "C" XV	8	5	..	3	96	72
"D" XV	3	1	1	1	32	18
Total	68	40	4	24	1003	574

ST. BARTHOLOMEW'S HOSPITAL *v.* LONDON WELSH.
(From *Daily Telegraph.*)

Result: Bart.'s, 0; London Welsh, 8.

November 23rd, at Winchmore Hill.

London Welsh are still unbeaten, but St. Bartholomew's Hospital gave them a desperate struggle at Winchmore Hill before it was all over. In the end the margin in favour of the Welsh was a goal and a try (8 points) to *nil*.

It was a wonderful game—a better will not be seen in London this season. And this in spite of the fact that heavy rain just before the beginning and during the early stages of the match made the ground into a marsh, and seemed certain to reduce the affair to a mere scramble in the mud. But far from it.

There were deeds in this match that would not have disgraced sides with much "bigger" names playing under perfect conditions. For sheer intensity of purpose from start to end we have seen nothing to equal this encounter for a long, long time. Except at inside half-back the superiority of the Welsh backs was the deciding factor. There was no comparison between Ralph, John Roberts and Arthur Jones and the men on the other side. Ralph is not far removed from being the best outside half-back playing to-day. Into his stride like a flash, Ralph has all the attributes that go to make the international—speed, remarkably safe hands, a long kick, and best of all, the eye for an opening.

Roberts put in some great work in defence, with an occasional burst that was full of venom to Bart.'s—from one of these the second try was obtained. And A. H. Jones revealed in all he did the coming of another player of genius. This boy—he is little more—will be heard much of later on.

What of Powell? The famous Welshman is not the player he was even a season ago. It is true he did not have the best of service from the scrums, but only on rare occasions did he give Ralph a pass to admire, and he showed up appreciably towards the end.

His opposite number—Taylor—was a lot too quick for Powell, and his many daring raids into enemy's country were always fraught with danger for the Welsh. Had Ralph had Taylor as his partner it is impossible to say to what heights the former might have risen.

The struggle between the forwards was something to remember. Bart.'s pack compares with any in London—there are no backsliders. With Lewis, Robertson and Jackson in the front row, Capper a really great forward, and Williams in the middle, and the Jenkins brothers and Thompson at the back, it is well balanced and an altogether smoothly-working machine. Every one of them fought like heroes; that the men behind them were so poor was their misfortune.

Although beaten for possession in the tight, the Welsh made up for it by their dashing work in the open. It was truly magnificent, though even here they were not masters of Bart.'s. They just held their own. R. Jones, Evans, Morris and Thomas were always ring-leaders. Baverstock threw away one try because he was tying a bootlace when the ball came his way.

For all but one minute of the first half the relentless struggle in the mud went on, and nothing had been scored. The Welsh then won a scrum on the line, and as it half broke up Powell dived over for a try.

The referee had no hesitation in awarding it, but the point might be raised as to whether Powell did not place himself off-side in touching his own forwards as he went through.

Evans could not convert.

The Welsh seemed to have assumed some supremacy after the interval, and within six minutes Roberts burst through after a Bart.'s mishkick and sent H. H. Jones in with a clear run.

This time Evans converted.

From then until the end Bart.'s forwards fought an unavailing fight. Once or twice these loose rushes nearly achieved their purpose. On the other hand, the Welsh backs several times went close to the line without getting over.

A truly great game.

Team: T. J. Ryan (*back*), G. F. Petty, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* DEVONPORT SERVICES.

Result: Bart.'s, 3; Devonport Services, 14.

November 30th, at Devonport.

Capper kicked off for Bart.'s, the start having been delayed a quarter of an hour owing to our late arrival. From a drop-out the Services took up the attack and Hinde cut out a neat opening for Knapman to carry play into the Bart.'s, "25."

Petty provided a thrill a moment later by breaking away on the wing and racing up to the home line, but when he punted ahead Gosling was able to touch down. The Services had slightly the better of the scrummages in the first half; the Hospital forwards seemed to be feeling the effect of the long train journey and the late lunch. It was not till the second half that the Bart.'s pack got together and began to get their share of the ball in the tight. The Bart.'s backs showed quite good form at times and were unlucky not to score on more than one occasion.

Taylor played well, but his opposing number kept him fully occupied.

Laird scored the Services' opening try after a spectacular run; five minutes later the Services increased their lead when Wood scored an unconverted try. Bart.'s then made a determined effort to reduce the lead, but were unsuccessful.

Soon after half-time the Services again attacked and Home broke away; beating Ryan, he touched down under the posts. Knapman converted.

Bart.'s again attacked, and Petty, after a delightful movement, raced down the wing to score the most spectacular try of the match. Capper's kick just failed. Pressure was again exerted on the home defence, and Bart.'s had another fine chance of scoring when Burrows cut through, but a forward pass brought the movement to an end. Just before "no side" a smart follow-up of a long kick by Gosling caught Ryan napping, and the ball went over the Hospital line for Dumbleton to dash up and touch down. Knapman's kick was a trifle wide.

Team: T. J. Ryan (*back*); G. F. Petty, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* R.N.E.C. (KEYHAM).

Result: Bart.'s, 20; R.N.E.C., 0.

December 2nd, at Devonport.

R. M. Kirkwood and A. T. Blair came into the side, T. E. Burrows and J. R. Jenkins standing down. Bart.'s showed much better form than against the Services; the ground was like a quagmire, but despite this the Hospital backs managed to handle the greasy ball with a great deal of accuracy.

Petty opened the scoring after a clever round of passing, the kick failing.

The College managed to hold the Hospital attack, and on several occasions went near to scoring, but faulty handling near the line spoilt their chances.

Gosling, the College full-back, was the outstanding player on the field, and but for his resolute tackling and fine touch-finding the score might have been very much greater.

Capper kicked a penalty goal for Bart.'s, and this ended the scoring of the first half.

In the second half the College defence slackened somewhat, and Taylor, Burrows, Petty and Lewis all added tries, Capper converting one.

The home side never looked so dangerous as in the first half, and although their forwards played well they were unable to turn the game; they were inclined to kick too far ahead.

The Bart.'s pack played better than against the Services, and their work in the open was especially creditable.

Team: T. J. Ryan (*back*); G. F. Petty, R. M. Kirkwood, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. J. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, B. S. Lewis, A. T. Blair (*forwards*).

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

Result: Bart.'s, 23; R.M.A., 6.

December 11th, at Winchmore Hill.

Bart.'s were without V. C. Thompson and C. B. Prowse, J. A. Nunn and D. W. Moynagh filling the vacancies.

The first half was well contested, and it looked as if the Hospital would have to fight hard to win.

The visitors' defence soon slackened and we were able to score fairly frequently.

Our forwards did not play as well as they might, but managed to get the ball a good deal in the tight. The chief fault lay in the ball not being heeled properly in the loose, and if our forwards had let Taylor have more of the ball the score might have been very much greater.

The Woolwich backs were dangerous at times, but found the Bart.'s defence too sound.

Many passing movements on both sides were spoilt by the terrific wind blowing across the pitch. The game was a disappointing one.

Team: T. J. Ryan (*back*); G. F. Petty, J. A. Nunn, R. M. Kirkwood, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, H. D. Robertson, W. M. Capper, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis, D. W. Moynagh (*forwards*).

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

Result: Bart.'s, 6; Moseley, 8.

December 14th, at Winchmore Hill.

Bart.'s were without W. M. Capper and C. B. Prowse. A. T. Blair and J. A. Nunn came into the side to fill the vacancies. The ground was in excellent condition and a close game was anticipated.

Bart.'s scored an early try, Kirkwood getting over near the corner flag after a good effort by C. R. Jenkins.

The first half was very evenly contested. Bart.'s did most of the attacking. In the tight scrummages the Hospital pack found themselves up against a really strong opposition, and the heavier Moseley pack pushed our forwards off the ball time and again. In the loose our forwards were always upon the ball, but the heeling was very slow, and Taylor, with all his skill, found it difficult to get the ball away to Beilby.

The Hospital backs played splendidly, and were unlucky not to have got over the visitors' line on several occasions.

Moseley had two enterprising wing three quarters in E. M. Barlow and H. K. Easton, the later scoring the visitors' opening try, which Foulds converted.

R. N. Williams scored the Hospital's second try after a good run by Thompson, the kick was disallowed.

Moseley soon afterwards drew further ahead through Monoham, who scored an unconverted try. From now onwards to the end Bart.'s exerted terrific pressure on the home line and were within an ace of scoring, but faulty handling and passing lost them the game, and so Moseley managed to keep their lead and thus revenge their previous defeat.

Team: T. J. Ryan (*back*); G. F. Petty, J. A. Nunn, R. M. Kirkwood, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis, A. T. Blair (*forwards*).

ASSOCIATION FOOTBALL CLUB.

The Association Football Club has completed the first term of this season with the following record: Played 9, won 4, lost 4, drawn 1. This is not a discouraging record when the unusually large number of absentees through illness and injury is considered. Next term we hope to have our captain, C. A. Keane, back again, and as the team's personnel is now fairly definitely settled, our hopes of winning the Inter-Hospital Cup must be considered distinctly good.

On November 23rd we met University College—probably the best team we have played this term—and it was encouraging to defeat them by 3—2, after a very closely fought struggle. Features of this game were the cohesion, understanding and dash of the forward line, and the excellent display in goal of R. L. Wenger.

Fortune favoured our opponents in another very close game on November 30th, when we played Selwyn College at Cambridge. Selwyn led by 2 goals to *nil* early in the game, but we fought back and made the score 2—2. Selwyn scored again, however, in the last few minutes, so that we were compelled to admit defeat after a very enjoyable game.

December 7th found us at Winchmore Hill matched against Selwyn College "on tour." The ground was in an extremely muddy condition, which made good play practically impossible, but, as in the previous match, there was a very close struggle. Until a late period in the game we led 2—1, but Selwyn scored the equalizer and we finished up with honours even. In both these Selwyn games H. J. Roache was the outstanding player of the Bart.'s side, his soundness in defence being invaluable.

Results.

November 23rd: 1st XI *v.* University College, away; won, 3—2.
November 30th: 1st XI *v.* Selwyn College, Cambridge, away; lost, 2—3.
December 7th: 1st XI *v.* Selwyn College, Cambridge, home; draw, 2—2.

REVIEWS.

THE INTERNAL SECRETIONS OF THE OVARY. By A. S. PARKES, M.A.(Cantab.), Ph.D.(Manch.), D.Sc.(Lond.). (London: Longmans, Green & Co., 1929.) Pp. 242. Illustrated. Price 21s. net.

The present time is most opportune for correlating the facts connected with the internal secretions of the ovary, and for that reason this book is of great value. The section dealing with the morphology of the œstrous cycle is excellent, but the author has confined himself to those species which have been studied in detail. The *rôle* of the ovary as an organ of internal secretion is discussed fully. The author believes that at least two ovarian hormones may be said to exist, and eventually three will be demonstrated, as originally suggested by Marshall. On the other hand, Frank has prepared œstrous-producing hormones from ovaries, placentæ and corpora lutea, and believes that only one ovarian hormone is present.

To the clinician the section dealing with the œstrous-producing hormone is all-important, and the history of the preparation of this substance makes fascinating reading. The chemical properties and methods of administration of œstrin are fully described. Arising from the latter, it is worthy of record that amounts of œstrin, known to be active by other routes of administration, are inactive orally. It is hoped that the oral administration of this substance will be abandoned and also the oral administration of the many inactive preparations on the market will cease; for such methods cannot fail to bring ovarian organo-therapy into disrepute.

The identification of œstrin has advanced greatly following the discovery of Stockard and Papanicolaou that the vaginal changes in the rodent could be used to determine the œstrous cycle in the intact animal. The wide distribution of œstrin is discussed at length, and the isolation of this substance from testes, male urine and plants such as willow catkins seems to arouse little concern. It must be realized that the œstrous-producing hormone has been found in so many situations where it could not possibly have been elaborated that its discovery at any particular site affords no evidence of its origin there. As regards the function of œstrin, up to date, clinical research has not advanced greatly owing to the difficulty of administering adequate amounts of oily extracts; this, however, should be remedied with the introduction of water-soluble preparations.

The exact relationship between the anterior pituitary and the ovary is still not clear, but there seems little doubt that the former plays some part in regulating the normal ovarian cycle.

The *rôle* of the corpus luteum is well described, and it is apparent that four functions may be attributed:

(1) Inhibition of ovulation and œstrous changes in accessory organs.
(2) Sensitization of the uterus for implantation of fertilized ova.
(3) Certain mammary changes.
(4) The maintenance of pregnancy.

The final chapter makes clear the importance of hormonic stimuli in the initiation of labour.

The illustrations are of a high standard and the bibliography is complete, there being 661 references. We have every confidence in recommending this book to students of problems connected with the female generative system.

STARLING'S PRINCIPLES OF HUMAN PHYSIOLOGY. Fifth edition. Revised by C. LOVATT EVANS. (London: J. & A. Churchill, 1930.) Pp. 1039 + xv. Illustrated. Price 21s. net.

Before Starling's untimely death in Jamaica in May, 1927, the fourth edition of his famous book had been published. Starling was in the forefront of physiologists both as an experimenter and a teacher. This latter quality is retained in his *Principles of Human Physiology*, the story of the former being preserved in his published papers. He was a man greatly beloved by his pupils, and the task of revising the book for the present edition must have been no mean one.

Prof. Lovatt Evans has undertaken this at Starling's expressed wish, and the result of his labours is now before us. As it is five years since the last edition was published progress along various lines of knowledge has occurred, so that a great deal of revision has become necessary.

The book has been somewhat reduced in size by omitting old figures and by abbreviations in style. Some parts have, however, been almost entirely recast. Prof. Hartridge has done this in the case of the central nervous system, with which he has placed some portions previously presented in the special senses chapters. Some people may consider that this part of physiology really requires a separate volume, and that it should be written by one who is primarily a neurologist, or perhaps even a clinical neurologist. Prof. Hartridge, however, has his own methods of teaching, and with the aid of new illustrations he has been able to make this most difficult part of physiology intelligible. He undertook a hard task, but his completion of it is a real asset to the book in its present form.

For the revision of the remainder of the book we have to thank Prof. Evans, who now holds Starling's chair. He has faithfully carried on the great tradition. The portion dealing with the heart, which was Starling's special domain (his Law of the Heart is one of the texts of physiology) remains a monument to its founder. Our knowledge of metabolism is still mediocre, but the recent advances made by the Hampstead workers as to that of carbohydrate bring this part of the subject to our present state of learning. The position of that relating to fat and protein is still even less satisfactory, but it is to be hoped that before the next edition appears some of the omissions will be able to be filled. Reference is made to the belief of Maclean that the chlorine ions of the stomach contents are a constant secretion. Sulphur metabolism is still largely an untravelled path, but perhaps mention might have been made of Hele's painstaking work in this subject.

The view that the pulmonary epithelium plays a purely passive part in the interchange of gases between the alveoli and blood is accepted. Does this mean the end of the controversy between the Oxford and Cambridge schools of thought? This portion dealing with respiration shows the reviser's hand in many places. The final chapter on reproduction has been much altered, and due reference is made to Shaw's notable work on this subject. All the remaining parts have been thoroughly revised.

That this volume will continue to be the leading text-book of human physiology is assured. Prof. Evans is to be congratulated on the manner in which he has carried on Starling's work. It seems as if the mantle of the founder has passed to him. That the book will still pursue its successful course is the earnest wish of the reviewer. The production, as would be expected from Messrs. Churchill, leaves nothing to be desired.

THE ESSENTIALS OF CHEMICAL PHYSIOLOGY. Twelfth edition. By W. D. HALLIBURTON, J. A. HEWITT and W. ROBSON. (London: Longmans, Green & Co., 1929.) Pp. 383 + xii. Price 9s. net.

This is a new edition of this well-known book. It was first published in 1893, but the last edition was brought out seven years ago. In this present one the general scheme of the book as a practical guide to chemical physiology is unchanged. It has been brought up to date, and many detailed additions can be noted. Among these are accounts of Hopkins's work on glutathione, Hill's work on blood-pigments, Hagedorn and Jensen's method of blood-sugar estimation, and the action of insulin. No reference is made, however, to the action of insulin on the blood-phosphate, and the metabolism of phosphates is not well presented.

The book, however, maintains its former high standard, and will undoubtedly be continued to be used as a text-book for practical work in the subject. As in previous editions, the production is excellent.

AN INTRODUCTION TO THE STUDY OF THE NERVOUS SYSTEM. By E. E. HEWER, B.Sc., and G. M. SANDES, M.B., B.S. (London: William Heinemann [Medical Books], Ltd., 1929.) Illustrated. Price 21s. net.

This book, if for nothing else, is remarkable for the kaleidoscopic brilliance of the diagrams it contains. The authors are careful to title the book "An Introduction to the Study of the Nervous System," and in their preface express apology for a certain amount of dogmatism. An introduction it may be, and full of dogmatisme it is. In 100 pages they attempt to condense the anatomy, the physiology, some pathology of the nervous system and even some historical facts. It is astonishing how well it has been condensed. For students we hesitate to recommend it mainly on account of its dogmatisms, its reduction of the nervous system to the level of an electrician's plan for the wiring of a large building, and its unattractiveness to a lover of the English language.

SEX AND DISEASE: A SCIENTIFIC CONTRIBUTION TO SEX EDUCATION AND THE CONTROL OF VENEREAL DISEASE. By ROBERT V. STORER, M.R.C.S.(Eng.), L.R.C.P.(Lond.). With Introduction by Col. J. S. PURDY. (Revised Popular Edition of *Venereal Diseases: Their Nature, Prevention and Treatment.*) (Sydney, Australia: Butterworth & Co., Ltd., 1929.) Pp. 131. Price 8s. 6d.

A work ambitiously described as "containing information for Medical Practitioners, Parents, Social Workers, Teachers, Students, Chemists, Patients, and all Young Men," should be written in language of studied restraint and compromising discretion. The lay public will as readily appreciate the author's frank and simple style as medical readers will deprecate his uncontrolled sentimentality. The price of the book is as prohibitive as its general make-up is discouraging. Apart from an exuberant optimism concerning the cure of gonorrhœa and syphilis, the author's views of prevention and treatment are sound and practical. Though the obstinate spelling of "Littre" jars a critical eye, the book may be helpful to many.

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

BARNES, E. BROUGHTON, F.R.C.S.(Ed.) (and GIMBLETT, C. L., M.D., F.R.C.S.). "Gradenigo's Syndrome followed by Complete Recovery." *British Medical Journal*, December 14th, 1929.

BARRIS, J. D., F.R.C.P., F.R.C.S., and DONALDSON, M., F.R.C.S. "Radiological Work in the Gynæcological Department, St. Bartholomew's Hospital." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.

BOYLE, H. EDMUND G., O.B.E., M.R.C.S., L.R.C.P. "Gas-oxygen in Midwifery." *British Medical Journal*, December 7th, 1929.

CANTI, R. G., M.D. "Biological Effects of Radium Irradiation." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.

CAPPS, F. C. W., F.R.C.S. "Swelling of Left Arytenoid and Fixation of Vocal Cord: for Diagnosis." *Proceedings of the Royal Society of Medicine*, October, 1929.

CARSON, H. W., F.R.C.S. "The *Rôle* of the Practitioner in Acute Surgical Abdominal Disorders." *Practitioner*, December, 1929.

CHANDLER, F. G., M.A., M.D., F.R.C.P. "Puncture of the Chest: Its Occasions and Technique." *Lancet*, November 23rd, 1929.

CHOPRA, R. N., M.A., M.D.(Cantab.), I.M.S. (and DE PREMANKUR, B.Sc., M.B., M.R.C.P.[Edin.]). "*Saussurea Lappa* (Kut Root) in Pharmacology and Therapeutics." *Indian Journal of Medical Research*, October, 1929.
——— (and CHOUDHURY, S. G., M.Sc.). "The *Rôle* of Surface Tension on the Activity of Cinchona Alkaloids." *Indian Journal of Medical Research*, October, 1929.
——— (and DIKSHIT, B. B., M.B., B.S.[Bombay], D.P.H.[Cal.], and PILLAI, K. VENKATACHALAM, L.M.S.[Madras]. "Pharmacological Action of Pseudo-Ephedrine from the Indian Varieties of Ephedra." *Indian Journal of Medical Research*, October, 1929.
——— (and GHOSH, SUDHAMOY, D.Sc., F.R.S.[Edin.]). "Observations on Certain Medicinal Plants used in the Indigenous Medicine." *Indian Journal of Medical Research*, October, 1929.
CLARK, A. J., *M.C.*, M.D., F.R.C.P., D.P.H. *Applied Pharmacology*, Third edition. London: J. & A. Churchill, 1929.
COYTE, RALPH, M.B., B.S., F.R.C.S. "Cystoscopy." *Practitioner*, December, 1929.
DONALDSON, MALCOLM, F.R.C.S. *See* BARRIS AND DONALDSON.
DUNDAS-GRANT, Sir JAMES, K.B.E., M.D. "Carcinoma of the Larynx Benefited by Treatment with Radon Seeds." *Proceedings of the Royal Society of Medicine*, October, 1929.
EVANS, E. LAMING, C.B.E., F.R.C.S. "Case of Kienböch's Disease." *Proceedings of the Royal Society of Medicine*, September, 1929.
EVANS, GEOFFREY, M.D., F.R.C.P. "Constipation: Its Nature and Diagnosis." *British Medical Journal*, December 7th, 1929.
FINZI, N. S., M.B., D.M.R.E.(Camb.). "The Therapeutic Uses of Radium applied Externally." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.
——— (and LEVITT, W. M., M.B., D.M.R.E.[Camb.]). "X-Rays in the Treatment of Malignant Disease." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.
GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S., and MOIR, E. D., F.R.C.S. "The Technique of Radium Treatment of Carcinoma of the Tongue and Mouth." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.
HARMER, W. DOUGLAS, M.A., M.B., *M.C.*, F.R.C.S., and RUSSELL, BEDFORD, M.A., B.Ch., F.R.C.S. "Radium Treatment of Malignant Diseases of the Upper Air Passages." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.
HERNAMAN-JOHNSON, F., M.D.(Aberd.), D.M.R.E.(Camb.). "The Management of Patients Suffering from Cancer of the Breast." *Lancet*, November 23rd, 1929.
HOPWOOD, F. L., D.Sc., F.Inst.P. "The Radium Department of St. Bartholomew's Hospital, London." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.
HORDER, Sir THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "More Medical Notes." *Clinical Journal*, November 27th, 1929.
HORNE, W. JOBSON, M.D. "Cancer of the Vocal Cords: Difficulties in Diagnosis and Fallacies in Statistics." *Proceedings of the Royal Society of Medicine*, October, 1929.
KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. "The Treatment of Primary Carcinoma of the Breast with Radium." *Acta Radiologica*, vol. x, fasc. 4, October, 1929.

EXAMINATIONS, ETC.

University of Oxford.

The following degree has been conferred:
B.M.—Duncan, C. M.

University of Cambridge.

The following degree has been conferred:
M.D.—Stewart, J. D. M.

University of London.

Third (M.B., B.S.) Examination for Medical Degrees, November, 1929.

Pass.—Boyd, A. M., Dalzell, P., East, C. J., Evans, M. J., Everett, A. D., Griffiths, T. R., Tait, C. D. V., Wise, C. S.

Supplementary Pass List.

Group I.—Clark, A., Dale, C. H., Harris, R. L. H., Pope, E. S., Riley, A. C.

Group II.—Baker, E. F. D., Bennett, R. C., Edwards, F. A., Hartley, K. W. D., Price, R. K.

Royal College of Surgeons.

The Diploma of *Fellow* has been conferred on the following:
Beattie, W. J. H. M., Dannatt, R. M., Dawson, J., Forty, F., Greenwood, W. P., Joshi, M. S. K., Laurence, N. E., Mason, A. J., Modi, M. V., Norrish, R. E., Peiris, M. V. P., Row, A. W. L., Russell, S. F., Smith, J. O., Underwood, W. E.

The following were successful at the examination held for the *Primary Fellowship*:
Beattie, D. A., Hogg, J. C., Ishmael, D. T., Snell, V. C., Williams, A. C., Williams, H. M.

CHANGES OF ADDRESS.

BOYLE, H. E. G., 13, Queen Anne Street, W. 1. (Tel. Langham 1586.)
BROWNE, Surg.-Cmdr. E. M., R.N., H.M.S. "Malaya," Atlantic Fleet.
CLAXTON, E. E., c/o Lloyds Bank, 44–5, Aldersgate Street, E.C. 1.
CUMBERBATCH, E. P., 18, Manchester Square, W. 1. (Tel. Welbeck 3036 and Ealing 0623.)
SEDDON, H. J., Department of Surgery, University Hospital, Ann Arbor, Michigan, U.S.A.

APPOINTMENTS.

HENSMAN, J. STUART, M.R.C.S., L.R.C.P., appointed House Physician to the Hospital for Sick Children, Great Ormond Street, W.C. 1.
ROTH, E. J. H., M.R.C.S., L.R.C.P., D.M.R.E.(Cantab.), appointed Radiologist to St. Peter's Hospital for Stone, London.

BIRTHS.

BRIDGEMAN.—On December 3rd, 1929, at 17, Egerton Gardens, to Alice, wife of Cmdr. Paul Bridgeman—a son.
GARNHAM.—On December 4th, 1929, to Esther (*née* Long Price), wife of Dr. P. C. C. Garnham—a daughter (Cicely Mary).
ROXBURGH.—On November 26th, 1929, at 5, Redington Road, Hampstead, the wife of A. C. Roxburgh, M.D., F.R.C.P., of a son.

MARRIAGES.

WALSH—JACKS.—On November 16th, 1929, at St. Mary's, West Kensington, Robert Arthur, son of Mr. and Mrs. R. W. Walsh, of Kensington, to Marian, youngest daughter of Mr. and the late Mrs. T. W. M. Jacks, formerly of Glasgow.
WHITEHURST—MACDONALD.—On December 14th, 1929, at Holy Trinity Church, Northwood, by the Rev. Cecil Walker, M.A., Vicar, Dr. T. H. Neville Whitehurst, only son of Mr. and Mrs. G. H. Whitehurst, Chiltern, Northwood, to Jessie, elder daughter of Mr. and Mrs. Donald Macdonald, The Pines, Northwood.

DEATHS.

CUMMING.—On December 7th, 1929, suddenly, George William Hamilton Cumming, M.D., of "Overton," Torquay.
CURGENVEN.—On November 25th, 1929, suddenly, at Granthams, Chiddingfold, Surrey, John Sadler Curgenven, late of 12, Craven Hill Gardens, London, aged 66.
WOOD.—On December 2nd, 1929, John Forrester Wood, F.R.C.S. (Eng.), of Beaver Grove, Bettws-y-Coed (late of Southport), aged 62.

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, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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. 1. Telephone: National 4444.*

St. Bartholomew's Hospital Journal.

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

VOL. XXXVII.—No. 5.] FEBRUARY 1ST, 1930. PRICE NINEPENCE.

CALENDAR.

Sat., Feb. 1.—Rugby Match *v.* Devonport Services. Home.
Association Match *v.* Emmanuel College, Cambridge. Home.
Mon., ,, 3.—Special Subject: Clinical Lecture by Mr. Just.
Tues., ,, 4.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Tues., Wed., Thurs and Fri., Feb. 4, 5, 6 and 7.—At 8 p.m. in the Great Hall: **The Amateur Dramatic Club presents "The Mask and the Face."**
Wed., Feb. 5.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Thurs., ,, 6.—**Abernethian Society: Mid-Sessional Address by Prof. Barcroft, at 8.30 p.m.**
Fri., ,, 7.—Dr. C. M. Hinds Howell (acting) and Mr. Harold Wilson on duty.
Sat., ,, 8.—Rugby Match *v.* Old Leysians. Away.
Association Match *v.* Old Malvernians. Home.
Hockey Match *v.* R.M.C., Sandhurst. Away.
Mon., ,, 10.—Special Subject. Clinical Lecture by Mr. Rose.
Tues., ,, 11.—Prof. Fraser and Prof. Gask on duty.
Wed., ,, 12.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
Hockey Match *v.* Keble College, Oxford. Away.
Fri., ,, 14.—Sir Percival Hartley and Sir Holburt Waring on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.
Sat., ,, 15.—Rugby Match *v.* O.M.Ts. Away.
Association Match *v.* University College. Home.
Hockey Match *v.* R.E., Chatham. Away.
Mon., ,, 17.—Special Subject: Clinical Lecture by Mr. Elmslie.
Tues., ,, 18.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Wed., ,, 19.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Hockey Match *v.* Epsom. Away.
Thurs., ,, 20.—**Abernethian Society: Clinical Meeting, 5.30 p.m.**
Last day for receiving matter for the March issue of the Journal.
Fri., ,, 21.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., ,, 22.—Rugby Match *v.* Old Blues. Away.
Association Match *v.* Keble College, Oxford. Home.
Hockey Match *v.* Mill Hill. Away.
Mon., ,, 24.—Special Subject: Clinical Lecture by Mr. Scott.
Tues., ,, 25.—Dr. C. M. Hinds Howell (acting) and Mr. Harold Wilson on duty.
Wed. ,, 26.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling
Association Match *v.* Centels (Annual Charity Match). Away.
Fri., ,, 28.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.

EDITORIAL.

NON-PROFESSIONAL CASE-NOTES.

DR. MUNDY, in a letter published elsewhere in this issue, draws attention to an account of lobar pneumonia by Arnold Bennett. Such a lay description of disease from the pen of a master of modern prose is of peculiar interest. Aldous Huxley in *Point Counter Point* has drawn unforgettably a fatal case of meningitis; and the medical man in the course of his general reading must find many like examples.

The converse question comes naturally to mind, what comment the *littérateur* would have for the strange language of professional case-notes. Accustomed to summing up the perfect specimen of Nature's masterpiece as a being of such an age and such an occupation, who looks healthy, whose pupils are equal, central and circular, whose eyes react to light and accommodation, whose *conjunctivæ* are not pale, and so through the accepted formula, our descriptive urge appears to be more easily satisfied than his. To learn from his more individual and understanding use of language might be an advantage, but the danger is lest what we look for should become as inelastic as the words in which we set down what we see.

Such discernment in favour of lay writing must not blind our eyes to the beauty of certain classical descriptions of disease, which can be culled from the canon of medicine itself. Addison's account of *Addisonian Anæmia* (1855), made current professional coin by Osler, is one of the most striking; while Paget on *Osteitis Deformans* (1877) and Gee on *The Cœliac Affection* (1888) stand out from the Bart.'s *Athenæ*. From the works of Percival Pott, readable still for their "scholarly grace and elegance" as well as for their matter, the account of a case of puffy tumour of the scalp (1760) possesses just

that picturesqueness of detail which makes it stick in the memory like a burr.

The Bible and the Plays of Shakespeare have been summoned to do the work of literary diagnosis, prognosis and treatment for long enough. An anthology of modern pen-pictures of disease would be a welcome and instructive change.

* * *

ANATOMY, ORTHODOX AND HETERODOX, IN RELATION TO SURGERY.

On Wednesday, February 19th, at 5 p.m. in the Theatre of the Royal College of Surgeons, Mr. McAdam Eccles is to deliver an Arris & Gale Lecture on the rather cryptic subject of "Anatomy, Orthodox and Heterodox, in Relation to Surgery." All students who would care to attend may do so without cards of admission. Mr. Eccles's reputation as a lucid and cogent lecturer will ensure for him an appreciative audience.

* * *

PROF. FRASER'S B.M.A. ADDRESS.

Prof. Fraser is to address fourth and fifth year students and those recently qualified in the Great Hall of the British Medical Association House, Tavistock Square, on Tuesday, February 11th, 1930. His subject, "Before the Finals: and After," is sufficiently near their hearts to make encouragement to attend superfluous. Tea will be served at 5 p.m. in the Members' Lounge, and the lecture will begin at 5.30 p.m.

* * *

Congratulations to Sir Charles Wakefield on being made a Peer. He has taken the title of Lord Wakefield of Hythe. A Governor of the Hospital in his capacity of Alderman, he was a frequent visitor to the East Wing in the days of his Mayoralty, when that wing was doing military service.

* * *

Congratulations to Dr. R. J. Brocklehurst, who has added another distinction to his already distinguished career, having been appointed to the Chair of Physiology at Bristol from August 1st, 1930.

* * *

Sir Gordon H. Campbell has offered four five guinea prizes for Fancy Dress Ball Costumes of Rahere as a Monk, as a Jester, and (*en tableau*) of Henry I handing the Charter to Rahere. The awards will be judged by photographs. Entrance forms and further details may be had from the Appeal Department at the Hospital.

* * *

The Warden requests us to state that the closing date for applications for House Appointments in May is 12 noon, Saturday, February 15th, 1930.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

ON SOME URINARY DISEASES.

(1) The custom of collecting the twenty-four hours' urine and putting up a specimen for examination, whilst being a useful routine procedure in general cases, is far from being the best in special cases. Saving individual specimens separately as they are passed often gives valuable information in urinary diseases, especially when focal lesions are suspected.

(2) The significance of casts in the urine must be taken in relation to the question whether or no the material was centrifuged before the search is made. In the latter case the finding of an occasional hyaline or granular cast in the urine of a patient over fifty is not necessarily pathological.

(3) The odour of the urine in coliform urinary infection is so characteristic that a diagnosis can often be made by this observation alone. The smell is quite different from that of ammoniacal urine, with which it is sometimes confounded. The smell is not present in coccal infections, however severe.

(4) Relapses are so common after acute coliform infection of the urinary tract that their occurrence constitutes a feature of the disease. The presence of excess of mucus or (and) phosphates in the urine should be regarded as a danger-signal in this connection. The source of these re-infections is probably, in a considerable number of instances, a residual prostatitis.

(5) The significance of the isolation of staphylococci from the urine is quite different, according as the coccus is *S. aureus* or *S. albus*. In the former case the presence of staphylococcus pyæmia is to be suspected, with subcapsular or perinephric foci. In the latter case the coccal infection is probably secondary (to calculus, tuberculosis, gonorrhœa, etc.).

(6) It has been suggested that in albuminuria the nature of the protein helps to distinguish the "functional" from the "organic" cases, the protein being wholly or mainly serum-globulin in the former, and wholly or mainly serum-albumen in the latter. Fuller experience, however, has shown that this inquiry possesses no differential diagnostic value.

(7) The appropriate treatment of a case of "functional" albuminuria is almost the antithesis of the appropriate treatment of a case of nephritis. If, therefore, a functional albuminuric is treated as nephritic he fails to improve. This fact sometimes seems to confirm the diagnosis of organic disease, and so the error is prolonged.

(8) It is important to remember the frequency of associated renal lesions—pyelitis with calculus, pyelitis with calculus and with neoplasm. The demonstration of pyelitis, therefore, especially if chronic or recurring, should never be accepted as a full diagnosis until other conditions have been considered and, so far as possible, eliminated.

(9) Hæmaturia in association with morbus cordis occurs in three conditions: (i) In septic endocarditis, the blood resulting from renal infarction, mostly in small (and it may be microscopic) amounts; (ii) in mitral stenosis, the blood again resulting from renal infarction, but generally in larger quantity; (iii) in dilatation, with visceral engorgement, the source of the bleeding being the renal congestion.

(10) If hæmaturia occurs in an elderly man as the result of prostatic bleeding, the condition of the prostate is more likely to be a "simple," soft, adenomatous enlargement than a carcinoma.

(11) Symptomless hæmaturia is generally due to a readily ascertained focal lesion, such as vesical papilloma, renal neoplasm or renal calculus; or it escapes explanation altogether ("essential hæmaturia").

RECENT OBSERVATIONS ON THE PITUITARY BODY.

A Clinical Lecture delivered at St. Bartholomew's Hospital.

By W. LANGDON BROWN, M.D., F.R.C.P.

IT has been well said that the progress of a science may in general be measured by the degree to which it has been put on a mathematical basis. But I should like to utter a caution against a premature attempt to do this, for not only does it convey an idea of accuracy which is wholly illusory, but it actually delays progress, because it offers a temptation to fit the facts to a mathematical formula. The kidney still refuses to work according to Ambard's coefficient, and it is still impossible to express a man's constitution in terms of pH. The equation and the graph are so mentally satisfying, things "come out" so neatly that there is a distinct temptation to apply them too soon to clinical work. Nevertheless it remains true that the nearer a science is to correct mathematical expression, the more exact it will be.

In organotherapy one is constantly struck by the great discrepancy between the confident claims of the manufacturer and the pained agnosticism of the laboratory worker. The laboratory worker not only demands proof that a gland yields an active principle in a form the body can utilize—in which he is right—but he is highly sceptical of the value of any other kind of evidence—in which he is wrong. I assert this positively, remembering that all the pioneer observations on myxœdema, acromegaly, Fröhlich's syndrome and Addison's disease were made at the bedside.

The early easy successes of thyroid administration led to an undue optimism; the problem looked much simpler than it really was. In the case of the thyroid gland we have a reservoir containing a large quantity of an active hormone, which can be assimilated by oral administration, presumably because that gland originally opened into the alimentary tract. But in other cases neither the reservoir nor the method is so adequate. Organotherapy of necessity lags behind endocrinology, which is perhaps just as well. If all the preparations which have been given had really been active much harm might have been done. But that we are going along right lines and that further advance may be expected along such lines is suggested by the way in which the results of the new work drop into place like the pieces of a jig-saw puzzle. I propose to illustrate this by some of the more recent observations on the pituitary.

We recognize the double origin of this gland from an invagination from the pharynx and a downgrowth from the brain. This suggests the possibility of its secretion being effective if given by the nasal route, just as thyroid extract is by the oral route, and this has proved to be the case. Pledgets of cotton-wool moistened with pituitrin and placed high up in the nose can control diabetes insipidus, while more recently a snuff containing dried and powdered pituitary gland substance has also been successful.

Physiologically we must distinguish between anterior lobe, posterior lobe and the stalk. The pars intermedia seems functionally to belong to the posterior lobe. It has been known for a good many years that the anterior lobe contains both eosinophile and basophile cells; it has also been recognized that this lobe is concerned with both growth and sexual development. But now H. M. Evans and M. B. Simpson have been able to separate a distinct hormone for each of these functions and to associate them with a particular type of cell. Moreover,

[NOTE.—The illustrations from Prof. Cushing's Oration before the Medical Society in 1927 are published here, by kind permission, from the Society's *Transactions*, vol. 50.]

there is a definite antagonism between them, the growth hormone being capable of completely nullifying the other if they are simultaneously injected. Nature has provided the necessary adjustment in the relative amounts of the two substances secreted. That growth precedes sexual maturity is presumably due to the early predominance of the growth hormone. The retardation of sexual maturity in the interest of somatic growth is

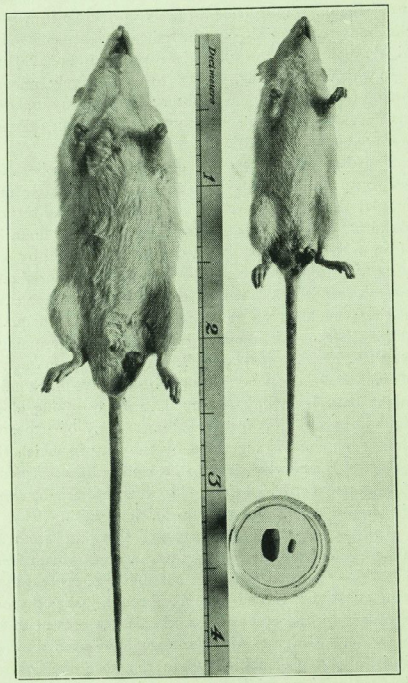


FIG. 1.—LITTER-MATE BROTHERS; 3 MONTHS AFTER REMOVAL OF THE PITUITARY FROM THE ONE ON THE RIGHT.—(P. E. SMITH.)

similarly determined by the action of the pineal body and the thymus gland. The association between the eosinophile cells and growth is indicated by the coincidence of eosinophilous adenoma with gigantism or hemihypertrophy if it develops before the epiphyses join up, and acromegaly if it develops after this date, while a definite relationship has been established between the basophile cells and the gonads. When the basophile cells are able to assert themselves over the eosinophile cells, puberty occurs. Transplantation of gonads is only effective when there is also such an active anterior pituitary to maintain their activity. Injection of anterior pituitary extract will cause sexual development in the young and restoration of function in the old.

It is noteworthy that over-activity of the anterior pituitary as expressed in basophilic adenomas tends, like adrenal cortical tumours, to produce virilism. I

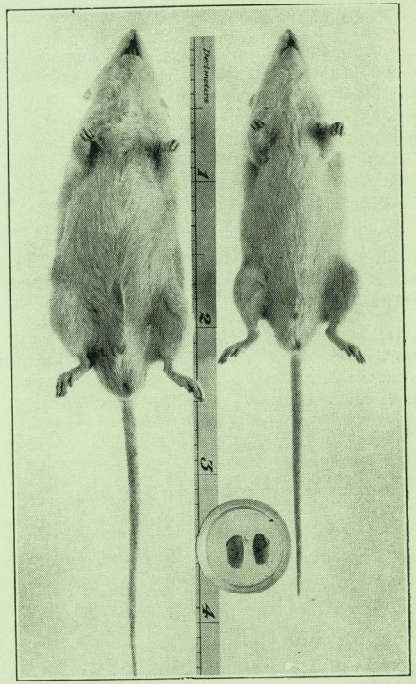


FIG. 2.—THE SAME 3 MONTHS LATER SHOWING THE EFFECT OF PITUITARY TRANSPLANTS ON THE ANIMAL FROM WHICH THE PITUITARY HAD BEEN REMOVED.—(P. E. SMITH.)

have reported cases of virilism in women due to this cause.

Before Evans and Simpson had thus separated the functions of the anterior lobe P. E. Smith had carried out some interesting observations on rats. He removed the pituitary from one of two litter-mate brothers. Fig. 1 shows the effect on the growth of the whole body and of the testes three months after this operation. The dwarfed and sexually infantile animal then had a pituitary

transplanted into him each day. In another three months he had almost caught up his brother in growth, and the remaining testis was almost the same size in both animals (see Fig. 2).

This would lead us to associate dwarfism without sexual hypoplasia, as distinct from infantilism, with a defective development of the eosinophile cells of the

FIG. 3.—PATIENT AGED 8, SUFFERING FROM PROGERIA.—(CUSHING.)

anterior pituitary, and I have seen dwarfs in which the pituitary fossa was small. But the most convincing evidence was supplied by Simmonds of Hamburg in 1914. He pointed out the frequency with which the pituitary, in the course of septic infections, may be affected by embolic processes. The symptoms naturally vary with the age of onset. His first series of cases had chiefly occurred in consequence of puerperal sepsis. In one instance the patient's premature senility, somnolence and death were found to be associated with almost complete cicatricial destruction of the gland. The viscera were atrophic, in sharp contrast with the splanchnomegaly of acromegaly.

If such an infarct occurs in childhood and involves only the anterior lobe the results are even more striking. In 1918 Simmonds reported a case of a dwarf, only 2 ft. 11 in. in height, who died at the age of 21. These patients may show an extraordinary premature senility, as first described by Jonathan Hutchinson, and subsequently more fully by Hastings

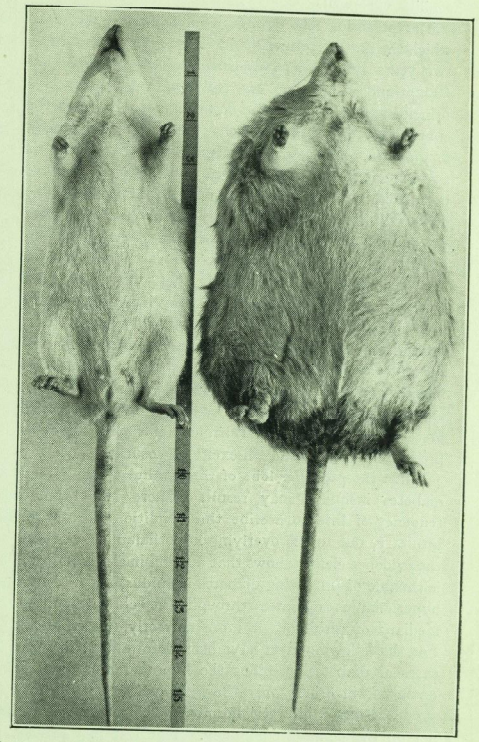


FIG. 4.—LITTER-MATE SISTERS; THE ONE ON THE RIGHT WAS SUBJECTED TO A LESION OF THE HYPOTHALAMUS, WITHOUT REMOVAL OF THE PITUITARY, 22 DAYS BEFORE THE PHOTOGRAPH WAS TAKEN.—(P. E. SMITH.)

Gilford under the name of "progeria," signifying premature old age. The "enfeebled old dotard of five" of the "Bab Ballads" is an example of this. Some of these cases show a failure of the adrenal cortex to develop, and the condition has been referred to this failure. But it would appear to be equally liable to

result from damage to the anterior pituitary. It is interesting to note that just as basophilic over-growth of the anterior pituitary or adrenal cortical tumours may produce premature sexual development always tending to virilism, so lack of anterior pituitary (presumably eosinophilic) or of adrenal cortex may lead to dwarfism with premature senility. Fig. 3, a case of Cushing's in a patient aged 8, shows this premature senility very well.

The posterior lobe produces an active secretion to which the name "pituitrin" has been given. But some two years ago it was established by the researches of Kamm and others that this really contained two active principles, one *oxytocin* or *pitocin*, which stimulates the contraction of uterine muscle, the other *vaso-pressin* or *pitressin*, which raises blood-pressure, affects diuresis and antagonizes insulin. Both these principles have been isolated in the form of white, stable water-soluble powders. The chemical processes involved do not alter the original active principle or principles, since they can be recombined to form a pituitary extract identical with the original form from which they were prepared. Overaction of the posterior lobe may lead to pituitary glycosuria, which is often characterized by its rhythmic intermittence, and by bony changes indicating that the anterior lobe is involved. Rhythm is typical of pituitary (note its association with the menstrual cycle), and the definite antagonism between pituitrin and insulin first described by J. H. Burn explains why an overproduction of pituitrin will excite glycosuria.

When the posterior lobe of the pituitary is in defect, diabetes insipidus may result. There has been a tendency of late to ascribe this condition, not to the pituitary, but to the overlying hypothalamus. I think the evidence clearly shows that a lesion in either position is capable of producing diabetes insipidus, and that the hypothalamus operates through the chemical intermediary of pituitrin, or more correctly, of pitressin. For the following facts have been determined: in some cases of diabetes insipidus the hypothalamus alone is damaged, in others only the pituitary; the pituitary produces an antidiuretic hormone; this hormone will act on the denervated kidney. This last fact proves, to my mind, that even when the hypothalamus is responsible, it must act, not through a nervous, but through a chemical mechanism, and that this mechanism resides in the underlying pituitary.

With regard to oxytocin, it is important to note Dixon and Marshall's observations on the effect of the interstitial hormone of the ovary in stimulating its secretion, and to the inhibitory effect of the luteal hormone upon it. In this way the presence of the corpus luteum provides for the maintenance of pregnancy, and, as Fränkel's earlier experiments showed, its destruction is inevitably followed by abortion. When the corpus luteum begins to undergo fatty degeneration it no longer exerts this inhibitory effect, and the interstitial hormone initiates parturition through the pituitary. As Dixon says, it is remarkable that medical men, in using pituitary extract to stimulate uterine contractions, should have adopted the method which Nature has employed from time immemorial. And it may be added that they used it empirically before this chain of events was known.

In this same way the pituitary seems necessary to the involution of the uterus after pregnancy, and Leslie Pugh has found that failure of the corpus luteum of the cow to atrophy led to subinvolution.

It is not clear yet whether the so-called galactogogue effect of pituitrin is due to pitocin or pitressin. It is usually stated that this is merely due to a contraction of the muscles in the mammary ducts, but this would hardly account for three cases of pituitary tumour I have seen associated with lactation lasting seven, three and two years respectively. In the latter two cases administration of extract of corpus luteum promptly checked the secretion of milk. The other case I only saw in the post-mortem room.

The sharp bitemporal headache sometimes suddenly experienced by a woman on putting the child to the breast appears to be due to the demand made upon the pituitary, and I have known it to be relieved by pituitary extract.

Much light has been thrown on the pathology of Fröhlich's syndrome by another of P. E. Smith's experiments on rats. Fig. 4 shows the result of an injury to the hypothalamus without damage to the pituitary itself. The animal became enormously fat, while the sexual apparatus atrophied. It would therefore appear that the essential features of Fröhlich's syndrome can be produced by merely interfering with the relations between the pituitary and the hypothalamus. I put it in this way because it appears to me probable that it is interference with the communication between the gland and the central canal system of the brain that is directly responsible. But in Fröhlich's syndrome the functions of both lobes must be interfered with, for sex is associated with the anterior lobe, and that pituitrin produced by the posterior lobe helps in the transport of fat. Leathes found that saturated fat is sent from the tissue depôts to the liver to be desaturated before it can be metabolized; hence the accumulation of saturated fat in the liver in hepatic toxæmias. Coope proved that an injection of pituitrin was followed by a transference of fat from the tissue depots to the liver. We can therefore understand why the subject of hypopituitarism becomes obese, for the tissue fat cannot be properly metabolized. And as we know, this fat tends to accumulate, particularly round the limb girdles. From the close association between the gonads and the pituitary we can understand why castration or gonadal defects lead to obesity. But many cases of Fröhlich's syndrome have been due to a chromophobe adenoma in the pituitary. Last year I saw a man who had recently become obese, and had developed large mammæ. He had lost most of the hair on his body and his genitals had shrunk. An X ray showed his pituitary fossa to be definitely enlarged. He was evidently suffering from an adenoma of this sort, but I did not venture to advise operation. However, this was subsequently carried out, and I am informed that his condition has returned to normal.

Table of Pituitary Functions and Diseases.

	Secretion.	Diseases from— Over-action.	Under-action.
Anterior lobe	Growth hormone from eosinophilic cells	Gigantism Hemihypertrophy Acromegaly	Dwarfism. Progeria.
	Sex hormone from basophilic cells	Virilism in women	Of both lobes. Fröhlich's syndrome.
Posterior lobe	Pitocin, contracting the uterus		Some cases of subinvolution of the uterus.
	Pitressin, raising blood-pressure, affecting diuresis and antagonizing insulin	Pituitary glycosuria	Diabetes insipidus.

It is interesting to note that while chromophile adenomas are associated with increased function, the chromophobe ones lead to diminished function of the gland. This suggests that the former are homoplastic and composed of true secreting cells, while the latter are heteroplastic and merely act as foreign bodies.

It is clear that mixed conditions may be produced of a puzzling kind. Thus pressure effects may be associated with a chromophile tumour, which causes symptoms of hyperpituitarism, or with a cyst or chromophobe tumour, causing symptoms of hypopituitarism. Further, the over-action of one lobe may first irritate and then suppress the function of the other by pressure on it, while the over-acting lobe may itself subsequently pass into a condition of exhaustion. Moreover, hypothalamic damage may lead to hypopituitary symptoms. Thus recent work on the effects of damage to the hypothalamus explains the cases of obesity and diabetes insipidus following lethargic encephalitis, which may attack this region.

Again Cushing regards wide-spread pluriglandular syndromes as specially characteristic of pituitary disorders, and as differentiating them from the disorders primarily affecting any other of the ductless glands. But before we unravel such complexities, it is essential to have a clear impression of the ordinary functions of each lobe and of the results of increase or diminution of each of these functions. It is in the hope of clarifying those impressions that I have drawn up a table embodying the results of recent investigations.

A few words in conclusion on the psychological accompaniments of pituitary diseases. It is curious that many of these are the same whether associated with excess or defect of pituitary activity. In fact we can in general only speak of the psychological effects of *dyspituitarism*. It is true that a well-developed anterior lobe is often associated with an imaginative force which can be controlled and brought to the service of an active brain; the fortunate possessor is also often musical and, in short, a practical visionary. It is also true that sufferers from a minor degree of hypopituitarism compensate for it by persistent conscientious effort, often in excess of their physical strength. But both the pituitary giant and the Fröhlich tend to lack inhibitions. They may lie and steal and commit offences in a foolish, pointless way, often apparently merely to attract attention. They try to compensate for their feeling of inferiority by a craving for the limelight, and if they cannot achieve this with their social equals, they seek for it from their social inferiors. They are very prone to fantasy-thinking, seeking a dream world in which to escape from this feeling of inferiority. In two cases recently, one in

a girl of only 17, the craving for a child led to fantasies of pregnancy. Another girl stole a gold wrist-watch from a school-fellow, and on her return home for the holidays told her mother it had been given her as a prize for good conduct! The following interesting case came under my notice not long ago: A girl was arrested for shop-lifting. Her doctor told me he was sure that she had an incarcerated pituitary. As she presented no physical stigmata of pituitary disorder, I told him we could not put forward that defence without X-ray evidence. Much to my surprise the skiagram revealed that the anterior and posterior clinoid processes were almost in apposition, showing that the stalk of the pituitary was tightly constricted.

THE INTRADERMAL TUBERCULIN REACTION.

THE variety of tuberculin most commonly employed in the various diagnostic tests is that originally elaborated by Koch and commonly designated O.T. It consists essentially of a glycerin broth culture of tubercle bacilli, human or bovine, incubated for six weeks and filtered, and it therefore contains a mixture of the products of autolysis of the bacilli, consisting chiefly of endotoxin and the proteins of which the organisms are composed. When originally published, the discovery was hailed as an infallible guide to the diagnosis of tuberculosis, but reliance on the result led the earlier investigators into such a maze of error and contradiction that for a period the test fell into disrepute. Of recent years, however, additional work has been performed in many countries, showing that the tuberculin test has a very definite sphere of usefulness, and more especially in the field of veterinary surgery the test has been shown to be at times of great diagnostic value.

In the investigation of human tuberculosis the test has been applied in a great variety of ways, all of which possess some obvious advantages and disadvantages, and in the practical application of the test some knowledge of the common pitfalls is essential to the correct interpretation of the result. The ideal test should possess certain main attributes. It should be simple to perform and the result should be easy to interpret; it must obviously not be harmful to the patient. In addition, the result should convey some clear indication of disease or of its absence; a test which yields positive reactions in a large proportion of healthy adults is of little assistance in clinical diagnosis. The following are the commoner methods in use at the present time:

(1) *The subcutaneous test of Koch.*—For this test the patient must be kept in bed and the temperature carefully recorded at frequent intervals; this is likely to be inconvenient in a large clinic where many patients may need investigation. A subcutaneous injection of 0·1 mgrm. of O.T. is given in the morning. Should no rise of temperature follow upon this first injection the dose is doubled on the following day. If, however, there occurs a rise of temperature, even if no more than 0·5° F., then the dose is not increased, but the same dose is given again after the temperature has returned to normal. Very frequently it becomes evident that the second reaction is more severe than the first, although the dose has remained the same. This is a phenomenon very specially characteristic of the tuberculin effect, and can be regarded as an infallible sign of tuberculosis.

The writer has little practical experience with this test, and is not in a position to express any opinion as to its reliability. It is definitely cumbersome, and the necessary confinement to bed may prove irksome to a patient who feels comparatively well, and in whom the diagnosis may rest only on suspicion.

(2) *The ophthalmo-reaction of Calmette.*—This consists in the instillation of diluted tuberculin into the conjunctival sac. The resultant reaction, if at all severe, may easily be detrimental to the patient, and consequently the test is not often employed—in this country at least.

(3) *The cutaneous reaction of von Pirquet.*—In this test a drop of O.T. is placed on the skin of the patient. A scratch, about 3 mm. in length, is then made through the fluid, but not sufficiently deeply to draw blood. The drop is wiped off after five minutes; the resultant reaction consists, if positive, of an area of redness and swelling at the end of twenty-four hours.

Most observers have found that the majority of adults yield a positive reaction to this test, so that its diagnostic value is not great. A negative finding, on the other hand, will have a correspondingly greater weight in excluding the diagnosis of tuberculosis.

(4) *The intradermal reaction of Mantoux.*—This is the most recent addition to the series of tuberculin tests, and a discussion of its significance is the main object of the present paper.

The most obvious advantage which the test possesses is its uniformity. In each instance, an exact quantity of tuberculin can be placed with certainty in the deeper layers of the skin, so that the resultant reactions in a whole series of patients will be strictly comparable, and the extent and significance of the reaction in any particular patient can be interpreted with greater accuracy in the light of previous experience.

During the past two years the writer has been engaged upon a clinical investigation of lymphadenoma under the direction of the Rose Lymphadenoma Research Committee.

It has been frequently stated that this disease is really an atypical variety of tuberculosis affecting the lymphatic glandular system, and, although there is little clinical or pathological evidence in support of such a theory, it was considered desirable to subject a series of patients to the tuberculin test, from an unprejudiced point of view, in order to accumulate a further piece of evidence for or against the theory.

The intradermal test was the one finally selected for the purposes of the investigation on account of its simplicity. In addition to cases of lymphadenoma, cases of proved tuberculosis and cases apparently quite free from tuberculous infection were tested simultaneously, in order to control the results obtained in the series under investigation.

As the method was then comparatively recent and little used in this country, a considerable time was spent in working out the conditions under which the most satisfactory results could be achieved. It is unnecessary to detail here the various modifications which were found necessary as the work progressed; the final result and a satisfactory technique are the chief concern of the reader.

In performing the test the following essentials must be kept in mind. In the first place the dose injected must be sufficient to give positive reactions where such reactions should occur, yet it should not be so great as to cause severe reactions in the patients. The tuberculin should be freshly diluted shortly before use. It is stated that diluted tuberculin will give positive reactions if kept for as long as four weeks, and this may be true, but if the solution be kept for any length of time it loses some of its potency and the resultant reaction tends to become weaker. In the tests recorded in this series the tuberculin was never kept for more than forty-eight hours.

Lastly, the site selected for the injection should be carefully considered, not only from the point of view of ease of injection, but also in order that a strongly positive reaction shall not interfere with the function of large joints with consequent avoidable discomfort to the patient.

After considerable preliminary work, and following the experience thus gained, a standard method was evolved which has since been rigidly followed, with, on the whole, satisfactory results. The method is described in detail below:

(*a*) *Preparation of the material.*—A single batch of Koch's old tuberculin was obtained from Messrs. Allen & Hanbury, and this material has been used throughout. On the morning of the test $\frac{1}{10}$ c.c. of this material is diluted with sterile normal saline solution to a concentration of 1 part in 1000 of fluid. Each cubic centimetre of the diluted tuberculin, therefore, contains 1 mgrm. of O.T. At the same time a similar quantity of the control solution, consisting of a sterile glycerin broth, supplied by the same firm, is diluted in exactly the same way and two special tuberculin syringes and intradermal needles are sterilized by boiling.

(*b*) *Injection into the patient.*—After several trials it was found that the forearm is the most suitable site for injection. It is easily accessible, and the skin is fairly thick and easily immobilized. The dose eventually selected and consequently standardized, is $\frac{1}{10}$ c.c. of the 1 in 1000 dilution, equivalent to $\frac{1}{10}$ mgrm. of O.T. This is best injected into the palmar surface of the forearm, midway between the elbow and the wrist. Injection of this material near the elbow-joint should be carefully avoided. Occasionally quite severe reactions are obtained even with this small dose, but in no case has any inconvenience been caused to a patient. The control solution should be injected at least 2 in. on the proximal side of the tuberculin injection. In no case was any reaction obtained with the control solution, and this corresponds with the experience of other observers.

In both cases the injection is made into the deeper part of the skin, raising a small wheal which disappears within half an hour. Care should be taken to avoid leakage of tuberculin into the subcutaneous tissues, as unexpected temperature reactions may develop in tuberculous patients if this should occur. As far as the actual technique of the injection is concerned, it differs in no respect from that of intra-cutaneous injections in general.

(*c*) *The reaction.*—As far as the control is concerned, no example of a positive reaction was found, so that discussion can be confined to the tuberculin reaction alone. These reactions were always examined forty-eight hours after the injection had been given, as it was found that the maximum change occurred at this period.

The typical positive reaction was found to possess two distinct features: In the centre would be found a pale, rounded swelling which might be slightly tender to the touch, and surrounding this there was usually a circular area of erythema. The relative sizes of these two component features of the reaction varied considerably in the different cases. In the case of strong reactions there might also be some local irritation of the

skin, but general reactions were only observed in three cases in which there was a suspicion that there might have been some subcutaneous leakage of tuberculin.

When reading the reaction separate notes were taken of the extent of the areas of swelling and erythema.

It was found that in some cases they were dissociated, either occurring without the other, and the cases in which this phenomenon was noted were further studied. It was then seen that whereas a simple erythema without swelling was associated with cases which were either doubtful or apparently non-tuberculous, swelling without erythema, on the few occasions on which it occurred, was invariably associated with proven tuberculosis. The importance of this point in reading a reaction is obvious. *Attention must be paid only to the area of swelling, and erythema alone should be disregarded.*

The estimation of the degree of reaction is rather arbitrary, but when the area of swelling is less than 1 cm. in diameter, it may be considered "weak positive"; between 1 and 2 cm. in diameter is the usual finding, and may be classed as "positive." Any reaction in excess of this is rarely found, but may be classed as "strongly positive" when in occurs.

During the past two years many cases have been tested in this manner, and the more significant results will be considered briefly in the following categories:

(1) Cases of proven tuberculosis: In this group are included only cases in which tubercle bacilli could be demonstrated, or at least typical giant-cell systems were present in sections. These cases may be further subdivided as follows:

(i) Pulmonary tuberculosis: Of 9 cases tested, 8 yielded a positive and one a negative reaction. The negative case was one of very acute phthisis and the patient died soon after.

(ii) Tuberculous infection of lymphatic glands: Fifteen cases were tested and all gave positive reactions. It was in this group that the strongest reactions were recorded.

(iii) Tuberculosis elsewhere in the body: Of 7 cases tested, 6 gave positive reactions and one a negative.

(iv) Acute miliary tuberculosis: It has been repeatedly observed that, in the acute state, the intradermal test is negative, and this was confirmed in three cases. On the other hand, in 31 cases of chronic tuberculosis a positive result was obtained 29 times.

(2) Cases which were almost certainly tuberculous: In this group are included cases of pleurisy with effusion, cases diagnosed clinically as tuberculous peritonitis and a few cases of bone and joint disease. Of the 48 cases tested, 42 gave a positive and 6 a negative reaction.

(3) Cases in which no evidence of tuberculosis could be found: This group is the most difficult of all, for it is almost impossible to be sure that there is no tuberculous lesion present, even on post-mortem examination. The cases consisted chiefly of apparently healthy individuals and proved cases of malignant disease, bronchiectasis, diseases of the blood-forming organs, and other cases in which the presence of tuberculosis could be reasonably excluded. In this control series of 103 cases, 29 yielded positive and 74 negative reactions, and it should be noted that the cases in this group were mostly adults.

(4) Cases of lymphadenoma: Of the 40 cases tested, 7 gave positive and 33 negative reactions. In 3 of the 7 positive cases there was evidence of the co-existence of a tuberculous lesion, and the conclusion to be drawn from this series is that, if any importance whatsoever is to be attached to the test, lymphadenoma is not caused by the tubercle bacillus.

Conclusions.

From the results quoted above, it can be seen that in a proved chronic tuberculous lesion the intradermal test is usually found to be positive, whereas in non-tuberculous cases the results are frequently, but not invariably, negative. It must, of course, be remembered that a positive result does not indicate that any given lesion is necessarily tuberculous, for there is nothing to prevent tuberculous disease in one part of the body co-existing with some other lesion elsewhere. In other words the tuberculin test must be interpreted in conjunction with all the other clinical evidence available, and a little experience quickly enables one to assess the weight to be attached to the result in any given case. Employed as an auxiliary in suitable cases the test may prove of considerable value; as a mainstay in diagnosis, however, it is apt to prove untrustworthy.

JAMES MAXWELL.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The British Journal of Venereal Diseases—The Broadway Bulletin de l'Hôpital Saint-Michel—Caduceus—The Clinical Journal—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East African Medical Journal—The London Hospital Gazette—Long Island Medical Journal—The Medical Journal of Australia—New Troy—The Nursing Times—The Post-Graduate Medical Journal—Revue de Médecine—The Speculum—St. Mary's Hospital Gazette—The Student.

ELYSIAN FIELDS.

"We dwell too much in corners, and, consumed with the petty cares of a bread-and-butter struggle, forget that outside our routine lie Elysian fields into which we may never have wandered, the tillage of which is not done by our hands, but the fruits of which we of the profession fully and freely enjoy."—*Osler.**

IN the autumn of 1927 there returned to this Hospital, which had nursed the tender dreams of his youth, "a very foolish, fond old man, four-score and upward, not an hour more nor less." Though jealous Nature had shorn him of strength and sight, he found solace in filling his darkness with the vagaries of a busy life which had left their perfume in his memory. And lovingly his thoughts must have wandered along noisy Holborn, turned down the "Turnstiles," and crossing the gardens of Lincoln's Inn Fields, entered "The College," which was his spiritual home. In the dusking twilight of his musings, the statue of John Hunter with the dreamy eyes and the fiery brain loomed large before him—patron saint of the Hunterian Museum.

Alban Doran's life-long association with this Museum began in 1873, when, as anatomical assistant to Sir William Flower, he rapidly built up for himself a reputation as a skilled and delicate dissector. The "Doran Collection of Ear Bones" and his scholarly paper "On the Comparative Anatomy of the Auditory Ossicles of the Mammalia" serve as memorials of this period. For eight years Doran worked with Sir James Paget and Sir James Goodhart, compiling the Pathological Catalogue of the Museum. It was work of this kind that brought out Doran's encyclopædic knowledge, his untiring industry in research, his religious attention to minutiæ, his literary skill, and his memory, which was little short of miraculous. His ambition, however, was to become a surgeon in large gynæcological practice. But he had no surgical hands, and his eccentric personality hampered his success as a consultant.

Retiring from practice in 1909, he returned as a volunteer worker to the Museum, where he embarked upon the most ambitious adventure of his life, on which he lavished all his scholarship and energy—the preparation of a descriptive catalogue of the obstetrical and other instruments. This he completed after thirteen years. Overflowing with accurate and learned comments and bristling with odd information it forms a chapter of medical history.† Doran also brought out catalogues of Lister's and Hunter's instruments.*

An incessant talker and an unsurpassed raconteur, whose fund of anecdotes and out of the way knowledge was inexhaustible, Doran was an amusing man and a delightful and entertaining guide to the historical collections, over which he gloated with joy and affection. He took a kindly interest in young people. In the shadow of his small active figure and his pleasantly flowing stream of conversation, the privileged visitor came to regard the galleries of the Museum as Elysian fields, across which he heard the unbroken and melodious echo of the voice of those who have left him the glorious heritage of medicine. The historical excursions with "dear old Doran" always brought solace and sometimes advanced one a little in wisdom; for he was a true guide, who made it his business to rely on the history of medicine for the interpretation of many problems of practice.

When eyesight and bodily health deserted him, Doran was only able to attend the Museum on two days in the week, in order to keep the catalogue up-to-date, and in the last year of his life he obtained the voluntary assistance of Mr. C. J. S. Thompson, recognized authority on the history of medical and surgical appliances, and one who wears the burden of his learning lightly and genially. After Doran's death Mr. Thompson was appointed honorary curator of the historical section of the Museum. The collections to which he gives his voluntary, devoted, and scholarly services could not be in safer custody.

By order of the Council Mr. Thompson has now published a Guide to the surgical instruments and objects in the Historical Series,† which is sold for the modest sum of half-a-crown. Let us take this guide on a hurried tour of inspection. As the collection now numbers over 2000 items, we cannot linger long over individual specimens, but in so far as these illustrate the evolution of a series to which they belong, they arouse our interest and merit our attention. In this quest the little book in our hand is a true guide, with its leading features printed in large fat type. We are interested to watch the development of the scalpel through its Babylonian, Greek, Egyptian, Roman, Arabian and English representatives; and we are attracted by the history of the cautery and of tracheotomy. We enjoy looking at the fistula knife belonging to our old friend, Percival Pott, and his own description,

* *Boston M. and S. J.*, 1891, cxxv, p. 425.

† *The Catalogue of the Obstetrical Instruments* (1921) has been printed, but is not for sale. The remaining volumes are typewritten and can be consulted in the Museum.

* Printed, but not for sale.

† *Museum, Royal College of Surgeons of England: Guide to the Surgical Instruments and Objects in the Historical Series, with their History and Development.* By C. J. S. Thompson, M.B.E. With a foreword by the Conservator, Sir Arthur Keith, M.D., F.R.C.S., F.R.S. Issued by order of the Council. London: Taylor and Francis, 1929. Pp. 92, illustrated. *2s. 6d.*

which we are given an opportunity to read, stands out in the mind. We are allowed to catch a glimpse of the fascinating evolution of the obstetric forceps. This, of course, was a subject which Doran had made essentially his own.

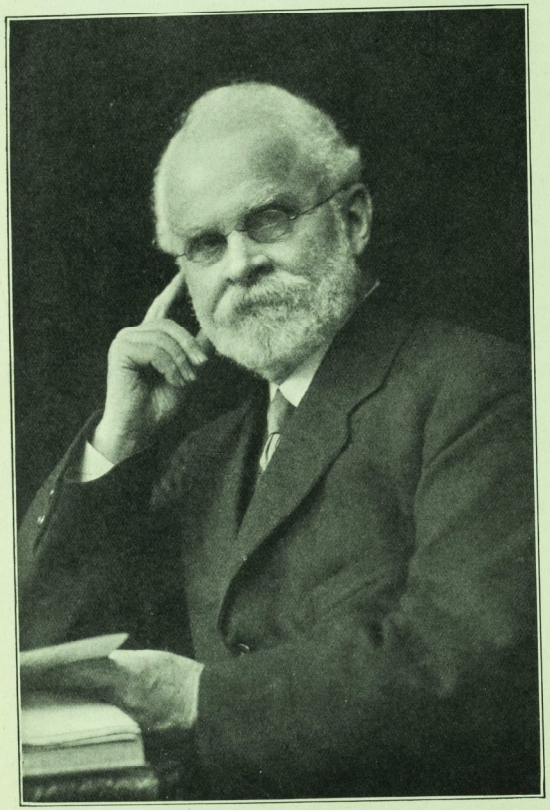


Photo: John Russell & Sons. ALBAN DORAN.

Like the reels of a film, there passes before our eyes the graphic history of the tourniquet, of the trephine, and of the letting of much blood. The cocoanut shell used by barbarous races for receiving blood during venesection changes in this hall of miracles as it were in the twinkling of an eye into a superb pewter bleeding-bowl which is dated 1671, and back again into a striking representation on a Greek vase about 500 B.C. Everywhere in this amazing Valhalla of *memorabilia* we become conscious of the transmutation of the medicine man of the dim past with his few implements and his rich imagination into the Harley Street specialist with his bewildering armamentarium of instruments and drugs. Yet both are the very personification of the spirit of the healing art. How salutary to look down from the height of our experience into the great plain which we have crossed. It is necessary to pause from time to time, if but for a moment, and to survey the long road that stretches into the very origin of time and fades into the mist and into the silence.

The systematic classification and sympathetic grouping of these historical exhibits enables us across the gulf of the years to shake hands with the fathers of medicine who begat us. 'Tis thus we come to regard ourselves but as links in the endless chain of medicine. What an education to glance at the exhibits illustrating the genesis of the clinical thermometer, whose story the guide tells so freshly and so entertainingly! In the seventeenth century Sanctorius constructed the first clinical thermometer, which he used in the diagnosis of disease, correlating variations in body temperature and weight. He got very near to appreciating the meaning of metabolism. John Hunter discovered the significance of the terms "cold-blooded" and "warm-blooded" animals, though he never realized that muscular action is the principal source of animal heat. It did not occur to him to employ the thermometer in disease. The story ends with Sir Clifford Allbutt, who introduced the clinical thermometer as we know it into practice.

The Historical Room proper is still marked "Private"—a grim relic of the days when visitors were indeed intruders, and the Librarian of the College was allowed to occupy a room with a door that locked! But now a visit to the Library is enhanced by the pleasure of meeting Sir D'Arcy Power, who never seems to weary of helping those in trouble, and a visit to the Historical Room by the pleasure of meeting its genial Curator. It is not wise, however, to spend more than half an hour

in this *omnium gatherum*. For mental dyspepsia is the just reward of the indiscreet. Hands of pugilists, shoes once worn by giants, tattooed human skin, chastity girdles, Napoleon's small intestine, phallic charms, the hands of Thomas Beaufort, son of John of Gaunt, shrunken heads—grim trophies which Bland-Sutton brought home from the Amazon! But let us pause before the embalmed body of the first wife of Martin van Butchell, which, arrayed in a garment of fine linen and lace, he piously kept in his sitting-room. In the course of time his affections changed, and there was no room in his house for two wives. This quack-doctor, who was a pupil of John Hunter, was in the habit of riding in Hyde Park on a white pony painted with purple spots.

On our way out just a glance at the exquisite cabinet containing Lister's instruments and manuscripts in Room I and at the Hunterian relics so reverently displayed. This to us seems to be the lesson taught by the history of medicine: That when it really comes to the point the fundamental ethical and humanistic principles of the healing art have changed but little.

The little guide, well printed and illustrated, eloquent of the exploits of the past, appealing to the sympathy of the present, and ever looking ahead into the future, deserves a place in the library of all who take an intelligent pride in their profession. And a few of us who read between the lines "are mightily helped by a dead man's touch."

W. R. BETT.

PSITTACOSIS—OR PSUGGESTION.

(A number of human cases of psittacosis or parrot-fever have lately been reported prominently in the daily Press.)

WHEN Peter's Poll turns up its toeses
In spite of Peter's hourly doses,
The vet., as Poll in death reposes,
Psuspects it's Psittacosis.

Next day, when foolish Peter blows 'is
Proboscis, which a vivid rose is,
He trembles lest a beak-like nose is
A psign of Psittacosis.

Ere long when Peter in the throes is,
A specialist in diagnosis
Hastens to see what he supposes
Is psurely Psittacosis.

So long the tale of Peter's woes is
His plaintive lips he scarcely closes;
With horrid joy our friend composes
Psagas of Psittacosis.

The doctor then his view discloses:
"*That* Psittacosis! Holy Moses!
You've got what every student knows is
Psimply a psittacine Psychosis."

C. H. A.

MORE "CLERIHEWS."

With apologies to Mr. E. Clerihew Bentley, author of 'Biography for Beginners,' and to numerous other distinguished gentlemen who are—

(*a*) *Included.*

(*b*) *Not included* (*as having unrhymable names*).

Sir H— W—
Is said to be given to swearing
In a rather encouraging way
At the Young Men of To-day.

Sir P— H—
Percusses the thorax so smartly,
And murmurs, "Cough-spit, if you please,
Tibi dabo hirudines tres!"

Sir T— H—
Talks rather like this: "Let us order,
Ung. hyd. ammon. co. (5 per cent.),
For this query-luetic event."

Dr. L— B—
Has a figure well known about Town,
And I'm ready a fortune to wage,
That *he* isn't a "Tachyphage."

Professor F. R. F—
Every Wednesday morning is as keen as a razor;
"It's an awful good show,
But what they all talk about, I don't just know!"

Of Dr. H— H—
It is almost impossible to fall foul,
Even when he sticks pins,
Into innocent shins.

Dr. A. E. G—
Is no longer a bachelor now;
He has taken a wife,
Let us wish him good luck and long life!

You *must* know Dr. G—
His enthusiasm for golf would betray'm.
Does he like C_2H_6O?
"The answer is—No."

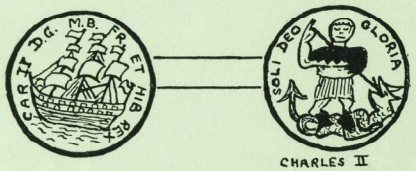
Dr. G— E—
Is seldom at sixes or at sevens
On finding a physical sign,
And, as for his treatment, "It's FINE!"

DISPARU.

THE KING'S EVIL.

THERE began in England in the time of Edward the Confessor, and there ended in Rome at the death of the Cardinal Duke of York, in 1807, the custom of touching for the King's evil.

Among the early descriptions of this custom is that of William Clowes, who was surgeon to Queen Elizabeth and to St. Bartholomew's Hospital. His treatise was called *The Cure of the Malady, called in Latin, Struma, and in English, The Evill, which is Performed by the Kings and Queens of England*, in which he describes a disease which would now be diagnosed as tuberculous infection of lymphatic glands, frequently with sinus formation and superadded pyogenic infection.



CHARLES II
GOLD ANGEL
OBVERSE -
Ship in full sail.

CHARLES II
GOLD ANGEL
REVERSE -
St. Michael slaying
the Dragon.

For the origin of the custom it is necessary to search deep in the mists of antiquity. Cures of King's evil by Pyrrhus and Vespasian are recorded by Pliny and Tacitus, but according to William of Malmesbury no cures were performed in this country until the reign of the Confessor, and it was not until Henry VII that an elaborate ceremonial was introduced for touching. The ceremony, which was started by Henry VII and which was used with minor alterations by the later kings, consisted in lengthy prayers being said for the sufferer, after which the King would touch the sores and hang a gold touch-piece or Angel round the suppliant's neck.

When James I came to the throne in 1603, he, "the wisest fool in Christendom," refused to perform the rite, regarding it as an idle superstition and akin to witchcraft, and it was only when the popularity of the custom was pointed out to him by his English advisers that he consented to touch.

Charles I appears to have performed a large amount of touching; his touch-pieces bear the legend "Amor populi præsidium regis," *i. e.* "The love of his people is the safeguard of the King." Dr. Raymond Crawfurd, in his book on this subject, says, "As the royalist and republican factions rose steadily to a climax, so the ceremony of healing assumed a greater and greater importance as evidence of the King's Divine Right." In later years, when things were going unhappily with Charles, Sir Charles Wiseman, who was an Army surgeon with the royalist forces, tells us that "small pieces of silver were his gift, for alas he could not arrive to other; 'twas not the golden age with him."

With regard to contemporary medical opinion on the matter, it is of interest to note that Sir Thomas Browne showed no incredulity, and went so far as to send patients to Charles II during his exile and wrote enthusiastic letters to his son describing the Royal Healing, and yet he was the author of *Inquiries into Vulgar and Common Errors*, as well as *Religio Medici*.

Touching was continued with increased popularity till the time of William of Orange, who, to the great delight of Jacobites, refused to have anything to do with it. James Francis, known to some as the "Old Pretender," and to others, who have perhaps a better sense of justice, as James III, touched in exile, and of him Andrew Lang writes, "Had not his very looks proclaimed him to be a King, he had proved his claim by touching for the King's evil at Strathmore's house and all the patients recovered."

The gift of healing was never assumed by the House of Hanover. Robert Chambers, in his *History of the Rebellion*, gives an account of how a partisan of the Hanoverian succession brought his son to George I and asked that he might be touched; George told him to "go over to the Pretender," at which the father changed his politics and a satisfactory cure was performed by James III.

The "Young Pretender" touched at Holyrood, but judging from the great rarity of Charles Edward touch-pieces he could not have performed the rite frequently, and it was left to the "Last of the Stuarts," that is, Prince Charles Edward's brother—the Cardinal Duke of York—the man whose pathetic motto ran, "Angliæ Rex, non desideriis hominum, sed voluntate Dei," to make a final practice of the royal gift of healing in Rome.

Similar ceremonies of healing were performed by the Bourbons and Hapsburgs, and, amazing as it may seem, Stuart relics are kept by many to this day in the fond belief that some healing power may still remain in them.

In conclusion three opinions on the matter may be quoted. Clowes: "A mighty number of his Majesty's most loyal subjects and also many strangers are daily cured and healed, which otherwise would most miserably have perished." Fuller, the Church historian, says: "If it be the will of God to visit me with the King's evil, I trust I may have the favour to be touched of His Majesty." From the other point of view, Macaulay, in *History of England*, writes: "Theologians of eminent learning, ability and virtue gave sanction of their authority to this mummery; and what is stranger still, medical men of high note believed, or affected to believe in the balsamic virtue of the royal hand."

Thus King's evil is a disease which had probably a greater political importance than any other, for its cure was one of the main props of the Divine Right of Kings, and from its purely medical aspect will remain a subject of interest and speculation; it will always have its supporters and its defamers, being in many ways comparable to the Lourdes of to-day. Possibly Lord Strangford, in the following verse, comes nearest to the right attitude towards such things:

"Oh blame not their blindness,
'Twas the blindness of love
Made them think that this kindness
It came from above.
And when 'twas thus given
To those who had need,
That something of Heaven
Was Majesty's meed."

R. E. M. FAWCETT.

ABERNETHIAN SOCIETY.

A MEETING of the Society was held in the Morbid Histology Laboratory on Thursday, November 28th, at 5.30 p.m., the President, Mr. Hutchinson, in the Chair. The minutes of the last meeting were read and signed.

Dr. T. H. G. Shore gave a demonstration of Museum Specimens from a different point of view. Museums were first built up as collections of specimens of diseased conditions and of organs, and with such collections the idea of teaching became associated. The lecturer proposed to describe and to show certain milestones in the history of our Museum.

The first record is a minute of the Governors, dated June 23rd, 1726: "Two rooms under the 'Cutting Ward' shall be set apart, one as a mortuary, the other as a Repository for Anatomical and Chirurgical Preparations . . . it is likewise ordered that whatever preparation should be given to the repository shall be numbered, and the name of the person who gave it and the history of it be entered in a book to be kept in the Comping House for that purpose. And that Mr. Freke do keep the key of it who shall be accountable for the loss of any preparation; and when he shall decline it the youngest Assistant Surgeon shall do the same." Unfortunately the loss of the book prevents our knowing the number and the nature of the earliest specimens. In the next year Freke was given charge of eye cases, and so, after being the first Curator, became the first Ophthalmic Surgeon at Bart.'s. At this time surgeons and physicians were private teachers, having their own collections, some of which survive in the present-day museums, such as that of John Hunter at the College of Surgeons; the Hospital's own collection was probably quite small.

In 1831 Stanley published the first printed catalogue of the Museum, and there is thus a silent gap of a hundred years except for a few specimens associated with Percival Pott. Two, a carious spine and spinal cord (C.58, T.232) are said to have been mounted by him; two syphilitic calvaria (A.346, A.347) came from the venereal wards in his time, and into the hernia (M.74) Pott is said to have placed the roll of paper. Another carious spine (C.57) was described by Stanley as coming from a case under Pott's care, in which the benefit of "issues" has been demonstrated.

One specimen (ML.69) was taken by Stanley from a man who was wounded at Waterloo, and in 1825 Peter Mere Latham presented a portion of bowel showing dysenteric ulceration.

Stanley's and Abernethy's collections were used quite widely in the Hospital, and in 1828, upon the latter's retirement, the two collections, said to amount to "several thousands," were formally given to the Museum. It was then decreed by the Governors "that teachers are required not to make any separate collection, but to add all preparations and drawings to the said Museum." Stanley, in his Catalogue (1831), described 1613 specimens and wrote of the earlier collections—"Only those morbid specimens have been preserved which might be expected to retain their original characters in a sufficient degree to render them useful as objects of future reference." There was probably a wholesale clearance. Of Abernethy's connection with the Museum three specimens remain to bear witness—a sequestrum in a tibia (A.111), dextrocardia (TE.93) and an innominate aneurysm (F.116).

Stanley, Lawrence, secretary of the Society before it took Abernethy's name, Skey, Wormald, Dr. Bond, Sir George Burrows and Dr. Patrick Black were all represented by specimens, the last three by some early stethoscopes. The next great figure was that of Sir James Paget, Curator from 1837–1843, and his specimens include one of osteitis deformans (A.409). The specimens of the disease of the nipple and the quiet necrosis known by his name were not presented by him, and his preparation of the *Trichina spiralis*, which he had discovered in the dissecting-room and described in a paper to this Society, was thrown away between 1884 and 1889. In 1846 the first volume of the second catalogue was published by Paget, the second volume appearing in 1851.

Two important specimens of septic endocarditis (E.67, E.68) remind us of W. S. Kirkes' historic paper on "Detachment of Fibrinous Deposits from the Interior of the Heart" (*Med.-Chir. Trans.*, 1852). In 1862 Sir William Savory published a supplementary volume to Paget's catalogue. The Museum had been on the site of the present Anatomy Department, but in 1879 a move was made to the newly erected building, where it still remains. At this time Matthews Duncan presented his unique collection of obstetrical specimens, which he had brought with him from Edinburgh, and which include his series of deformed pelves. In 1882 Sir Frederic Eve's catalogue was published, since which time many specimens have been added by the members of the Staff.

The vote of thanks was proposed by Prof. H. KETTLE, who described the feelings of one who had known other museums, and had in this experienced state first come in contact with and under the spell of the wonderful Museum of which Dr. Shore had given so interesting an account. The vote was seconded by Mr. FAWCETT, and carried unanimously.

The Secretaries beg to add that this lecture was particularly difficult to report owing to the varied nature of the exhibits, and that no account could do justice to Dr. Shore's easy delivery of, and light touch with, the solid matter of his discourse.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

As we take up our pen, the sweet odour of Richmond's historic turf gently bathes our nostrils. The shout of forthcoming cup-ties has gone out. It is rumoured that the cup, tired of the cosmopolitan atmosphere of the Borough, has made a wish to take up its residence within the walls of ancient Smithfield.

We hope the Junior Cup will not desire to change its annual home, for we have come to look upon this trophy as being a permanent fixture in the literary surroundings of our Library. Recent games have been most encouraging, for after the 'Quins had been beaten by so decisive a margin, the Old Haileyburians fell an easy prey, and at Gloucester, although beaten, the Hospital put up a remarkably fine performance. On present form it may be safely said that we stand a very strong chance of winning the Cup.

J. M. J.

1ST XV RESULTS.

January 4th: *v.* Harlequins (home), won, 25—11.
January 11th: *v.* Old Haileyburians (home), won, 20—0.
January 18th: *v.* Gloucester (away), lost, 5—11.
1st XV record up to January 18th: Played 16, won 7, drawn 1, lost 8. Points: For 162, against 143.

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

Result: Bart.'s, 25; Harlequins, 11.

January 4th, at Winchmore Hill.

Owing to the trial game at Twickenham, the Harlequins were without several of their star performers, but even their absence was not sufficient to account for their decisive defeat, for, in the second half, the Hospital showed themselves to be decidedly the better side at all points of the game. In the first half Bart.'s played against the wind and managed, by the extremely capable hooking of Robertson and by the excellent work of the whole pack, to hold their own. The opening stages of the game were rather scrappy, many mistakes being made by both sets of backs. The Hospital had many chances but the passes were dropped; their opponents were little better, and it was not till after twenty minutes' play that movements began to be combined and unspoilt by mistakes. Half-time arrived with the Quins' leading by 8—6.

When Rice-Evans ran through the Hospital side directly after half-time it looked as if the Harlequins would win, even against the wind. But Bart.'s played with magnificent determination. Beilby, standing up closer to Taylor, opened up the game well. Nunn was always the chief schemer for openings, and Powell not only showed great determination in running round Gray on two occasions, but also tackled quite relentlessly. Taylor, to show his adaptability, was also a hero in defence. In the later part of the second half the 'Quins were completely outshone, for the whole of the Bart.'s side had touched the height of their form. We congratulate all on a most spectacular display, won entirely by determination!

Teams.—Bart.'s: T. J. Ryan (*back*); G. F. Petty, J. A. Nunn, C. D. Prowse, J. D. Powell (*three quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

Harlequins: J. T. Hubbard (*back*); C. B. Gray, J. Hutton, J. M. Rice Evans, P. E. Hodge (*three-quarters*); H. C. C. Laird, D. M. Phillips (*halves*); D. P. Willis, A. G. Prescott, E. H. Fouraker, M. L. Jackson, C. R. Hinde-Howell, J. H. Sears, R. H. Corker, T. C. Dunkerley (*forwards*.)

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD HAILEYBURIANS.

Result: Bart.'s, 20; Old Haileyburians, 0.

January 11th, at Winchmore Hill.

R. N. Williams and E. M. Darmady were engaged with their counties, while G. F. Petty, having injured his ankle against the Harlequins, was unable to turn out.

At the start the playing conditions were appalling, and they steadily became worse as the game progressed, for the day, which had started with spring-like sunshine, ended by pouring forth rain and snow upon us. The superiority of the Hospital lay undoubtedly at half-back, where J. T. C. Taylor was again in excellent form, and combined well with F. J. Beilby, his stand-off. These two, considering the atrocious conditions which prevailed, did very well, their handling and running being in marked contrast to the fumbling and hesitancy of the Haileyburian pair, who could do little that was right. J. D. Powell opened the scoring with an unconverted try for Bart.'s, which was followed closely after by two excellent tries by Taylor.

In the second half the Haileyburian defence stiffened considerably and their forwards began to carry some of the scrummages, but the Hospital backs soon began to exploit to the full the advantages given them. W. M. Capper, A. H. Grace and Taylor added further tries, one of which Taylor converted. The game, owing to the unkindness of the elements, was wretched and disappointing, and everyone was glad when "no side" was given.

Team: T. J. Ryan (*back*); A. H. Grace, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis, A. T. Blair (*forwards*).

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

Result: Bart.'s 5; Gloucester, 11.

January 18th, at Gloucester.

Bart.'s made the journey to Gloucester without W. M. Capper, who had to stand down on account of a recently vaccinated arm. Gloucester kicked off in fine weather, and on excellent turf; play was evenly contested, but the Gloucester backs were very shaky to begin with. Bart.'s obtained an early success when C. R. Jenkins, after some clever inter-passing movements between the centres, obtained possession and ran through the home defence, without anyone attempting to tackle him; he converted his own try. Gloucester then began to pull together and combined most effectually; in the pack, the home forwards managed to gain possession more often than the Hospital, and their backs had many fine openings, but nothing came of them. The tackling of the whole Bart.'s side was magnificent; time and again many hopeless positions were saved by real cup-tie-like tackling; the centres were especially noteworthy in this respect.

The second half was played at a terrific pace, both packs putting in a number of loose rushes and some gruelling tackling. Bart.'s played well throughout and were unlucky in having so many penalties awarded against them; the chief reason of the Gloucester success was their greater ability to take their chances and the fine display of kicking by Boughton.

Teams.—Bart.'s: T. J. Ryan (*back*), A. H. Grace, J. A. Nunn, C. D. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, J. M. Jackson, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

Gloucester: H. Boughton (*back*); Roy James, M. A. McCanlis, E. W. Lovegrove, R. Baker (*three-quarters*); F. Price, D. Meadows (*halves*), L. E. Saxby, A. Carpenter, T. Hiam, F. Wadley, C. Foulkes, J. Hemming, F. Russell, E. Comley (*forwards*).

CHIEF ASSISTANTS *v.* RESIDENT STAFF.

Result: Chief Assistants, 3, Resident Staff, 8.

January 8th, at Winchmore Hill.

Although not widely advertised within the Hospital, this fixture, a revival of the past, attracted a number of ardent followers of the game to make the unwholesome pilgrimage to Winchmore Hill. We sympathize sincerely with all those who did not see this great attraction, for it was one of those rare occasions when the mighty come down from their exalted positions and take part in the happenings of the democracy.

The Residents, ably led by C. R. Jenkins, kicked off in perfect conditions and before an enthusiastic gate. The opening play was chiefly in the Resident Staff's half, and remained there till a free kick was awarded against the "Clinicals" for deliberate picking out of the scrum (we mention no names). C. H. Taylor (a relic of the "B" XV), with a beautiful kick and follow up, brought play back to the Clinicals' "25." Lloyd-Williamson brought off a spectacular movement which nearly ended in a try; he was, however, tackled and the ball went loose. The Residents continued to press for about five minutes, and it was not till Briggs (a temporary clinical assistant) secured possession of the ball that play was brought to the half-way line. B. B. Hosford from some unknown source gained possession of the ball and completely outstripped the majority of the Residents' defence; he was finally tackled, and after a bit of very suspicious work on the part of the residents the referee (a well-known north-country professional) awarded a penalty. D. J. Stephens, temporarily forgetting his old age, managed to kick a splendid goal. Such a reverse completely lowered the prestige of the Residents, and the Clinicals (sometimes known as the "Asses") held the superiority for a time. Carmichael brought off a magnificent kick to touch, but at this stage of the game play had to be momentarily suspended while B. B. Hosford was moved to full back on account of nausea; Briggs came up to the forward ranks. On resuming play the Residents, having recovered from the success of the Clinicals, managed to exert themselves. Lloyd-Williamson, after a pass from Taylor, raced down the touch like Pegasus, to score a magnificent try for the Residents between the posts. Jenkins had no difficulty in converting. Half-time was then given.

Score: Resident Staff, 5; Chief Assistants, 3.

On changing over the Clinicals kicked off, but Jenkins, who should have known better, fumbled badly and play settled down in the Residents' half. A series of penalties was awarded against the Residents; these were taken by Stephens, who gained much ground by his fine kicking, but Taylor relieved the pressure with a breakaway. He was eventually tackled by Briggs and the ball went loose. Bennett, however, soon afterwards obtained a pass from a forward and managed to score for the Residents fairly far out; Jenkins was unable to convert. For the remainder of the game play was very keenly contested, with the Clinicals pressing hard. On more than one occasion they were unlucky not to score, but the deadly tackling of Nicholson, Rait-Smith and others kept the Residents' line intact. Some consternation was shown at intervals by certain of the spectators as to the referee's decisions, but on the whole we consider he performed his functions satisfactorily, and we congratulate all on an extremely amusing game.

Teams.—Chief Assistants: G. D. S. Briggs (*back*); J. F. Varley, H. Burt-White, E. A. Carmichael (capt.), A. Clarke (*three-quarters*); C. F. Watts, D. B. Games (*halves*); B. B. Hosford, J. H. Hosford, K. M. Ross (representing J. Paterson Ross), G. H. Bradshaw, T. Meyrick-Thomas, D. J. Stephens, P. J. Richards, R. F. Phillips (*forwards*).

Resident Staff: H. V. Knight (*back*); J. C. F. Lloyd-Williamson, M. L. Kreitmayer, C. H. Taylor, E. C. Darke (*three-quarters*); B. Rait-Smith, W. Buckley (halves); J. H. Attwood, F. Ward, W. A. Nicholson, E. G. Recordon, F. A. Richards, A. Bennett, A. M. Boyd, C. R. Jenkins (capt.) (*forwards*).

Referee: J. T. C. Taylor.

SAILING CLUB.

The Annual General Meeting and Dinner of the United Hospitals Sailing Club were held at the Café Chantecler on November 28th 1929, Dr. T. S. Nelson, of St. George's, being in the chair.

By an almost unanimous vote it was decided that the club head-quarters should remain at Burnham-on-Crouch.

A cup was gratefully accepted from A. W. Bourne, Esq., F.R.C.S., to be competed for by the individual hospitals on the basis of points gained in the various races held by the Club throughout the year. It was further decided to paint the dinghies different distinguishing colours for the coming season, and a sub-committee was appointed to inquire into and prepare schemes for the establishment of some form of club accommodation for members at Burnham. Since the meeting the committee has studied the possibility of renting a shed on the river bank, at present used as a store, which can readily be converted into a club-house with sleeping accommodation for a few members. It is hoped that this scheme may shortly be put into execution.

The following flag officers were elected for the coming season: Commodore, Dr. T. S. Nelson (St. George's); Vice-Commodore, W. H. Ogilvie, Esq. (Guy's); Rear-Commodore, F. S. Cleminson, Esq. (Middlesex).

About 47 members were present at the dinner. All the flag officers of the St. Bartholomew's section of the club were present, but the ordinary Bart.'s members were unfortunately very poorly represented, although a large number had promised to turn up. This must be rectified this year.

P. de G. Benson, Esq., Rear-Commodore of the Royal Corinthian Yacht Club, H. Warwick-Smith, Esq., Rear-Commodore of the Royal Burnham Yacht Club, A. F. Challis, Esq., Vice-Commodore of the Crouch Yacht Club, Richard Davis, Esq., and A. W. Bourne Esq., F.R.C.S., were present as guests of the Club.

Suitable speeches were made by the flag officers and the recipients of the Sherran, Wilson and Ogilvie cups, and after the flag officers had been toasted most effectively by "Gentlemen of the Port and Starboard Watches" respectively (the gentlemen of the starboard watch winning easily), a very happy evening was successfully concluded.

Several of last year's members have now left the Hospital. It is hoped there will be plenty of new members. Anyone interested in sailing, and not necessarily only those who are already accomplished helmsmen, are welcome. The Club is proposing to organize a week on the Norfolk Broads in April, the purpose being to teach anyone interested how to sail a boat. The expenses for a week are £4. This includes railway fare, hire of a cabin cruising boat and food. Anyone who has not experienced the Broads in the spring should not miss this opportunity, as it is a wonderful holiday. Anyone wishing to come should give his name to the secretary, who will then make the necessary arrangements.

J. HOPTON,
Hon. Sec.

REVIEWS.

HOSPITALS AND THE STATE. By R. W. CHALMERS, M.D., Ch.B. (London: John Bale, Sons & Danielsson, 1929.) Pp. ix + 143. Price 6*s.* 8*d.* net.

The burning question of "voluntaryism" or State control is nowhere more acute than in the hospital world, and to all who are interested, and who desire a sound knowledge of the case, this book will prove to be valuable and well worth reading. The writer deals fairly with most of the obvious problems, and compels the reader to face the essential facts at the beginning, by realizing first that "State assistance and State control has become established as an inherent and inevitable part of our social progress, and the growth of the humanitarian spirit."

The historical survey, which occupies a considerable part of the book, is full of interest, and the important part played by leprosy and plague in demonstrating the necessity for public responsibility and public control of disease is made clear as the result of the limit of capacity of private hospitality and philanthropy being exceeded. Once the acceptance of public responsibility for shelter and isolation of the sick was established, the extension of that responsibility to include the *cure* as well as the *care* was inevitable.

The early stages of the Poor Law in the form of "measures for policing the victims of destitution" are made clear. State interference and State control in their incipient form began by dividing the poor into those who could work and those who were in the stage of helplessness through age, infirmity or disease, and by dealing with the latter class first by organized charity, and subsequently by compulsory assessment. The repressions and degradations of the labourer, which reached a climax in the reign of Elizabeth, are shown to have played their part in compelling the State to interfere on behalf of the distressed and the destitute, even while the mediæval hospitals, with their amazing accompaniments of superstition and trickery, were establishing those foundations of voluntaryism and charity upon which the modern voluntary hospital is built. An excellent condensed account of the Great Plague in London in 1665 and its effect upon the problem is given. From the earliest times hospitals have received State support and have been in some degree subordinate to the State, and the early associations between "Bart.'s" and the City of London are mentioned.

In dealing with the development of the Poor Law generally the author has wisely drawn largely from the writings of Mr. and Mrs. Sidney Webb, whose words are quoted, and to whose books the reader desirous of pursuing the subject is referred. Regarding the Commonwealth the writer makes the remark that "The period was significant in all those political ideals and changes which made it the source of those distinctively democratic developments which ultimately were brought to bear in after years upon the problems of the poor, and the question of State intervention.

The book covers an extraordinarily wide field and makes interesting reading all through. Its value, however, would have been greatly enhanced by a good index, which is badly needed.

Everybody associated with hospital work or interested in the problem will do well to read everything in this little book.

RECENT ADVANCES IN CARDIOLOGY. By C. F. TERENCE EAST, M.D., F.R.C.P., and C. W. CURTIS DAIS, M.C., M.B.(Oxon.), M.R.C.P. (London: J. & A. Churchill, 1929.) Pp. 342. 12 plates and 57 text-figures. Price 12*s.* 6*d.*

The authors of this excellent book showed great width of vision when they decided that "cardiology" should mean a study of the circulation as a whole, and that "recent advances" should be interpreted as the progress made during the last twenty-five years.

This breadth of view has resulted in a book which is essentially practical, and, as far as present knowledge allows, serves the clinical and therapeutic needs of the day.

A mass of material has been collected into a well-written, orderly and restrained whole. Controversial points are clearly stated in each chapter, and followed by a guarded but definite opinion as to the most likely truth.

Academic material has not been excluded. Considerable detail is given throughout on electro-cardiographic findings, but these are relegated to their proper place and not allowed to prejudice the general interest.

The authors are well aware that in diagnosis and prognosis, knowledge gained by instrumental aid must be subsidiary to the facts of accurate clinical observation. In other words, the machine must not, as in *Erehwon*, be master of the man, and the dangers of accepting electro-cardiographic manifestations without correlating them with the condition of the patient is well shown in the chapter on evidences of myocardial disease.

It is not possible in the space of this review to discuss in detail the various chapters, but only to mention a few points.

The second chapter on thrombosis of the coronary arteries and myocardial infarction is certainly one of the best in the book. The clinical picture is stated in a particularly clear and lucid way. So, also, with angina pectoris, where no half-hearted diagnoses, such as pseudo-angina, etc., are tolerated.

Cardiac irregularities are classified in an original and attractive form, and stress is laid on the importance of regarding them as symptoms of disease, and not as maladies in themselves.

The use of digitalis and quinidine in the treatment of cardiac disorder receives good handling, and the vexed question of giving morphia in heart failure is discussed and receives the authors' blessing. Unfortunately, the still more debated question of administering alcohol is dismissed in a few lines.

It is to be regretted that the chapter on infective endocarditis, rheumatism and cardiac syphilis is not of greater length. For instance, the question of mitral regurgitation occurring without stenosis in rheumatism is not mentioned.

It is refreshing to read that the arseno-benzole may be given with safety in syphilitic carditis. The danger of so doing has too long been a bugbear to the physician.

But it is the last few chapters that will make the greatest appeal to the clinician. They deal with a variety of subjects, from hyperpiesia to the condition of the heart in pneumonia, and include a chapter on examination of the heart and aorta by X-rays.

The scope of the book might be still further extended, in the next edition, to include a chapter on the influenzal heart.

The diagnosis of the healthy heart brings a good book to a fitting conclusion.

ACUTE INFECTIOUS DISEASES. A Handbook for Practitioners and Students. By J. D. ROLLESTON, M.D., M.R.C.P., F.S.A. Second edition, revised and enlarged. (London: William Heinemann [Medical Books] Ltd., 1929.) Pp. ix + 419. Price 15s. net.

Instruction in the diagnosis and treatment of "fevers" has been enclosed by force of sanitary circumstance within a special three months' course. The student inevitably approaches the subject as one out of relation with the general body of medicine, and the effect of separation is heightened by such characters as self-limitation, known incubation period, definite skin signs, which mark the disease process. The more necessary is it that he should choose to read a book which deals with acute infectious diseases in their widest sense.

Such a book is this of Dr. Rolleston's, the publication of the second edition of which means, we hope, that it has become a permanent member of the household of standard text books. The accounts of the diseases, as is to be expected from so experienced a teacher and writer, are full and clear, and the "reference" lists are valuable for collateral reading. The author is especially to be congratulated upon the historical introductions, which are long enough to contain the main events, and short enough to hold the attention of the unhistorical.

The book is well produced, makes excellent reading, and is to be recommended both to students, as a guide to their clinical observations, and to practitioners, as a reliable source for reference.

A MANUAL OF MIDWIFERY. By HENRY JELLETT, M.D., F.R.C.P.I., and DAVID G. MADILL, M.B., B.Ch. Fourth edition. (London: Baillière, Tindall & Cox, 1929.) Pp. xii + 1281. Illustrated. Price 25s. net.

From the examination point of view the midwifery text-book is often regarded as easy prey—to read up surgery or medicine a week before an examination is a hopeless task, but to cover midwifery is not impossible. The book is not so long as the others, and after all the thing goes with something of a swing about it. The start may be somewhat sluggish as the anatomy and physiology are mastered; the pace may become well-nigh non-existent as the embryology is reached; but having coped with—or skipped—the Müllerian mist of uncertainty, progress is rapidly made.

But Jellett and Madill is no cram-book and is not to be hustled in this way. For ordinary examination purposes therefore it is not to be recommended, but as a work of reference to be consumed leisurely and inwardly digested it is a remarkably sound investment.

The fourth edition is a wonderfully comprehensive work. It contains well over 1000 pages and every conceivable obstetrical subject is dealt with.

The sections new to this edition are those on anæsthesia in labour, pyelitis during pregnancy, nephritis, toxæmia and pre-eclamptic toxæmia. The treatment of these subjects is orthodox, and no special point of interest is raised.

The sections on eclampsia, the treatment of contracted pelvis and the ætiology of ante-partum hæmorrhage have been rewritten.

The book can be thoroughly recommended to those who wish to delve a little more deeply into obstetrics than is necessary for ordinary pass examination purposes.

UNDULANT FEVER. By Capt. W. DALRYMPLE CHAMPNEYS, M.A., D.M.(Oxon.), M.R.C.P.(Lond.). (London: H.M. Stationery Office, 1929). Pp. 78. Price 1s. 6d. net.

The subject of undulant fever is one of growing importance. At one time thought to be confined to the shores of the Mediterranean, it is now seen to be appearing in nearly every part of the world.

The concise account of the disease given in this monograph is, therefore, both timely and welcome.

The author first gives an historical survey, followed by a clinical account of Mediterranean fever. Then follows a description of the disease as seen in other countries. He shows that the causative organism in these cases, the *Br. abortus*, may be conveyed not only by goats, but by a variety of other animals, chief among which are cattle. He considers that the organism of Mediterranean fever and those carried by the others differ only in the slightest degree, or are even perhaps merely different members of one species.

Only fourteen cases of undulant fever contracted in this country have been recorded, and contagious abortion due to the *Br. abortus* is prevalent among cattle. This might lead one to suppose that humans were more or less immune to the British strain of organisms found in infected cattle. But here the author sounds a note of warning, and thinks it possible that the incidence in this country may be much higher than supposed, owing to the difficulties of diagnosis.

A very extensive bibliography concludes this valuable book.

MOTHERCRAFT. By LESLIE GEORGE HOUSDEN, M.B., B.S. (London: Herbert Jenkins, 1929.) Pp. 122 + index. Price 2s. 6d. net.

The results of efficient ante-natal care and rearing a child depend not only on medical advice, but on an enlightened public. This book is an honest attempt to educate the mother and for that reason serves a useful purpose. The book is written in a chatty manner and contains no new thoughts. The author insists on the importance of ante-natal care, but devotes little space to this matter. Very rightly he stresses the importance of breast-feeding, and shows how most failures in this direction are preventable. There is no doubt that this book can be of use to expectant mothers.

MANUAL OF PHARMACOLOGY. By W. E. DIXON, M.D., F.R.S. Seventh edition. (London: Edward Arnold & Co., 1930.) Price 18s. net.

The latest edition of this excellent manual retains the main characteristics of its predecessors in being both interesting and easy to read. For those commencing the study of pharmacology, the opening chapters contain a series of definitions, which clear up many of the initial difficulties of the subject. For others, the method of describing each group of drugs according to the same plan makes reference to it simple and rapid. Not content with clear and concise descriptions, the author has included many tracings of actual experiments to illustrate the salient points, and where possible a series of simple diagrams is used to show the points of action of the various drugs.

The statement in the preface that "the present edition of the manual has been completely revised in conformity with recent knowledge" is borne out by paragraphs on ephedrine, ultra-violet light and radium. A list of the better-known patent medicines, together with their constituents, which is included, is not only of interest, but also of practical value in these days, when many patients try out this type of medicament before consulting their medical adviser.

The edition will enhance still further the book's reputation earned by its predecessors as an essential both to student and to practitioner.

CLINICAL METHODS. A Guide to the Practical Study of Medicine. By ROBERT HUTCHISON, M.D., F.R.C.P., and DONALD HUNTER, M.D., F.R.C.P. Ninth edition, revised throughout. (London: Cassell & Co., Ltd., 1929.) Illustrated. Pp. xii + 684. Price 12s. 6d. net.

Laënnec published a two-volume *Traité de l'Auscultation médiate* to be sold with his invention, the stethoscope. It is a pity that the book is no longer bought together with the instrument, or failing that, that Gee's *Auscultation and Percussion* has not taken its place.

The next best thing, which should be bought after the stethoscope and certainly before the knee-jerk hammer, is this little book. It has been said that everyone ought to read it through once in six months, and with this dictum we are inclined to agree.

For the ninth edition the chapters on the Central Nervous System and on the Examination of Pathological Fluids have been revised, and that on Bacteriological Investigations rewritten at shorter length, so that the book is smaller by a few pages than the previous edition.

Hutchison and Rainy, or, as we must learn to call it, Hutchison and Hunter, is one of the indispensables in the outfit of every medical student.

THE EYE IN GENERAL MEDICINE. By A. MAITLAND RAMSAY, M.D. (London: Baillière, Tindall & Cox, 1929.) Pp. x + 255. Price 12s. 6d. net.

Since the introduction of the ophthalmoscope it has been possible, thanks to the accessibility of the eye and to the transparency and the high magnifying power of its media, to observe pathological processes in the living human body as they had never been observed before. Moreover, the eye is not an organ to be considered apart from the rest of the body. "The eye is not only in the body, but it is also of the body." Many of its diseases are simply a part of a general pathological process and may give the only, or at any rate the earliest clues to the correct diagnosis. The natural corollary is that it is useless to treat these conditions locally without also treating the body as a whole. In urging these two fundamental points the author is helping to bring together the sciences of medicine and ophthalmology, which cannot be considered separately without detriment to both.

The author urges a closer study of ocular symptoms and of such subjective tests as those for the threshold of light and for light difference, which may give indications of disease before there is any visible change in the retina. The appearance of the retina is liable to so much variation within normal limits that many slight changes which are described in this book could be appreciated only by the expert.

The book is written in a stimulating manner, and if it convinces the medical practitioner that he is working in the dark if he does not carry an electric ophthalmoscope as part of his equipment, it will not have been written in vain.

A COURSE IN PRACTICAL BIOCHEMISTRY FOR STUDENTS OF MEDICINE. By A. T. CAMERON and F. D. WHITE. (London: J. & A. Churchill, 1930.) Price 8s. 6d.

This new book on practical biochemistry has one great advantage over the many already in existence, and that is, although consisting only of just over 200 pages of actual text, it adequately covers the course required for the 2nd M.B., leaving out all superfluous detail.

The arrangement is on familiar lines, but the matter is absolutely up to date. A commendable attempt has been made to group together the quantitative estimations under particular headings, useful alike to both student and teacher. The book is exceedingly well printed, and has four plates and twenty-three text-figures.

An innovation, which to the reviewer seems rather unnecessary, is the inclusion of an appendix giving first-aid procedures for laboratory accidents.

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

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RAWLING, L. DAINE, B.A., M.B., B.Ch., F.R.C.S. *Landmarks and Surface Markings of the Human Body*. 7th edition. London: H. K. Lewis & Co., 1929.

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ROTH, E. J. H., M.R.C.S., L.R.C.P., D.M.R.E.(Camb.). "The Mecapion: An Ionization Apparatus for the Absolute Measurement of X-Ray Dose." *British Institute of Radiology Exhibition*, December, 1929.

RUSSELL, H. G. BEDFORD, M.A., B.Ch., F.R.C.S. *See* HARMER AND RUSSELL, January No.

SELWYN-CLARKE, P. S., M.C., M.D., M.R.C.P., D.P.H., D.T.M.&H. *Report on the Yellow Fever Conference at Dakar*, 1928. Gold Coast Government Printing Office, 1929.

SLOT, GERALD M., M.D., M.R.C.P., D.P.H. "Some Aspects of Rheumatism in Childhood." *Clinical Journal*, September 25th, 1929.

TAIT, C. B. V., M.R.C.S. (Sir PHILIP MANSON-BAHR, D.S.O., M.D., F.R.C.P., and C. B. V. T.). "On the Symptomatology of Intestinal Amœbiasis Based on a Study of 150 Cases." *Lancet*, November 16th, 1929.

THURSFIELD, HUGH D. M., F.R.C.P. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

TWEEDIE, A. R., F.R.C.S. "Apparatus for Control of Conversation Test." *Proceedings of the Royal Society of Medicine*, October, 1929.

WALKER, KENNETH, F.R.C.S. "The Interpretation of Tests of Sterility and Fertility in the Male." *Lancet*, November 9th, 1929.

WARING, Sir HOLBURT, M.S., F.R.C.S. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

WEBER, F. PARKES, M.D., F.R.C.P. Discussion on the Indication for and the Results of Splenectomy. *Proceedings of the Royal Society of Medicine*, September, 1929.

YATES, A. LOWNDES, M.D., F.R.C.S.(Edin.). "The Evolution of the Sense of Hearing." *Proceedings of the Royal Society of Medicine*, September, 1929.

CORRESPONDENCE.

BRUCELLA ABORTUS IN NEW ZEALAND.

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

DEAR SIR,—I read with great interest Drs. Bloxsome and Davey's article on a "Case of *Brucella abortus* Infection in Man" in the JOURNAL of September, 1929, as it arrived by the same post as a report from the Auckland Hospital to the effect that the blood of a patient of mine agglutinated *Br. abortus*.

This patient was a boy of 12, who had a practically continuous pyrexia for about 9 weeks. Symptoms were few apart from headache and langour. The only physical signs were a furred tongue, some distension of the abdomen and tenderness over the cæcum. The highest titre to *Br. abortus* was 1–2560. In this case there was a definite history of contact with cows suffering from contagious abortion and drinking their milk unboiled.

The only treatment, apart from symptomatic, given was salol and dimol by mouth, and the boy is now convalescent.

Three cases in this country have been reported in the *New Zealand Medical Journal* of August, 1929, by Drs. Gilmour and Ludbrook, and my case is, as far as I know, the fourth.

Yours faithfully,
L. J. FORMAN BULL.

Pukekohe, N.Z.;
December, 1929.

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

DEAR SIR,—I suggest that the solid black lettering in which the Resident Staff names are inscribed adds a funereal touch to an already well-shaded corner.

Why not red for the surgeons—blood; blue for the physicians—cyanosis; and green for the anæsthetists—?

I am,
Yours,
AN ADMIRER.

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

SIR,—May I recommend Arnold Bennett's *Lord Raingo* to Bart.'s men for a comprehensive and vivid clinical picture of lobar pneumonia with its complications?

Would we could have all our medical fare dished up so attractively!

I am, Sir,
Yours very truly,
M. MUNDY.

Kensal Green, N.W. 10;
December, 1929.

EXAMINATIONS, ETC.

University of Oxford.

Final Examination for the B.M., B.Ch., December, 1929.

Materia Medica.—Brunyate, W. D. T., Nunn, J. A., Scott, R. B.
Pathology.—Jenkins, J. F.
Forensic Medicine and Public Health.—Brunyate, W. D. T., Duncan, C. M., Hawking, F., McMenemey, W. H., Newton, R. D.
Medicine, Surgery and Midwifery.—Duncan, C. M.

University of Cambridge.

Second Examination for Medical and Surgical Degrees, December, 1929.

Part II. Human Anatomy and Physiology.—Bray, J. S. B., Saigol, A. T., Saunders, S. B. H.

Third Examination for Medical and Surgical Degrees, December, 1929.

Part I. Surgery, Midwifery and Gynæcology.—Barnsley, R. E., Fordham, M. S. M., Franklin, A. W., Hancock, P. E. T., Harris, A. G. J., Hobday, F. T. J., Knight, H. V., Nicholson, B. C., Orr, R. G., Prowse, C. B.

Part II. Principles and Practice of Physic, Pathology and Pharmacology.—Fox, P. H., Gurney, A. H., Helme, A. C. de B., Hensman, J. S., Hutchinson, H. P., Neill, E. J., Wood-Smith, F. G., Wright, B.

University of London.

M.D. Examination, December, 1929.

Branch I. Medicine.—Eyton-Jones, F. M. M., Hosford, B. B.
Branch V. State Medicine.—Brocklehurst, G. L.

First Examination for Medical Degrees, December, 1929.

Pass.—Conway-Hughes, J. H. L., David, J. E. A., Evans, D. M., Kennedy, A. R., Lavy, R. E., MacCarthy, D. de la C., Norman, G. H. G., Tregaskis, T. G., Yates, F. H.

CHANGES OF ADDRESS.

BRAIMBRIDGE, C. V., c/o Glyn, Mills & Co., Holt's Branch, 3, Whitehall Place, S.W. 1.
BRANSON, W. P. S., 16, Brunner Close, N.W. 11.
CROOK, E. A., 99, Harley Street, W. 1. (Tel. Welbeck 6450.)
FLEMING, Lt.-Col. J. K. S., I.M.S. (retired), 14, Tite Street, Chelsea, S.W.
GURNEY-DIXON, S., 7, The Close, Winchester.
HADFIELD, G., Pathological Department, Royal Free Hospital, Gray's Inn Road, W.C. 1.
JONES, W. BLACK, "Penderi," Creigiau, Cardiff.
KEYNES, G. L., 11, Arkwright Road, Hampstead, N.W. 3. (Tel. Hampstead 3923.)
MCDONAGH, J. E. R., 42, Wimpole Street, W. 1. (Tel. Welbeck 0847.)

APPOINTMENTS.

CHAMBERLAIN, A. G., M.R.C.S., L.R.C.P., appointed Medical Officer to the Bridport Hospital.
EDDISON, F. R., M.R.C.S., L.R.C.P., appointed Coroner for the Northern District of the North Riding of Yorkshire.
STEWART, G. G., M.R.C.S., L.R.C.P., D.P.H., appointed Assistant Medical Officer of Health and Assistant School Medical Officer, Hendon Urban District Council, Public Health Department, The Burroughs, Hendon.

BIRTHS.

TELFER.—On January 14th, 1930, to Dr. and Mrs. A. C. D. Telfer, of 18, Howard Road, Walthamstow, London, E. 17—a daughter.
WILLCOCKS.—On Christmas Day, 1929, at Springfield, Chelmsford, to Hope, wife of Dr. R. W. Willcocks—a daughter.

MARRIAGES.

BRIDGES—BROOKE-SHORT.—On December 28th, 1929, at South Kensington, E. Chittenden Bridges, M.D., of 36, Ashburn Place, S.W., to Mrs. M. Brooke-Short, of 7, Egerton Court, S.W.
WILLOUGHBY—MCEWEN.—On January 15th, 1930, at All Souls', Langham Place, W. 1, Hugh Mason Willoughby, Surgeon Lieutenant, R.N.V.R., only son of Dr. and Mrs. W. M. Willoughby, of Woking, to Kathleen, younger daughter of the late John McEwen and of Mrs. E. H. McEwen, of Hong-Kong.
WOOD—BOSTON.—On December 28th, 1929, at Birkdale, by the Rev. Harry Bisseker, M.A., Wilfrid Burton Wood, M.D., son of Peter F. Wood, of Chislehurst, to Lucy Heald Sutcliffe Boston, daughter of Mrs. John Boston, of Birkdale, Southport.

DEATHS.

FRANCIS.—On December 21st, 1929, at Colombo, Ceylon, Thomas Evans Francis, O.B.E., M.D., of Woodleigh, Huddersfield Road, Barnsley, aged 47.
PALGRAVE SIMPSON.—On January 4th, 1930, at Chilland, near Winchester, Hants, Reginald Palgrave Simpson, M.D. (late of Weymouth, Dorset), aged 85.

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, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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.1. Telephone: National 4444.*

St. Bartholomew's Hospital Journal.

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

VOL. XXXVII.—No. 6.] MARCH 1ST, 1930. PRICE NINEPENCE.

CALENDAR.

Sat., March 1.—Rugby Match *v.* Rosslyn Park. Home.
Association Match *v.* Old Brentwoods. Away.
Hockey Match *v.* Welwyn Garden City. Away.
Mon., ,, 3.—Special Subject: Clinical Lecture by Mr. Russell.
Tues., ,, 4.—Sir Percival Hartley and Sir Holburt Waring on duty.
Wed., ,, 5.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.
Fri., ,, 7.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Sat., ,, 8.—Rugby Match *v.* Old Paulines. Away.
Association Match *v.* Old Bradfieldians. Home.
Hockey Match *v.* St. Lawrence College. Away.
Mon., ,, 10.—Special Subject: Clinical Lecture by Mr. Elmslie.
Tues., ,, 11.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Wed., ,, 12.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.
Fri., ,, 14.—Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty.
Students' Union: Annual General Meeting in Abernethian Room, 1 p.m.
Sat., ,, 15.—Rugby Match *v.* London Scottish. Home.
Hockey Match *v.* Old Felstedians. Home.
Mon., ,, 17.—Special Subject: Clinical Lecture by Mr. Just.
Tues., ,, 18.—Prof. Fraser and Prof. Gask on duty.
Fri., ,, 21.—Sir Percival Hartley and Sir Holburt Waring on duty.
Sat., ,, 22.—Rugby Match *v.* Bedford. Away.
Association Match *v.* Old Cholmelians. Home.
Hockey Match *v.* Wimbledon II. Home.
Tues., ,, 25.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Fri., ,, 28.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Sat., ,, 29.—Rugby Match *v.* Plymouth Albion. Away.
Hockey Match *v.* Hampstead II. Home.
Mon., ,, 31.—Rugby Match *v.* Redruth. Away.

EDITORIAL.

POLITICS AND MEDICINE.

THE epidemic constitution of 1930 begins to reveal itself by a slow encroachment upon our numbers. The obituary columns swell; and in the chorus of the Surgery, cough, influenza and the acute exanthemata form the dominating themes. Yet even now both man and Nature show forth the promise of delights to come. The first hyacinth has poked up its rash head by King Henry's Gate—and the Abernethian Room is to be cleaned and painted.

The note of Spring is sounded, too, by yet new voices singing yet new chants of invocation to Prosperity. Medicine and Politics have little in common. A glance through past Editorials shows how seldom the political hurricane has ruffled the tranquil seas of medicine. Some men there are who have tried to drive the double yoke; but for St. Bartholomew's the tragic fate of its first appointed Physician, whose political adventure ended at the gallows, stands as a dreadful warning.

The politician, used to promising in such abandoned terms the happy issue of his treatment, would destroy the zest of his art if he learned the physician's caution in prognosis. But the lesson of caution in treatment he might learn. It is said of Sydenham that, when he was in doubt, he consulted his own reputation and the patient's safety by doing nothing. When, on the other hand, he was in no doubt, he pursued his treatment with all his energies. It may be that a political Sydenham is at hand, who, free from dogma as from doubt, will have the opportunity of trying his skill upon the body politic.

* * *

GOLDEN LANE.

The move of the Special Treatment Centre from Golden Lane to Smithfield is celebrated in prose and verse

elsewhere. The Female side of the Department has been organized by Dr. Wilfred Shaw, and is to be accommodated in the Gynæcological Department. The hours of attendance will be—

For men: Monday, from 5 to 7 p.m.
Thursday, from 12 to 2 p.m.

For women: Tuesday, from 4 to 6 p.m.
Friday, from 12 to 2 p.m.

* * *

THE "DUNN LAB."

Another change, attended like so many important revolutions by no ceremony, was the evacuation last month of the old Sir William Dunn Laboratories. The Pathological Departments of the Medical and Surgical Units are now housed upon the fifth floor of the New Surgical Block. The steady light of knowledge diffused from the fifth floor by day makes a strange contrast with the fitful beam which continues to revolve upon the roof by night.

* * *

Those who heard Prof. Fraser's B.M.A. address will be pleased, and those who did not, relieved, at the news that it is to be published in these columns in April and May.

* * *

Congratulations to Dr. F. G. Chandler upon his election as Assistant Physician. We hope that his reappearance in the Hospital will make him once more a contributor to the JOURNAL, of which in 1912 he was the Editor.

* * *

We are asked to announce that medical out-patients will in future be taken by Dr. Geoffrey Evans on Wednesdays, and by Dr. Chandler on Saturdays.

* * *

Congratulations to the Rugger team upon their victory in the second round of the Cup-ties.

Stop Press: And upon reaching the Final. The best of luck for the 19th.

* * *

MRS. F. COHEN.

We regret to announce the death of Mrs. F. Cohen, which occurred under tragic circumstances in the Great Hall during the evening of Thursday, February 6th. She had made of kindness to the Hospital a hobby, to which she devoted herself with real enthusiasm, and she had recently been elected a Governor. Her many gifts to individual wards were inspired by a personal interest, which made them the more appreciated. Her loss will be felt by a wide circle of patients, sisters, and staff, to whom she was so generous and so loyal a friend.

OBITUARIES.

DR. JAMIESON B. HURRY.

PUBLIC benefactors are not very numerous in this country, and they are especially rare in the medical profession. Dr. Hurry was a distinguished member of the band and should be honoured accordingly. Reading owed much to him, for he enriched the Town Hall with panels relating to the past history of the town; and at Cambridge he founded the Michael Foster Research Studentship. He was, too, a promoter of public libraries, museums and open spaces for the people, so that he might well have assumed the motto of Thomas Sutton, who founded the Charterhouse—"Deo dante, dedi."

Jamieson Boyd Hurry, son of the Rev. Nicholas Hurry, of Liverpool, was born on June 8th, 1857, and was educated at Neuchâtel and the City of London School. He matriculated from St. John's College, Cambridge; graduated B.A. with honours in the Natural Science Tripos in 1879; took the M.B. and was admitted M.R.C.S. in 1882, the D.P.H. and M.A. in 1884, the M.D. in 1885 and the B.Ch. in 1890. His medical education was carried out at St. Bartholomew's Hospital, where he acted as Midwifery Assistant under the inspiring influence of Dr. Matthews Duncan. He then went as a ship's surgeon for a year and afterwards settled at Reading in partnership with Mr. George May. Here he spent his working life from 1885 until 1926, and married Gertrude Louisa, daughter of Arthur Hill, J.P., of Erleigh Court, Reading, a niece of Miss Octavia Hill. At Reading he was Surgeon to the Dispensary and Medical Officer to University College. Elected a member of the Reading Pathological Society in 1885, he served as President from 1907–10 and acted as Honorary Consulting Librarian from 1915. He was a member of the Council of the Reading University and a Justice of the Peace for the Borough.

Hurry soon became well known as a writer in connection with disease, as an historian of his adopted town, and finally as an Egyptologist after becoming a member of the Egytian Exploration Society. He published in 1911 *Vicious Circles in Disease*, an interesting work showing the interrelation of disease, and how the weakening of vital resistance at one point may open the way to general disease. The book had an extensive circulation in English-speaking countries and soon reached a third edition. It was translated into French, Spanish and Italian and was followed by *Vicious Circles in Neurasthenia* and *Vicious Circles in Sociology* in 1915. Two years later he published *Poverty and Vicious Circles*, which was translated into Chinese, Japanese, French and Italian.

The historical contributions deal chiefly with Reading Abbey, of which he wrote a history, an octocentenary volume and some episodes. The work by which he will best be remembered is *Imhôtep*. This priest, Physician-Vizier to King Zoser, architect of the Great Pyramid, became a demigod, a god, and was finally confused with Æsculapius, the Greek God of Medicine. The theme is well worked out and plausible; the book was well written, and in the second edition profusely illustrated.

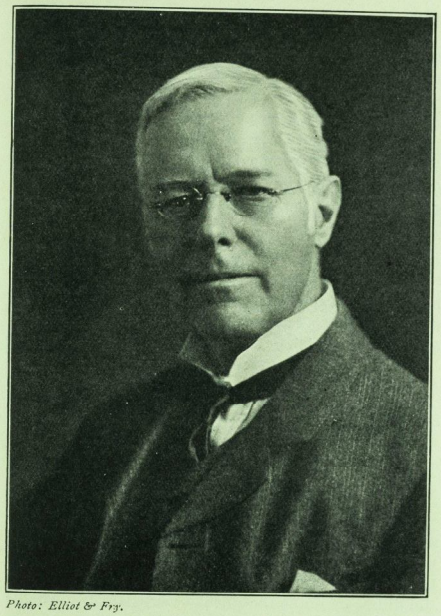

Photo: Elliot & Fry.

DR. JAMIESON B. HURRY.

Writing, however, by no means exhausted Hurry's energies. He was interested in economic botany, and established an educational garden in which he assembled many of the plants serving useful purposes as food, fibres, medicine or dyes. To this garden he attached a Museum showing the finished products derived from the plants in the garden. In 1926 he retired from Reading and presented his collection to the Corporation of Bournemouth, who have housed it in the King's Park, Boscombe.

Dr. Hurry died somewhat suddenly after a period of failing health at Heathland, Grove Road, Bournemouth, on February 13th, 1930, working to the last upon the subject of woad, which he was treating of exhaustively.

Mrs. Hurry survives him with a son and a daughter.

D'A. P.

§

PROF. DUNCAN SCOTT.

Prof. James Matthews Duncan Scott, M.D.Edin., Ph.D., D.P.H.Camb., Professor of Physiology, the University of Saskatchewan, died at Saskatoon on January 29th last.

Prof. Duncan Scott's career as a physiologist was a relatively short one. After taking an Arts Degree at St. Andrews, and qualifying in Medicine with Honours at Edinburgh, he joined the Forces during the Great War and served in Egypt. At the conclusion of the War he was for some years an invalid owing to a troublesome frontal sinus infection, which necessitated surgical intervention, and from which his death from pneumococcal meningitis may be directly traced.

After practising for a time in South Africa he felt called to undertake scientific work, which had always had a strong attraction for him, and in 1921 he proceeded to Cambridge, where he won a John Lucas Weekes studentship for research in pathology. While here he was attached to King's College and took the degree of Ph.D. in 1925. His work at Cambridge was largely concerned with the regeneration of the red blood-cells in anæmia, and with other researches on the blood. Taking interest in physiology, and particularly in the teaching of it, he obtained a post first as Junior Demonstrator and afterwards as a senior lecturer in Physiology at the then newly created physiological laboratories of St. Bartholomew's Medical College. Here he continued investigations which had been commenced at Cambridge in collaboration with Dr. Ffrangcon Roberts on the situation and connections of vagal and vasomotor centres in the medulla. This work he prosecuted with great assiduity and considerable skill as a research scholar of the British Medical Association. As an outcome of his teaching he also became interested in the physical chemistry of colloids and held highly original though not generally accepted views on that subject.

In the summer of 1926 he proceeded to the University of Saskatchewan to occupy the newly created

post of Professor of Physiology. This was an opportunity for the display of those fine qualities of orderliness and strict classification which had always characterized Duncan Scott. Before cutting himself away from his connections in England and proceeding to establish a physiological laboratory under such conditions of isolation he prepared and accurately classified down to the smallest detail a list of every article which would be required in such a laboratory. He regarded his work there as a field of high endeavour, and was on the whole well gratified with the results which came out of it, so far as the organization of the department was concerned. The duties of teaching, however, distracted him greatly from his research work, though he never entirely lost touch with this, and at the annual Physiological Congress at Boston he expressed the opinion that the bulk of the organization had now been definitely started, and he would be free to continue his research work. Dr. Scott leaves behind him a widow and three boys.

C. L. E.

MORE MEDICAL NOTES.

By SIR THOMAS HORDER, Bt.

ON SOME DISEASES OF THE HEART.

(1) The heart of some pubescent boys is not infrequently judged to be diseased because the impulse is a little heaving and the first sound at the apex is not quite clear. The failure to recognize these features as physiological sometimes leads to the boy being taken away from school or, almost equally unfortunate, places a veto upon his games.

(2) There is a form of chronic dilatation of the heart in which, though the apex-beat may be widely displaced, and the area of cardiac dullness may be considerably enlarged, the rhythm is perfect, there are no bruits present and no signs of "decompensation." Even the response to effort may show very little departure from the normal.

(3) During chronic dilatation of the heart the patient's symptoms may be contributed almost entirely by certain viscera upon which the brunt of the congestion comes at the moment. If this fact be not realized errors in diagnosis may be made very easily. (i) The lungs: hæmoptysis may be mistaken for pulmonary tuberculosis or for neoplasm. (ii) The liver: pain, tenderness and rapid swelling of the organ may lead to exploration for abscess. (iii) The kidneys: the resulting signs of renal insufficiency may be mistaken for nephritis. (iv) The brain: excitement and delirium may fail of the correct interpretation.

(4) In the absence of breathlessness with effort myocardial insufficiency can be excluded with considerable confidence. But if breathlessness be present, and especially if some unaccustomed exercise be imposed upon the patient in order to test his reaction to this, myocardial insufficiency must not be at once assumed. The three most common fallacies are obesity, emphysema and a sedentary life. This caution applies to the other features in the "effort syndrome" as much as to breathlessness.

(5) Acute ventricular failure does not lead to orthopnœa. In this condition it is the facies of the patient, rather than his posture, which helps in the appreciation of the state of affairs.

(6) The serious prognostic significance of Cheyne-Stokes breathing in diseases of the heart only appertains when the patient is awake. If this sign is present during sleep it is not necessarily *malum signum*.

(7) Despite the absence of evidence, both during life and after death, it is still commonly said that death in uncomplicated pneumonia is generally due to heart failure. In the majority of such cases death is due to the direct action of the pneumococcus toxin upon the bulbar centres.

(8) Alternate constriction and dilatation of the capillaries of the face (pallor and flushing) is sometimes seen in progressive heart failure in association with cardio-arterial sclerosis. It is a bad sign.

(9) The absence of physical signs, whether of cardiac or of aortic disease, in a patient who complains of anginal pain is often regarded as a good point. The converse is probably nearer to the truth—that if a patient describes attacks which leave no doubt in the physician's mind as to their anginal character, and examination is entirely negative, the outlook is bad.

(10) Sudden and very severe pain, resulting from causes extrinsic to the heart, if associated with heart shock, may simulate angina pectoris very closely. Such causes are (i) above the diaphragm: the onset of pericarditis or of diaphragmatic pleurisy; (ii) below the diaphragm: ruptured peptic ulcer, acute cholecystitis and acute hæmorrhagic pancreatitis.

AMŒBIC ABSCESS OF THE LIVER.

In the East infection with the *Entamœba histolytica* is common: in Great Britain, although the number of cases increased about the end of the Great War, it is a comparatively uncommon condition, and in most cases occurs in patients who have lived and contracted the disease in the East. A certain proportion only of these cases develop hepatic abscess

During the last nine years (1921–1929) there have been at this Hospital 16 cases of amœbic dysentery—representing approximately 0·02% of the total admissions, and of these 5 had abscesses in the liver.

The following case (Case 1) was considered worthy of record on account of some atypical points and on account of the comparative infrequency of the condition in this country.

CASE 1.—F. O—, æt. 37, commercial traveller, was admitted to Pitcairn Ward on November 2nd, 1929, complaining of abdominal pain and diarrhœa.

The *history* was that for the last six months he had had intermittent attacks of abdominal pain, chiefly in the upper left quadrant. He thought that the pain was brought on by food, following it by one or two hours; he had taken gin and peppermint without relief.

For the last five months he had noticed that his stools were loose and rather more frequent, and for the last two months blood, sometimes bright, sometimes dark, had been passed, usually with a stool, but occasionally alone. He had vomited at times, when the pain was severe; neither vomit, food nor defæcation relieved the pain. There was no history of hæmatemesis, jaundice, clay stools or dark urine.

He stated that on November 1st, after taking a glass of milk, he was seized with sudden abdominal pain, which doubled him up. It was situated in the right hypochondrium, and made worse by moving. There was no pain in the back or cyanosis.

There was no vomiting. Two loose motions without blood were passed.

The pain became gradually worse, so on November 2nd he came up to this Hospital and was admitted.

On examination he was seen to be well nourished, slightly cyanotic and obviously in considerable pain. The tongue was coated with a white, moist fur. The chest and upper limit of the area of liver-dullness were normal. The abdomen was not distended, but moved poorly; there was definite rigidity (but not to the extent of board-like rigidity) in the right hypochondrium extending down to the level of the umbilicus. The percussion note over this area was markedly diminished, but no shifting dullness was elicited.

On digital examination of the rectum no abnormality was felt, but the proctoscope revealed a velvety mucous membrane, which tended to bleed.

The blood-count was: Red blood-cells 4,360,000, white blood-cells 18,000. Temperature 99·2° F.; pulse 96; respirations 20 (at 5 p.m.).

After considerable encouragement he vouchsafed the information that in France during the Great War he had been in a casualty clearing station for one month with diarrhœa, and had been told that he had had dysentery. He had never been elsewhere abroad. Since then his stools had always been rather loose. He had never had emetine treatment.

His temperature, pulse and respiration rates rose hourly (10 p.m. T. 101·2° F., P. 112, R. 28), and the general condition was deteriorating. A provisional diagnosis of perforated dysenteric ulcer of the colon (hepatic flexure) was made, and immediate operation decided on.

Exploratory laparotomy was performed by Mr. R. T. Payne. The mesocolon appeared "milky" in colour, but no abnormality was found elsewhere except the liver, which was enlarged to within 1 in. of the umbilicus; the surface was smooth and normal in colour, except on the antero-lateral aspect, where there appeared to be some redness, a slight bulge and lymph together with a small quantity of turbid fluid indicative of localized peritonitis. On aspiration into this area about 1 in. from the surface thick white pus was obtained. The area was packed off from the rest of the peritoneal cavity, and a pair of artery forceps inserted along the track of the needle. A large drainage-tube was inserted into the cavity, the distal end being brought out through a stab wound in the anterior abdominal wall directly over the area; a gauze roll was inserted to pack off the tube, and the other end, together with a smaller drainage-tube, which passed down to the antero-lateral surface of the liver, was brought out through the original wound.

The cavity drained dry fairly rapidly, and the general condition of the patient improved almost at once.

The pus was found to be sterile but free from amœbæ; active amœbæ, however, resembling the *Amœba histolytica* were isolated on several occasions from the stools.

Two courses of emetine (intramuscular) were given, 15 gr. in all.

Sigmoidoscopy on December 6th showed two small healing ulcers, which tended to bleed.

He was discharged on December 18th, "well, wounds healed, three stools negative for amœbæ."

Of the other four cases of amœbic abscess of the liver the facts are shortly as follows:

CASE 2.—Male, æt. 30, had been in the Army in India, where he had had amœbic dysentery in 1910 and emetine treatment. Further attacks occurred every six months, following one of which, in January, 1921, he developed an amœbic abscess of the liver. Under treatment with emetine the liver decreased in size and the symptoms abated.

CASE 3.—Male, æt. 37, was in the Army in Mesopotamia and India. There was no history of intestinal infection, but in 1919 an amœbic abscess of the liver was aspirated, and a course of emetine given. He was well then till February, 1926, when he began to feel ill, sweat, and suffer from pain in the right side. He was found to have a much enlarged liver containing presumably an abscess or abscesses, and this rapidly decreased in size and the general condition improved under emetine treatment.

CASE 4.—Male, æt. 32, while in the Army in Mesopotamia in 1920 had an attack of amœbic dysentery, which was treated by emetine. In India in 1922 he developed a liver abscess, which burst into the lung, and the material was coughed up; further emetine given. After return to England had three or four attacks of diarrhœa a year. In May, 1927, a similar attack was followed by severe pain in the right hypochondrium, after which he coughed up "yellow stuff" and the pain was relieved. No amœbæ or cysts were found in the material; a radiogram showed a probable abscess at the right base. He was transferred to Millbank Hospital.

CASE 5.—Male, æt. 30, while serving in the Royal Navy in China in 1927 developed amœbic dysentery and received emetine. February, 1928, in hospital had pain in right side of chest and coughed up dark yellow material. He was discharged from the Navy still with a cough and some hæmoptysis. He was admitted to this hospital in

October, 1928. There were signs of a large abscess at the base of the right lung and ? of an enlarged liver. No trace of amœbæ seen in the sputum. The condition improved under emetine treatment.

It is of interest to note that of the 16 cases of amœbic infection (*a*) 15 were males—the average age being 33; (*b*) 14 had been to the East.

Of the exceptions the female case was that of a woman, æt. 37, who had had frequent attacks of diarrhœa from 1910 till 1925, when she was admitted. Amœbæ were found in her stools, and treatment with emetine produced a disappearance of symptoms. Neither she nor her husband had been to the East or out of the country. The other exception, who had not been to the East, was Case 1, who had been only to France.

Of the 5 cases of amœbic abscess of the liver, 2 were greatly improved and possibly cured by emetine, 2 had burst through into the lung (and of these one is known to have been improved by emetine), while the fifth was improved or cured by a drainage operation together with emetine treatment.

With reference to amœbic abscess of the liver the following salient points are noteworthy. Figures and much other help in this connection have been obtained from Sir Leonard Rogers's (1) excellent work on the subject:

1. No liver abscess ever follows bacillary dysentery.

2. Amœbic dysentery occurs among the white races predominantly among men—in our series 93·75%; this in part is accounted for by the fact that many more males than females go to the East.

3. Amœbic abscess may occur without previous symptoms of dysentery, as in Case 3.

4. Liver abscess is a serious complication of amœbic dysentery, the number of deaths due to it being nearly double those due to amœbic dysentery uncomplicated by hepatic abscess.

5. The ratio of liver abscess to amœbic dysentery in India fell (in one area) from 1:8 in 1898–1911 to 1:29 in the period 1912–1919. This is accounted for by the use of emetine, which, although it does not prevent the occurrence (as will be seen in Cases 2–5 quoted), definitely reduces the incidence of abscess.

6. Acute widespread amœbic ulceration of the bowel is usually followed by multiple hepatic abscesses and a high mortality; while single abscess is less dangerous, and is associated with the more chronic latent form of dysentery, as appears to be the case in the patients quoted.

In this connection McNeill Love (2), reporting the heavy mortality occurring in the cases of amœbic dysentery among the British troops in Mesopotamia, showed that acute infection and multiple abscesses were common.

7. The treatment of the liver condition may be summarized as follows:

If the abscess is sterile and single (or but two or three), repeated aspiration and emetine intramuscularly.

If infected, incision and drainage by the sterile syphon method, and emetine.

If small and multiple treatment with emetine alone may be effective.

In Case 1 the diagnosis of liver abscess was not made till exploratory laparotomy had been performed, and then, owing to the low position of the abscess and the localized peritonitis, drainage *per abdomen* was thought most suitable.

I wish to record my thanks to Sir Holburt Waring for permission to publish the detailed case.

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J. C. F. LLOYD WILLIAMSON.

ON EVOLUTION IN ITALIAN ART.

THE Exhibition of Italian pictures has again reminded us that every great epoch in art runs its course in an astonishingly short time. When Botticelli was born in 1447 Fra Angelico was still actively painting; when he died in 1510 Raphael and Titian were established masters. Indeed, except for the earlier group of primitives, his sixty years of life overlapped those of all the great masters of Italian painting. The great period of Greek Art and the Elizabethan drama had even a shorter life. Men like Lyly and Greene and Nash evolved the drama from the Miracle Play and the Morality. Their importance, to quote Addington Symonds, "consists in their having contributed to the formation of Marlowe's dramatic style. It was he who irrevocably decided the destinies of the romantic drama; and the whole subsequent evolution of that species, including Shakespeare's work, can be regarded as the expansion, rectification and artistic ennoblement of the type fixed by Marlowe's epoch-making tragedies. In very little more than fifty years from the publication of Tamburlaine, our drama had run its course of unparalleled energy and splendour." First the development of the form and technique, then the full-blown flower and then its decay in baroque extravagance. It is only necessary to mention the so-called Throne of Aphrodite now in the Baths of Diocletian, the Hermes at Olympia and the Laocoon in the Vatican to show that exactly the same sequence occurred in Greek sculpture. Spring, summer, and autumn follow as inevitably as in the seasons of the year.

All this is so well recognized as to be hardly worth insisting on. My excuse must be that this Exhibition has impressed on my mind afresh another biological law, which is in apparent contradiction with this. Once life has started it inevitably runs its course—true; but in lowly organisms we meet with a phase of suspended animation when conditions are unfavourable, the phase of encystment, which may be indefinitely prolonged, and emergence from which is followed by an active phase of rejuvenescence. And I find in Byzantine art the parallel to this state of suspended animation, since for about a thousand years it persisted with only minor changes. The crude frescoes in the Catacombs have always excited interest, but for me their chief interest is the extraordinary decadence they show when compared with the exquisite decoration of Augustan houses. By the time of Constantine all artistic impulse seems to have died down; his very Arch is a fraud, stolen from the Arch of Trajan and clumsily brought up-to-date. But when he moved his capital to the Bosphorus a new art arose, best known in mosaic, but assuming many other forms such as enamels and carvings in ivory. To-day we are realizing how much of this art came from Persia to blend with what remained from the Greek. A revenge for Marathon indeed! When most of Europe was ravaged by barbarian hordes the lamp of learning and of art still went on flickering at Constantinople, and when the Middle Ages began to develop a new culture it was from Constantinople that the germ of pictorial art came. That it came through a criminal act is beside the mark now. For in 1204 the Crusaders, balked of their legitimate prey, sacked Constantinople, chiefly at the instance of Venice. We prefer to close our eyes to that fact, and to forget that all the Crusades except the first were preposterous failures. If we did not, we should be less ready to use a term that really covered itself with disgrace. But of all the episodes that disgraced the Crusades none was so shameful as this sack of Constantinople. It enriched unscrupulous Venice, to be sure, but that was hardly the purpose for which the Crusades were undertaken. But it fatally weakened the extreme outpost against the Turk, who later overwhelmed it and advanced even to the walls of Vienna.

This earlier sack of Constantinople brought into Italy a number of Greek painters and pictures. The encysted life took on a fresh growth in its new environment. Setting aside Cimabue, if there ever was "sich a person," Duccio in Siena and Giotto in Florence transformed the old Byzantine mode into something new and living. The stiff hieratic forms lived and moved and had their being. We must not forget the influence of St. Francis of Assissi in this proto-Renaissance, if such a hybrid term may be permitted. As Clutton-Brock says, "When the baleful and inhuman Gods of Byzantine art grew more anthropomorphic, it may well have been due to his influence. He induced men to take an interest in the beauty of the visible world, which had previously been considered, perhaps not quite explicitly, as a snare of the devil." Certain it is, at any rate, that in the Church at Assisi, erected over his grave, we find the finest examples of this early vital art. But by the middle of the fourteenth century this impulse in its turn seems to have died down, and there is a gap of more than fifty years before the new and stronger growth began. This is a point which is often overlooked, and is the more remarkable when we remember its rapid and vehement development when it had once started. And here we encounter a curious result of political jealousy. Siena and Florence were rivals, and Duccio started the Sienese School just before the Florentine School began to blossom. Proud of their priority, the Sienese School maintained their style as untouched as possible, and steadfastly refused to accept any of the innovations that radiated from Florence. For two hundred years after Duccio the Sienese changed their style as little as possible. Towards the end of that time it was clear that they were being deliberately archaic; Francesco di Giorgio was contemporary with Raphael, yet he affected the primitive manner. Charmingly decorative, he was yet as deliberately out of touch with the art of his time as our Pre-Raphaelites were with that of theirs. This resistance to progress finally met with the inevitable fate of all failure in adaptation. The Sienese people wearied of this local brand of art and Sodoma was imported and given important commissions. His new, emotional way of painting captivated them, and the Sienese School came to an end. Byzantine art could remain static because the conditions were static, but Italy in the sixteenth century was changing rapidly, and those changes in the end swept away resistance as the incoming tide sweeps away castles in the sand.

Florentine and Umbrian painting never tried to stand still. It was eager and experimental. The Renaissance is sometimes attributed to the final fall of Constantinople

in 1453 liberating stores of classical learning to spread over Europe. But this cannot apply to the artistic side of that revival; Donatello had lived and died before it happened, and no one can deny that he is essentially of the Renaissance. It did, however, enormously stimulate an interest in the Classics, and mythological subjects largely replaced sacred ones. The old gods came to life once more and inspired some of Botticelli's most beautiful pictures. The obsession of sin weakened and man's spirit rose. Even in sacred pictures the note changed; the emphasis was different. You can trace it in the representations of the Madonna. The early pictures follow the stiff, hieratic tradition and the next lay stress on the virginity; but now the emphasis is laid on maternity. This, they seem to say, is akin to the miracle that may happen in any home. Compare Raphael's Madonnas with Lippo Lippi's if you doubt this. Of Raphael it may be said that it is necessary to pass through three phases to appreciate him. At first one accepts him on tradition as a very great painter, and then passes on to agree with those who consider that he painted extremely well in the manner in which any common-place individual would like to paint. Only after passing through this stage can one realize the greatness of the man. True, he fixed the style, and his followers killed it, but we must forget the imitators and realize his matchless construction and design, his flowing rhythms and his soaring imagination. If we find him conventional, we must remember that he created the convention.

Whether the Crusader's sack of Constantinople initiated the rise of Italian painting or no, the sack of Rome in 1527 by Charles V indubitably ended it. Only in remote Venice did it linger on. Titian, Palma Vecchio and Giorgione started together, and it is usually thought that the last named was the dominant influence at first. To Giorgione the formation of their distinctive style is usually attributed. It is at any rate probable that he introduced the psychological note which Titian elaborated. This is well seen in "The Tempest." Art critics complain that this picture has no central point of interest. But it portrays tempest without and tempest within, and the central point is the flash of lightning that divides the picture obliquely, separating the figure of the man from that of the woman and child. The parable is clear, and is emphasized by the two broken columns on the fountain. At Burlington House this picture severely suffers from the raspberry-coloured walls against which it unfortunately hangs. Titian survived Giorgione by nearly half a century, and developed their methods to great heights of glowing colour and emotional significance. It is interesting to find that in a letter to Philip II of Spain he spoke of being engaged on "two new poesies." Clearly, then, we are justified in assuming that his pictures were intended to express something more than merely "significant form," which some modern critics assure us is all that we should look for. He continued to paint until his hundredth year, though towards the end his pictures acquired a grimness that is foreign to the rest. There is a similar macabre note in Franz Hals's last picture, now hanging where he died in Haarlem.

After Titian, Venetian art still continued, though it gradually changed its form as Venice came to merit the description of "the Monte Carlo of its day." But in the rest of Italy art died with Michael Angelo, who, indeed, despite his genius, was the father of the baroque. The Eclectic Schools of Rome and Bologna followed the method of compilation. They selected the colour of one master, the design of another and the technique of a third, expecting in this way to resume the excellencies of all. Unfortunately they left out the essential ingredient—the genius that inspired each.

Is there not a similar danger to-day? I was recently assured by a well-known critic that the principles of art were now known and scientifically defined. But genius is indefinable. There is a tendency to intellectualize all the arts and rigidly to exclude emotion. They must be made incomprehensible except to the expert. To the onlooker art is in a chaotic state, seeking its inspiration anywhere and everywhere except in the classic forms. Whether this is believed to mark the end of an epoch or the dawn of a new one depends on the temperament, and largely on the age of the individual. Yet however much my æsthetic susceptibilities may be outraged by the art of to-day, my reason bids me hope. The horizon of man's mind has been widened enormously, not so much by the material achievements of science, as by the stimulus it is giving to his imagination. Even physics has become metaphysical. From such quickening a new art may yet be born, as from the quickening of men's minds at the Renaissance. Hope is of things as yet unseen.

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SUBACUTE TOXIC HEPATITIS.

SUBACUTE toxic hepatitis resulting from poisoning by certain known agents such as tetrachlorethane, the arseno-benzols, and perhaps syphilis, is a well-recognized condition. This form of hepatitis occurring with no apparent ætiological factor is, however, seldom described. It is for this reason that these three cases are recorded.

Each appears to be part of one morbid entity, and is characterized by recurrent attacks of jaundice terminating fatally. In none was a cause discovered. The clinical course of the disease in each case seems to differ only in time, and the pathological changes only in degree. Diagnosis, in life, is a matter of some difficulty. The post-mortem findings are degeneration, atrophy, fibrosis and regeneration of the liver tissue—rather similar to the morbid changes seen in poisoning by T.N.T. (1).

It is generally agreed that all degrees of degenerative change may occur in the liver, from acute yellow atrophy at one end of the scale to portal cirrhosis at the other. Miller and Rutherford (2) classified toxic hepatitis into three types—the acute, the subacute, and the multiple nodular hyperplastic. The latter differs from portal cirrhosis only in the greater rapidity of the initial destruction of the liver substance and in the greater softness and vascularity of the fibrous tissue.

According to this classification, the first two of these cases fall into the subacute, the third into the multiple nodular hyperplastic group.

CASE I.—L. K—, a boy, æt. 15, an electrical engineer, was first admitted to St. Bartholomew's Hospital under the care of Sir Thomas Horder on August 24th, 1927, complaining of "yellowness" and "swelling of the belly."

He had been well until 23 *weeks before admission*, when, following an electric shock, he felt tired. He improved after a week in bed and was fairly well for the next two weeks.

20 *weeks before admission* he became jaundiced, the urine dark, the stools pale. There was no pain. The boy remained in bed for ten weeks, during which time he had intermittent bleeding from the nose and gums. The jaundice gradually cleared.

Three weeks later, 7 *weeks before admission*, the jaundice recurred and the upper part of the belly began to swell. The jaundice persisted but the swelling decreased. The bleedings continued and he was constipated.

1 *week before admission* he vomited. He had had no pain and no loss of weight.

Past history.—"Jaundice" twelve years ago. Measles when a child.

Family history.—None of jaundice.

On examination (August 24th, 1927), temperature 99°, pulse 92, respirations 25; weight 7 st. 11 lb. The patient was jaundiced, but not deeply. The abdomen was distended. A "mass" was felt in the right upper quadrant, which extended down three fingers' breadths below the costal margin in the mid-clavicular line. It was smooth, regular and insensitive, and appeared to be part of the liver. The spleen was just palpable.

Urine.—Bile-pigments +, bile-salts 0, albumen 0, urobilin ++.
Fæces.—Well formed and clay coloured.
Blood.—

	Red blood-cells per c.mm.	Hæmoglobin.	White blood-cells per c.mm.
Aug. 24	3,080,000	58%	6000 (lymphocytes 3520)
Sept. 5	2,650,000	50%	4000
,, 12	4,110,000	64%	7400
,, 20	4,230,000	66%	8200

Van den Bergh reaction: Direct—biphasic reaction. Bilirubin units 6·2. Indirect—bilirubin units 7·0.
Wassermann and Sigma reactions: Negative.
Oxygen inflation of abdomen by Mr. Roberts, and X-ray: "The anterior border of the liver is more rounded than usual, and there is a further opacity in the mid-part of the liver which may be due to an enlargement or tumour on its under-surface."

The patient left Hospital at the end of four weeks, greatly improved. His weight was 8 st. 6 lb. (9 lb. gain) and the jaundice had disappeared. He was, however, still anæmic and the size of the abdominal swelling remained the same. He maintained good health for four weeks, when the recurrence of jaundice brought about his readmission to Hospital on October 27th, 1927.

On examination.—Temperature 99°, pulse 120, respirations 25. The swelling in the region of the liver was larger as a whole (four fingers' breadths), but the "mass" less definite than before.

Urine.—Bile-pigments +.
Blood.—

	Red blood-cells per c.mm.	Hæmoglobin.	White blood-cells per c.mm.
Nov. 4	3,700,000	45%	8,800
,, 10	2,890,000	42%	7,800
,, 14	2,600,000	33%	6,400
,, 21	2,760,000	33%	19,400

Platelet count: Within normal limits (122,000 per c.mm.).
Bleeding and coagulation times: Within normal limits.
Fragility of corpuscles: Slightly decreased (no hæmolysis at 0·4% saline).
Van den Bergh reaction: Direct biphasic. Indirect—bilirubin 12 units.

The patient was in Hospital for four weeks, during which time he became progressively more ill. The jaundice deepened, the anæmia became more marked, and there were frequent hæmorrhages from the nose and gums. Finally ascites and œdema of the legs appeared, and he died on November 23rd, 1927.

The *diagnosis* during life was ? cirrhosis (Hanot's type), ? hepatic neoplasm.

At autopsy the liver was irregularly enlarged and smooth. There was some perihepatitis. The left lobe was large, the right small. The Spigelian lobe, which projected below the lower border of the main organ, was greatly hypertrophied, and pushed forwards the liver in front of it, causing a swelling on its anterior surface.

The cut surface of the right lobe was firm and white. The left was much the same, save that dotted about were islands of yellow liver-tissue resembling areas of regeneration. These were especially numerous in the Spigelian lobe (see Fig. 1).

The *gall-bladder* and main bile-ducts were natural. The *spleen* was slightly enlarged.

Histology.—Right lobe of the liver (Fig. 4): There was complete absence of liver-tissue, which was replaced by a rather active cellular fibrosis. There was marked proliferation of the bile-ducts.

Left lobe of the liver (Fig. 5): There was a certain amount of coarse active fibrosis and hypertrophy of the remaining liver-tissue. The latter showed, in most parts, varying stages of degeneration, even to complete atrophy.

The spleen showed no marked change.

Note on Case 1.—The liver seems to have been subjected to a series of attacks, causing atrophy, replacement, fibrosis and regeneration. The Spigelian lobe showed the greatest regeneration, and the liver function appears to have been carried on for some time mainly by this part of the organ, until in its turn it was damaged and life became no longer possible. It was doubtless this enlarged lobe pushing forwards the superimposed liver which led to the vague palpable mass in the abdomen and to the X-ray findings in life.

CASE 2.—V. M. F—, a girl, æt. 18, single, was first admitted to the Woolwich Memorial Hospital under the care of Dr. East on September 6th, 1929, complaining of "jaundice."

12 *weeks before admission* she had loss of appetite and "wind" after food, which lasted for one week, at the end of which time she became jaundiced. She gradually improved in the succeeding three weeks until 8 *weeks before admission*, when she developed "chicken-pox." From this date the jaundice became more intense and persisted. She had occasional vomiting and two attacks of nose-bleeding. There was no pain and no loss of weight. She was not constipated.

Past history.—"Gastritis" nine years ago. Measles when a child.

Family history.—None of jaundice.

On examination (September 6th, 1929), temperature 98°, pulse 94, respirations 20; weight 7 st. 2 lb. The patient was deeply jaundiced. Apart from slight enlargement of the heart, no physical signs of disease were found in the chest. Nothing abnormal was discovered on examining the abdomen.

Urine.—Bile-pigments +, bile-salts 0, albumen trace; a few granular casts.
Fæces.—Well-formed, offensive, clay-coloured. Bile-pigments 0. Some undigested fat and fatty soaps present.
Vomit.—Free HCl absent. Total acidity 0·237% HCl.
Fasting gastric content.—Free HCl 0, bile 0.
Duodenal intubation.—No bile in duodenum. Bile-stained fluid appeared 5 and 10 minutes after introduction of magnesium sulphate (1 drm. in water 3 oz.).
Bacteriology: Mixed streptococcus and staphylococcus suggestive of buccal contamination.
Blood.—Red blood-cells 4,430,000 per c.mm., hæmoglobin 80%, white blood-cells 6400 per c.mm. (lymphocytes 1728 per c.mm.).
Van den Bergh reaction: Direct—immediate. Indirect—35 units.
Wassermann and Sigma reactions: Negative.

During the first three weeks in Hospital the jaundice deepened and there was occasional vomiting. There was no pain. On September 29th an exploratory laparotomy was performed by Mr. Cecil Rowntree. The liver was found to be smooth, small, and "fibroid"; the gall-bladder, the cystic and common bile-ducts appeared natural. The body of the pancreas was unaffected. The spleen was rather large. No radical surgical measures were performed, and the abdomen was closed.

Three weeks later the jaundice was less, although still present to a slight degree, and the girl was discharged (October 21st, 1929).

The diagnosis was "? toxic hepatitis with atrophy and sclerosis." For three weeks her condition remained stationary, but then the vomiting returned and the jaundice advanced. She became very constipated. There was no loss of weight.

On November 29th, five and a half weeks from the date of her discharge, she was readmitted to Hospital.

On examination, temperature 97·4°, pulse 106, respirations 22; weight 7 st. 3 lb. 10 oz. There was deep jaundice. Nothing abnormal was felt in the abdomen.

Urine.—Bile ++.
Van den Bergh reaction: Direct—immediate. Indirect—40 units per c.c.

The patient lived for two weeks, becoming more and more jaundiced. The area of liver-dullness decreased in size. She became hysterical, drowsy, incontinent, and died on December 11th, 1929.

At autopsy the liver was small with a smooth surface. Some perihepatitis was present. The cut surface showed, especially near the periphery, yellow areas resembling regenerating liver. These were set in a fibrous stroma (see Fig. 2). The spleen was rather large.

Histology.—Liver: There was coarse fibrosis, somewhat less active than in Case 1, with proliferation of the bile-ducts. Areas of hypertrophic liver-cells were scattered about, most of which were in various stages of degeneration and atrophy (see Fig. 6).

CASE 3.—E. M. F—, a woman, æt. 40, single, was first admitted to St. Bartholomew's Hospital under the care of Dr. Morley Fletcher on October 15th, 1923, complaining of "jaundice."

9 *months before admission* she had loss of appetite, and "wind," which was shortly followed by jaundice lasting six weeks. During this time she was in bed. The stools were pale, the urine dark. There was neither pain nor vomiting. After this she remained in good health until 1 *month before admission*, when the loss of appetite and jaundice recurred. She was constipated. She thought she had lost weight.

Past history.—Good health. None of "potus."

Family history.—None of jaundice.

On examination, temperature 97·8°, pulse 80, respirations 20; weight 7 st. 5 lb. There was deep jaundice. Nothing abnormal was found on examining the abdomen.

Urine.—Bile pigments +, bile-salts 0, albumen 0.
Stools.—Pale, not clay-coloured. "Urobilin" present in normal amount.
Blood.—Red blood-cells 5,160,000 per c.mm., white blood-cells 10,200 per c.mm.
Van den Bergh reaction: Positive indirect.
Lævulose tolerance test: No decreased tolerance.

In the following seven weeks the jaundice gradually lessened and finally disappeared. The pulse-rate never rose above 70 per minute. There was no loss of weight. On December 7th, 1923, she was discharged. The diagnosis was "? catarrhal jaundice."

For six years the woman remained in good health. She was readmitted, however, shortly after this period, on October 9th, 1929, complaining of "swelling of the stomach and legs."

8 *weeks previous to readmission* she had a pain in the upper part of the belly and shortness of breath. Later her belly began to swell and the shortness of breath became more severe. The pain, on the other hand, disappeared. She became constipated.

On examination (October 9th, 1929), temperature 98°, pulse 102, respirations 17; weight 10 st. There was no jaundice. There were signs in the chest of a bilateral pleural effusion and of œdema at the bases of the lungs, and, in the abdomen, of ascites. The size of the liver was not determined. The legs and back were œdematous.

Urine.—Albumen 0, casts 0.
Blood.—

	Red blood-cells per c.mm.	Hæmoglobin.	White blood-cells per c.mm.
Oct. 10	4,690,000	58%	6,800
,, 30	3,030,000	58%	10,200
Nov. 20	3,560,000	54%	14,200

Two weeks later she became jaundiced, bile appeared in the urine, and the Van den Bergh reaction gave a slight positive indirect reaction (2·7 units). There was some lowering of lævulose tolerance.

Thenceforward the condition of the patient steadily declined. The jaundice deepened, the ascites in spite of repeated withdrawals increased, and the œdema extended. Finally she became incontinent and comatose, and died on December 8th, 1929, about nine weeks from the time of her admission.

At autopsy there was a bilateral pleural effusion. The lungs were congested and œdematous. A large quantity of ascitic fluid was present. The liver was small and the surface covered with a profusion of "knobs." The cut surface showed a coarse but regularly distributed surface surrounding areas of bile-stained liver-tissue (see Fig. 3).

The spleen was large and showed a little fibrosis. The condition of the stomach was suggestive of gastritis.

Histology.—There were irregular lobules of regenerating liver-tissue showing variable amounts of fatty degeneration (mostly at the periphery of the lobules [Scharlach R.]), sometimes extreme, and even atrophy. These lobules contained a considerable amount of bile. They were supported by an abundant stroma of well-organized fibrous tissue, which was vascular and contained much biliary tissue (see Fig. 7).

DISCUSSION.

One of the features of interest of these three cases lies in the close similarity of the clinical and pathological findings. And although this resemblance is most marked in the first two, the differences in the third case could be explained by the greater length of time which elapsed between the attacks of jaundice. This would allow of more regeneration of the liver substance and greater organization of the fibrous tissue, and in consequence an alteration in the final clinical picture.

Briefly, the story is as follows: The disease commenced with jaundice associated with or preceded by symptoms of "indigestion." This jaundice was of the so-called "obstructive" type; the stools were deficient in bile. In two cases there were hæmorrhages from the mucous membranes. The red blood-cells showed an anæmia of the secondary type and the white cells a leucopenia—a common condition in T.N.T. poisoning (1). During this attack there was neither pain, fever, nor loss

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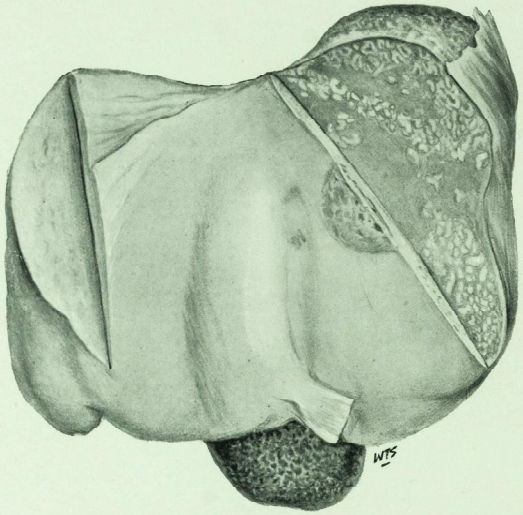
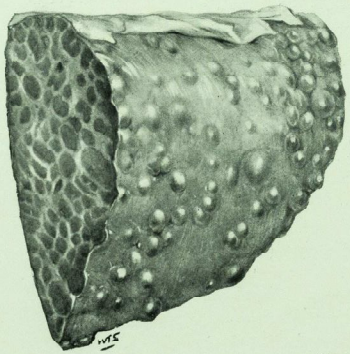
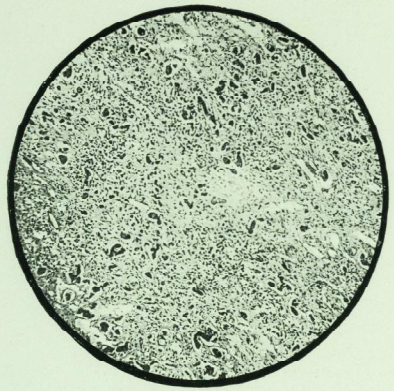


CASE 1.—SUBACUTE TYPE.
FIG. 1.

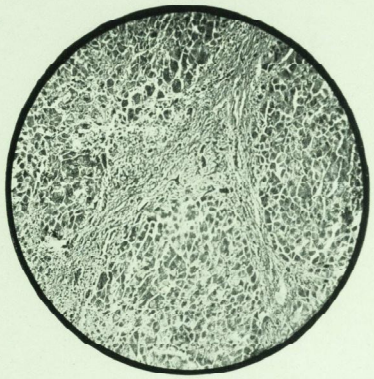
CASE 2.—SUBACUTE TYPE.
FIG. 2.



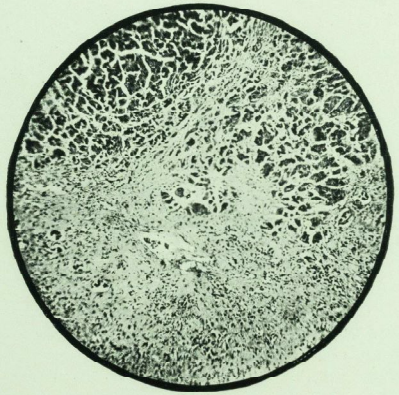
CASE 3.—MULTIPLE NODULAR HYPERPLASTIC TYPE.
FIG. 3.



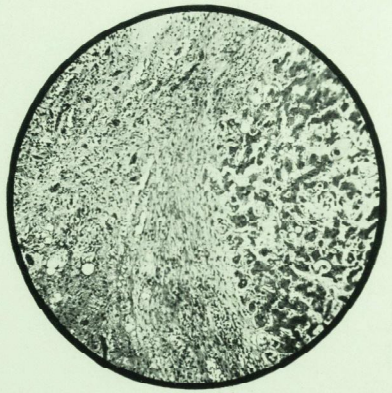
CASE 1.
FIG. 4.



CASE 1.
FIG. 5.



CASE 2.
FIG. 6.



CASE 3.
FIG. 7.

of weight. In a few weeks the jaundice cleared and the patient recovered. After a varying interval of time, however, a similar condition recurred, and again perhaps for a third time. Ultimately, during an attack, death took place.

There was nothing in the history which could be cited as a cause and diagnosis in life was difficult. The post-mortem appearances were those of successive attacks of subacute hepatitis.

If, as seems probable, some noxious agent produces these changes in the liver, what is its nature and whence its source? No definite answer can be given to these questions, conjecture alone being possible.

Regarding first the cause of the jaundice itself, it is seen that the "hæmolytic" type can be excluded, both by the clinical and pathological findings in life and the appearances after death. Nor is it a true obstructive type, for no obstruction to the bile-ducts is found. Rather, the jaundice seems to belong to the "hepatic" group, and due to damage of the liver-cells.

How, then, has this occurred? The diffuse nature of the changes in the liver and the absence of cholangitis make it difficult to believe that there has been an ascending infection of the bile-ducts from the duodenum. It seems more probable that the pathogenic agent has been borne to the liver by the blood-stream.

Moreover, many of the features in life, such as absence of fever and the generalized rather than focal distribution of the lesions in the liver, and post-mortem the lack of evidence in other organs of the body, suggest that the actual cause of injury to the cells is toxic rather than bacterial. As has been previously noted, the morbid appearances approximate closely to those found in cases dead from poisoning by trinitrotoluol and other known poisons, which have been carried from the intestines by the blood-stream to the liver.

It would be going beyond the evidence to suggest that the pathogenic agent in the present cases arises in the intestinal tract. It is true that in Case 2, the only one in which the gastric content was analysed, there was absence of free HCl, and that in Case 3 there was post-mortem evidence of gastritis. But these data are far too slender to allow of any hypothesis.

Whatever the causative agent may be, it must be something capable of bringing about repeated attacks of the disease, and its nature remains unknown.

These cases illustrate another noteworthy feature: Whereas the type of jaundice in life was "obstructive" in character, no evidence of biliary obstruction was found after death.

This raises an interesting point concerning catarrhal jaundice: The resemblance between individual attacks of the present disorder and catarrhal jaundice is striking. It has been widely held that although the latter complaint may be a hepatitis, it is caused by an ascending cholangitis and consequent biliary obstruction. No strong evidence has been brought to prove this view, which seems to have been mooted to account for the so-called "obstructive" character of the jaundice.

These cases suggest that a blockage in the bile-ducts is not a necessity when there is a deficiency of bile in the gut, damage to the liver-cells alone being sufficient to account for this.

Is it not possible that catarrhal jaundice is, as Brulé (3) and McNee (4) suggest, a primary affection of the liver-cells?

Of the three cases under discussion, it may be said, in conclusion, that they appear to be part of one clinical and morbid entity, and that the pathogenic agent remains unknown. Whether they represent a rare disorder, or whether they are severe examples of a more common disease which seldom comes to post-mortem, it does not seem possible to say.

I wish to thank Dr. Morley Fletcher, Sir Thomas Horder and Dr. Terence East for their kind permission to refer to these cases, and Prof. Kettle for his histological advice.

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EDWARD R. CULLINAN.

A CASE OF ACUTE INFLAMMATION OF A CYST OF MECKEL'S DIVERTICULUM.

A BOY, æt. 4, was admitted to the Worcester General Infirmary on October 11th, 1929, suffering from acute abdominal pain.

He had a history of attacks of intermittent pain in the region of the navel for the previous three years. On October 10th, 1929, the day before admission, he had commenced an attack of acute abdominal pain, his bowels were open three times, and during the night he vomited. On the day of admission (October 11th) the pain was worse, the bowels were not opened, but vomiting continued.

On examination he looked a well-nourished child, He appeared to be very ill, with a temperature of 101° F. a pulse-rate of 128, and a respiration-rate of 26. The tongue was dirty. The abdomen was generally distended and tender, the tenderness being more marked about the navel and in the region of the cæcum, while there was slight rigidity of the right rectus muscle. After admission he vomited, bringing up a green fluid. The diagnosis was made of acute appendicitis with general peritonitis.

Operation.—The abdomen was opened through an incision over the right rectus muscle, which was displaced inwards. The free fluid in the abdomen was not purulent. The appendix was found easily and was obviously not the cause of the trouble. The fingers were passed upwards and, in the region to the right of the navel, a cystic swelling like a gall-bladder was felt. The incision was enlarged upwards. The cystic swelling was found to be the size of a golf-ball and appeared inflamed. It was attached at one end to the navel, and at the other by a tubular process, resembling small intestine, to the small intestine about one foot from the cæcum. The inflammation was limited to the cyst. The tubular process was the size of a little finger. The small intestine above the point of origin of the process was at first smaller than that below, but later a wave of peristalsis passed along it, and it enlarged to the same size. Two fibrous bands attached to the cyst passed to the mesentery, and beneath each one a loop of small intestine was strangulated. These bands and the attachment of the cyst to the navel were divided, and the tubular process being treated like an appendix, the cyst was removed. With the consent of the anæsthetist the appendix was also removed. The abdomen was closed without drainage.

For three days after operation the child caused anxiety—there was dilatation of the stomach and a pulse of 140. The dilatation was treated by stomach wash-outs and enemata. On the fourth day the temperature was normal and the pulse 100. The child then made an uninterrupted recovery; the stitches were removed on the tenth day, and the patient left hospital on November 9th, 1929, quite well.

Microscopic examination (note by Dr. T. H. G. Shore).—The usual three coats of the ileum are represented in the diverticulum, but the mucous membrane is rather more simple and less glandular, and there is more sub-peritoneal fat. The blood-vessels are engorged, and other evidences of acute inflammation are seen in all parts of the wall of the diverticulum.

MARK BATES.

GOOD-BYE TO GOLDEN LANE.

EDITORS and Royalty have at least two points in common. When they speak they make use of the first person plural; when they invite they really command. I am reminded of this by a letter that lies before me. In it the Editor of the JOURNAL calls my attention to the fact that Golden Lane is about to die, and ends by inviting me to sing a dirge to its soul. "So famous a place ought not to die unsung" are his words.

I have always pitied the Editor of *Comic Cuts*. I have pictured him arriving at the office on Monday mornings, sitting down before his desk, picking up his pen, squaring his shoulders, looking at the blank paper in front of him, and saying, between clenched teeth, "Now I'm going to be funny." I have also adopted a sympathetic attitude towards the Poet Laureate when on the death of a celebrity he feels a compulsion to justify his salary by publishing a poem in the *Times*. Confronted with an invitation to be funny or poetic my sympathy has become deeper. No, Mr. Editor, I will neither be poetic *nor* funny however much you invite. I will merely tell in a few simple words the story of the Department that is at present in my charge.

The Venereal Department was born on August 13th, 1917, during the stress of the Great War, and dedicated to the task of coping with the great increase of venereal disease that invariably accompanies and follows in the train of armies. The child was a hearty youngster, but displayed in its facies certain stigmata that induced its parents hurriedly to find a home for it outside the family circle. After much talking and lunching on the part of civic and hospital authorities a suitable lodging was found in a building which had formerly been erected to meet the needs of a city epidemic and for long had stood empty and neglected. Mr Girling Ball gallantly volunteered to look after the youngster, feeling that, in spite of the stigmata that set it apart from the rest of the family, it was still a child of Rahere. A good experienced Swiss nurse was engaged at a large salary and everything was done to make the little outcast comfortable. Kind City gentlemen, after lunching at the Guildhall, made an annual pilgrimage to look at it, and pat it on the head, and the Ministry of Health kept track of its progress through the medium of countless forms and questionnaires which the poor Swiss nurse did her best to answer.

But although the child grew and in some measure thrived he was never really happy. This was not so much due to the fact that his nursery was over a delousing establishment, and next door to a mortuary, but

rather to a consciousness that there was something not nice about him, something that marked him off from his family. His brothers and sisters were all snug in the ancient Smithfield home and he alone outside.

And then Heaven intervened on his behalf. The City gentlemen began to tire of patting him on the head and tipping him half-a-crown. They looked at their account books and said that for such a small child he cost a great deal of money to keep. Either he must grow or else his own family must look after him. But the air of Golden Lane was not good for growing, and the family protested that their home was already crowded and that there was no room for anybody else. So the City gentlemen went on talking and the family went on protesting for three years, until everybody was tired. And then at last somebody had a bright idea and beautiful plans were drawn of a new nursery within the hospital. It was a very small one, but with shining walls of marble and fitted basins and fountains of coloured water. No expense was spared and everybody was delighted except the Swiss Nurse and Sister Attenbury, who had grown fond of the air of Golden Lane and thought the new premises rather cramped.

So why, Mr. Editor, should I write a dirge? Nobody is dead. All that is happening is that a small son of Rahere—a very nice little boy in spite of what some of the others may think—is busy packing to go home.

February, 1930. KENNETH WALKER.

THE PASSING OF GOLDEN LANE.

"There was sometime in this suburb without Aldersgate an hospital for the poor." (John Stow, *A Survey of London*.)

THE sunlight falls on Golden Lane,
And brightens with its beauteous beams
That special centre where were slain
A billion pallid treponemes.
Ah Phœbus! but thou canst not show
What those deserted rooms must know.

Up flights of stairs the hosts unnamed
Climbed, panting, to the specialist,
And bared their arms before that famed
Novarsenobenzologist.
And some went out with N.A.D.,
And some went out with N.A.B.

The shadows fall on Golden Lane.
Gone are the clerks of Kharsivan;
No more to lounge along Long Lane
Or burble on the Barbican.
Henceforth they study Neisser views
Within the purlieus of Bartholomew's.

W. V. C.

THE COUNTRY DOCTOR—NEW STYLE.

SO much is written for the edification and amusement of present-day medical men about the daily life of the doctor in the Victorian age before motor-cars, when the old type of family doctor was the guide, philosopher and friend of his patients, who seldom dreamt of consulting anyone but him, that it might not be out of place to set down a few notes about the daily routine of the modern country doctor. This might be useful, because a good deal has been written about the impending doom of the general practitioner: how he is being swamped by the tide of County Council clinics, his midwifery cases all being taken out of his hands by the trained nurses, the school children being seen by the special school doctors, the tuberculous cases by the county specialist, and the orthopædic cases by *their* special surgeon, without their even passing through the doctor's hands at all.

As I was told last month by a doctor with a first-rate country practice, that it was difficult to get a thoroughly good young partner because the young men from the hospitals think country practice is simply not good enough for those very reasons recited above, it is worth while trying to demonstrate that a country doctor's life nowadays is not in the least what the inexperienced may think it.

This is certainly an age of specialists, but we can avoid merely playing the *rôle* of the polite medical shop-walker bowing our patients to their appropriate specialists, as someone said recently in the *Observer*. A patient told me the other day, to convince me of the superiority of Denmark to England in the matter of doctors, that there were no general practitioners in Denmark at all. When her little boy had tonsillitis there, the Consul was at once able to give her the name of a specialist, and her little boy had the advantage of his special treatment during the course of the tonsillitis instead of merely being treated by a general practitioner, as he would have been in England. The mother added that this particular specialist turned out to be a gynæcologist; but still he was a specialist.

In the 'nineties you were very much on your own. There was your partner to consult with, or if you had not one, there were your neighbouring colleagues; but the great advantage of a consultation is to get the opinion of a man, whom you consider superior to yourself. While it is interesting to talk over cases with your partner or with the neighbouring practitioners, it is not very inspiring, which is what a consultation ought to be. You could only get a consultant to see your cases in the old days if the patient paid for him, or by sending the patient to the hospital, which is probably so far off that you could not go to the hospital yourself to hear first hand what the consultant thought.

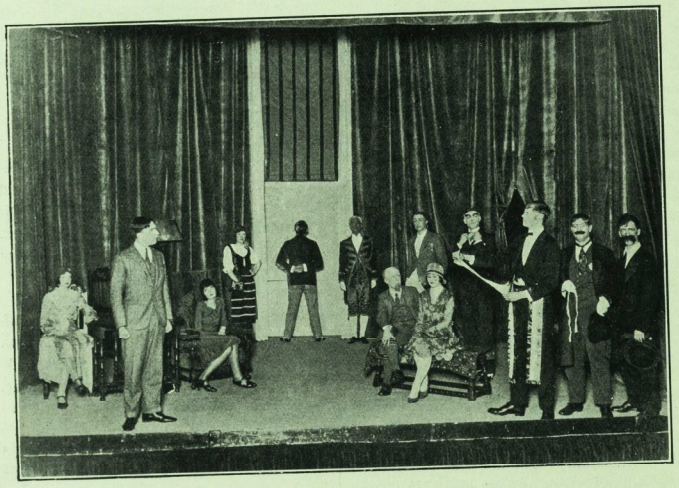
But we have changed all that—at least in Gloucestershire—and we are now in constant touch with a first-rate surgeon, who is full surgeon to a big general hospital, a first-rate physician, a gynæcologist, an oculist, an aurist and an orthopædist. All these are great advantages, but the greatest advantage of all in this particular practice is the existence of an excellent cottage hospital of 10 beds at the bottom of the doctor's garden. Here the surgeon, the physician, the oculist, the aurist, and the orthopædist all converge to give the patients of the best, to the great edification and pleasure of the general practitioner, who organizes clinic days when the surgeon does tonsils and adenoids, sees any other cases, and goes round the little wards (because he is also consulting surgeon to the hospital). The physician sees possible tuberculous cases and any other medical cases in the wards or in the tiny out-patient department, and the orthopædic surgeon comes down regularly to inspect the babies brought from the neighbouring villages (twenty-one villages altogether). The oculist has a day occasionally with the eyes of children under fifteen and willingly sees anyone else. It is one of the grievances of general practitioners that they are thus deprived of the fees they used to get by attending all these patients as private patients, but while they certainly did get fees from a good many of them, they are by no means unpaid now, for the County Council pay the general practitioner as well as the specialist for all these activities. The clinics, besides being well paid, are of great advantage and interest to the doctor, who thus meets the consultants often, and is allowed by them to make frequent and unstinted use of their brains. All the cases seen at the clinics are sent by one or other of the local doctors, who are present at the hospital when the surgeon or physician sees them. One necessary we lack, and that is an X-ray plant. We are so rural that electric light schemes have passed us by, so that our X-ray cases (and there are about three a fortnight), have to go thirty miles to the general hospital or nine miles to a neighbouring larger town, where they have electric light, an excellent X-ray outfit and an exceptionally good radiologist and physician. If we get a fractured femur in an old patient we treat it as best we can without X-rays, since to move it in an ambulance would do more harm than good. The cottage hospital works in with the big general hospital thirty miles away; we take in patients after operation when they want the bed, or one of the staff sends us a patient who would be better for our country air than in the town. All the patients subscribe *2d.* a week to the hospital scheme, and this entitles them to free treatment either in our hospital or in the general hospital. Practically everyone subscribes except the extreme poor, and those whose income exceeds £250.

As to one's patients, there are three classes roughly, and they are all extraordinarily pleasant to deal with in the country. Rural practice is much more mixed as regards social classes than in town; you have to attend the highest, and the lowest, and the middle, and it is exceptional to find any of them difficult to deal with, if you are not upset when even the best educated like to consult an osteopath or take up with the Abrams treatment. They will always come back to you after tarrying outside to have an imaginary bone that is "out" put in, and will naïvely tell you of the wonders of a "medical clairvoyante" lady they have met, who is almost as good as the X-rays. Many of us work single-handed and there is little leisure. The panel work keeps your nose not uncomfortably to the grindstone, and there is a parish appointment, a Post Office one, and a medical club, besides the private patients and the County Council clinics. There is not much time for hunting, and not much for fishing or golf, and as for holidays—well, you have to get a *locum*, and you do not have a holiday every year. But in the country, when you are out on the rounds most of the time that you do not spend in the surgery, you do not feel the need of fresh air as you would in Birmingham or Harley Street. Most of us do our own dispensing, but this particular practice has among its household relatives a highly-qualified nurse, who can do more than a little to help. Being a masseuse, too, she can do massage cases, and she knows all about the running of a practice and how to deal with patients. The book-keeping and all the business part are done by another very competent member of the household. Midwifery is mostly done by C.C. midwives, who only send if in difficulties, and private cases, even in a large country practice, are not many.

You work pretty hard from nine o'clock till dinner, but after that there is little. Night work is not what it was. A well-run practice ought in time to be able to eliminate many night calls by education. An afternoon and an evening off a week give a chance for tennis or

for a car ride, and altogether life is as easy as anywhere else.

I am sure it is not true that the G.P.'s day is over, and that he is held in less esteem than the old-type doctor. There is, and always will be, the personal touch, which you don't get if you have given up your family medical man. On the whole a young man from the hospitals might choose a life far less full of enthusiasms and usefulness, and as to income, he will make as good an income in the country, without losing his self-respect, as anywhere else. H. E. B.



ACT II.

Bunghi: "SIR, WHAT WAS THAT DEED?" "IT CONCERNED A WOMAN!"

Standing.—Mario, Teresa, Franco, Andrea, Georges, Praga, Bunghi, Town Councillors.
Sitting.—Delia, Wanda, Pier, Nina.

THE MASK AND THE FACE.

COUNT Mario Grazia having sworn publicly, or—more terrible—in the presence of his best friends, to kill his wife should she be unfaithful to him, believes himself called upon to carry out his threat. Whereupon he protests that he *has* killed her and thrown her body into the lake, banishes her to England, is tried for murder, acquitted through the services of his wife's assumed betrayer, and finds himself the hero of his country. In the hour of his triumph, surrounded by adoring and amorous ladies, flowers, twin souls, the town band, mayor, council, mayoral address, to which finally is added his wife, he realizes that *something* is more precious than his heroic morality. Comes the *dénouement*, and, blessed romance, the happy ending.

To interpret this rather tragic comedy Mr. James Taylor and the members of the Amateur Dramatic Society made their ambition. The interplay of character and conversation which comprised the play required a formidable fund of gesture and grouping, and to say that they succeeded is a greater commendation than to crown them with adjectival wreaths.

Count Mario Grazia (Leonard Sandell), if he was played at a pressure something too high, was a consistent and recognizable character. After his emphatic pronouncements he reached his best when, in the presence of his (deceased) wife, he silently debated the choice between his character and his love.

Pier Zanotti (Clive Barnes) had in his keeping some of the wittiest lines in the piece, and by his treatment of them proved himself full worthy of the trust. Ugo Praga (Derrick Coltart) embodied the Law with great skill, and gave perhaps the most finished performance in the piece. The incredible Bunghi, hopelessly but delightfully out of accord with his surroundings, was bravely played by Mr. Rowland Taylor, and remained a very human figure; while his comic councillors (Robert Cross and Richard McBride) occupied their brief appearances with a noticeable vivacity. Georges Almaire, a lion with the ladies, who roared as gently as any sucking dove, found a sympathetic interpreter in Mr. Keith Vartan, while Franco Spina (Mr. Gerald Norman), the villain of the piece, inspired in our bosoms the proper feelings of disgust. The ladies carried the day with honour. Miss Violet Warne, especially, played the difficult part of Savina Grazia with charm and grace.

The play was excellently produced, and rarely can the Society have played in so handsome a setting in its whole forty-seven years of life.

Pleasant music was purveyed by the Hospital Musical Society in the intervals.

The Amateur Dramatic Society deserves something better than an amateur dramatic critic. Let him, at least, while congratulating the Society, say "Thank you" for a delightful evening. F.

RAHERE REVUE, 1930.

WE were lucky to get into the Great Hall on February 10th, when this revival of the Christmas Shows was staged before an audience which, in its numbers and its enthusiasm, exceeded all the expectations of the producers. The performance began with a tableau in which Rahere was seen receiving from the King the Hospital's first Royal Charter. In the second tableau St. Bartholomew's Hospital, with its Beacon Light, appears as a vision to the kneeling monk. How this illusion was so successfully produced on the stage is a secret known only to Mr. J. R. B. McBride, the producer, and his co-workers, who managed the lighting effects.

Into this solemn atmosphere the "Labour Party" suddenly burst with their spirited opening chorus, and the rest of the evening was spent in howls of laughter at a quick succession of some of the most successful items in the Christmas Shows, which were still fresh in our memories. A substantial amount was realized by the collection which was made in the interval, and the profits were handed over to the Appeal Committee.

We hope that this mistura will be repeated in future years, in spite of the great difficulties which its production entails. Mr. McBride and his helpers are to be congratulated upon the great success which crowned their efforts. B.

STUDENTS' UNION.

RUGBY CLUB.

During the last month the 1st XV have settled down into an exceptionally smooth, well-balanced side, and have added four further victories to their credit. Against the Devonport Services and the O.M.T's. the backs showed remarkably good form, and it is hoped that they will reproduce it against the London Hospital in the semi-final of the Hospital Cup-ties. In our cup-tie against St. George's, although successful, the team had to work very hard to prevent defeat. The true form of the side was not reached; no doubt this was due to the effective defensive tactics of the whole St. George's side and the usual cup-tie type of game was produced. We congratulate St. George's on the fine display they put up, and in sympathy we hope that it will be the side which defeated them by so close a margin that will be the winners of the Hospital Cup.

J. M. J.

1st XV Results up to February 22nd:

January 25th: *v.* Pontypool, lost 5–8.
February 1st: *v.* Devonport Services, won 14—3.
February 8th: *v.* Old Leysians, won, 20—3.
February 15th: *v.* O.M.Ts., won, 20—8.
February 20th: *v.* St. George's (cup-tie), won, 9—5.
Played 21, won 11, drawn 1, lost 9. Points: for 230, against 167.

"A" Results:

Played 19, won 17, lost 1, drawn 1. Points: for 372, against 103.

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

Result: Bart.'s, 5; Pontypool, 8.

January 25th, at Winchmore Hill.

The Hospital were unlucky to lose, and with the turn of the luck should have won this match. Pontypool, one of the best of the South Wales sides, fielded a strong team, their outstanding member being Gwyn Bayliss, their full back. They kept going at racing pace, and the Hospital forwards found the opposition extremely difficult to overcome; it was indeed a useful test for the strengthening of our forward play before cup-ties. The Hospital try was scored by Marshall after an opening made by Nunn; Capper managed to convert with a fine kick from near the touch-line. In the closing stages the Hospital nearly crossed the visitors' line, but the fine tackling of the Welshmen prevented any further score.

Team: T. J. Ryan (*back*); R. M. Marshall, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* DEVONPORT SERVICES.

Result: Bart.'s, 14; Services, 3.

February 1st, at Winchmore Hill.

In spite of the fact that the Services fielded nine Navy players the Hospital managed to adapt themselves to the muddy conditions more effectively, and won by a goal and three tries to a try. By reason of the splendid work of their forwards the Services imposed a severe trial upon the Bart.'s defence for the greater part of the first half, but the Hospital steadily gained the upper hand. Taylor, in his usual form at the base of the scrum, set going many attacks. In the second half Powell, Marshall and Beilby all added unconverted tries as the results of movements usually started by Taylor.

Team: T. J. Ryan (*back*); R. M. Marshall, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, J. M. Jackson, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD LEYSIANS.

Result: Bart.'s, 20; Old Leysians, 3.

February 8th, at Wandsworth.

The conditions were against a spectacular display of the game, and it took the backs all their time to keep warm enough to enable them to handle the ball with accuracy. The Leysians' pack did well in the loose, but they tired towards the end and seldom gained possession in the tight. Capper gave Bart.'s the lead with a try which C. R. Jenkins converted. Philp replied for the Leysians, after some mishandling by Ryan. In the second half Taylor (2), Prowse, Capper and Marshall added further tries, but all the kicks failed. The goal-kicking was extremely disappointing.

Team: T. J. Ryan (*back*); R. M. Marshall, J. A. Nunn, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, W. M. Capper, R. N. Williams, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD MERCHANT TAYLORS.

Result: Bart.'s, 20; O.M.T's., 8.

February 15th, at Teddington.

This was a thoroughly keen game and closer than the score suggests. The Old Merchant Taylors actually led at half time by 8 points to 5, but it was evident, even in the first half, that there were very few weak points in the Hospital team, and a number of definitely strong ones. Taylor was the outstanding player on the field, and had the advantage of playing behind a very fine pack that was heeling the ball consistently, but he never made a mistake; he knew exactly when to go through on his own and when to set his three-quarter backs moving, and he had the happy knack of being in the right place at critical moments in defence. The three-quarter backs took their passes well and were sound in defence, but they have a dangerous habit of flinging the ball wildly away. It was this fault that cost them two tries.—*Daily Telegraph.*

Team: T. J. Ryan (*back*); J. D. Powell, C. B. Prowse, J. A. Nunn, R. M. Marshall (*three-quarters*), F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins, V. C. Thompson, H. D. Robertson, R. N. Williams, W. M. Capper, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

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

Cup-Tie (2nd Round).

Result: Bart.'s, 9; St. George's, 5.

February 20th, at Richmond.

After a very keen, though not at all a scientific game, Bart.'s managed to beat St. George's Hospital by three tries to a goal. Bart.'s kicked off under ideal conditions after losing the toss. For the opening ten minutes of play we attacked fiercely, but the handling of the whole team was extremely scrappy. St. George's defended admirably, and after obtaining possession in a tight scrum their inside half set their backs going in the most brilliant movement of the afternoon's play. They managed to cross our line, far out, for Jones-Davies to convert with a superb kick. Four minutes later Bart.'s, perturbed by this early reverse, managed to get going, and Prowse, after making an opening, sent Grace in for a try far out. The kick was unsuccessful. The remainder of the first half produced no further score and St. George's managed to lead by 5—3. The play was altogether very disappointing, as many fine chances were missed by faulty handling. Taylor, although thoroughly well marked by the opposing wing forwards, saved a great many mistakes which might have led to a further reverse. The centres were shaky at the outset, but improved considerably as the game progressed. The forwards were rather outweighted at first, but during the whole of the first half in the tight scrums they gained possession nine times out of ten; in the loose, at times, they showed their real form. Their backing up and quick heeling was magnificent, but the tackling might have been better. C. R. Jenkins, Capper and Williams were the most conspicuous, but this casts no shadow on the other members of the pack, who all played admirably. Ryan had comparatively little to do at full back in the way of tackling, but he brought off one or two spectacular runs after swerving past a number of the opposition. One noticed at times how terribly out of position he was.

In the second half the whole of the Bart.'s side improved considerably, but they never reached their real form. After six minutes we went further ahead by a clever try by Marshall, which was obtained after Taylor had dashed round on the blind side of the scrum. The kick again failed. The final score was obtained by C. R. Jenkins. For the remainder of the game we pressed most of the time, and although it ended in our favour, this game was very disappointing; this was no doubt due to the relentless tackling of the St. George's men and the customary cup-tie atmosphere which accompanied it.

Teams: St. Bartholomew's Hospital: T. J. Ryan (*back*); R. M. Marshall, J. A. Nunn, C. B. Prowse, A. H. Grace (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); C. R. Jenkins (capt.), V. C. Thompson, H. D. Robertson, R. N. Williams, W. M. Capper, J. R. Jenkins, B. S. Lewis, E. M. Darmady (*forwards*).

St. George's Hospital: T. R. Plummer (*back*); R. S. Lewis, T. E. Jones-Davies, E. H. Allen, C. P. Bailey (*three-quarters*); E. T. Lutter (capt.), F. N. Goggs (*halves*); H. J. Bergh, H. S. H. Gilmer, P. T. Cooper, W. E. Tucker, O. H. Bostock, C. E. Bevan, C. F. Patterson, R. Marnham (*forwards*).

ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* STREATHAM OLD GRAMMARIANS.

Result: Bart.'s, 5; Streatham, 2.

February 8th, at Winchmore Hill.

The Hospital had much the better of the opening exchanges, Dransfield scoring with a superb cross-shot. Our visitors retaliated, and until the interval, when the score stood at 3 goals to 2 in favour of the Hospital, play was very fast and very even. In the second half the home forwards played a wonderful game, and defence was sound during a period of continued pressure, Wenger being particularly safe.

Inter-Hospitals Cup: First Round.

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

Result: Bart.'s, 6; St. Thomas's, 2.

February 11th, at Winchmore Hill.

Bart.'s opened the scoring, and it was not long before St. Thomas's had levelled up. Play became very uncertain until two quick goals by the home team saved the situation. Immediately following this play was again very uncertain, and our opponents were allowed to score once more. Masterly forward play marked the opening of the second half, and in twenty minutes three great goals had put Bart.'s well ahead.

Scorers: Shackman 3, Gilbert 2, Dransfield 1.

Team: R. L. Wenger (*goal*); J. Shields, R. McGladdery (*backs*); F. E. Wheeler, C. A. Keane (capt.), H. J. Roache (*halves*); A. W. Langford, R. Shackman, R. G. Gilbert, C. M. Dransfield, W. Hunt (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. JOHN'S COLLEGE, CAMBRIDGE.

Result: Bart.'s, 5; St. John's College, 2.

February 15th, at Winchmore Hill.

Fresh from the joys of a very creditable cup-tie draw during the week, our opponents proceeded to find the net *vid* the shortest route. Our own forwards, too, had many a fruitful sally into enemy territory. Gilbert helped himself to four goals, though this was no reflection on the opposing centre-half, who played brilliantly throughout. But it speaks volumes for the team-work and judgment displayed by the Hospital as well as for the opportunism of our marksman.

Inter-Hospitals Cup: Semi-final.

Result: Bart.'s, 3; Guy's, 2.

February 20th, at Chiswick.

Guy's won the toss and started strongly. After a considerable period of pressure, Wheeler suddenly turned defence into attack with a sweeping pass down to Langford. The Guy's defence, however, was too good, and following some neat movements, they went ahead with a well-placed shot. Bart.'s worked like heroes to get on terms, and Langford levelled up the scores with a glorious first-time effort, which the opposing custodian did not see.

On resuming, the Bart.'s supremacy was now well established. Sparkling forward play forced a corner which Hunt placed well for Langford to head in. Soon after, Gilbert put Bart.'s still further ahead with a neat shot. Guy's retaliated very fiercely and scored a second time.

The team played brilliantly in all departments, to carry Bart.'s into the Final for the second year in succession. Our opponents will be London Hospital, who defeated Middlesex in the other semi-final. The match will take place on March 5th.

We should like to call attention to the fact that the proceeds of our Annual Charity match *v.* Centels will be handed over to the Secretary of the Bart.'s Appeal Fund, and that this match will take place at Chiswick on March 26th.

C. A. KEANE.

UNITED HOSPITALS HARE AND HOUNDS.

The United Hospitals Hare and Hounds beat the Orion Harriers' "A" on January 29th by 45 points to 34. H. B. C. Sandiford (St. Thomas's) was first home, and was well ahead of G. E. Ross (Orion); J. R. Strong (Bart.'s) was third.

The 7½ mile handicap on February 5th was won by J. T. Bliss (St. Thomas's) with a start of 1 min. 30 sec.

On February 12th, U.H.H.&H. beat Blackheath Harriers, "A" team, Sandiford again winning by a large margin.

The match against Dublin University Harriers on February 17th resulted in an easy win for the Hospitals. H. B. C. Sandiford (St. Thomas's) was first, E. C. Billington (St. Thomas's) second, and J. R. Strong (Bart.'s) third. The course was over 5½ miles and was won in 32 min. 37 sec. The Hospitals provided the first five men home, and scored 24 points against 54.

SAILING CLUB.

A meeting was held in the Committee Room on January 27th. Dr. Dudley Stone was in the chair. The following resolutions were passed:

(1) The Club should try to organize a trip to the Norfolk Broads this Easter, April 18th to 22nd or 23rd, the object being to teach people to sail a boat.

(2) The Bart.'s members of the United Hospitals Sailing Club were in favour of the acquisition of the hut on the sea-wall at Burnham-on-Crouch at a rental of £20 per annum.

(3) Should the negotiations for the hut be successful, that a fund be raised immediately to furnish it, so that it could be used during the present season as sleeping accommodation for members.

(4) That the Bart.'s members of the U.H.S.C. were in favour of a race being instituted for life members, the race to be sailed at the annual regatta. A cup might be provided by subscription, and permission sought from Claud Worth to call it the "Claud Worth Cup."

J. Hopton was elected secretary of the Club.

Dr. Lander, a Bart.'s man in practice at Burnham, has offered to lend any members of the Club his four-ton sloop "Sonia," which he is willing to put into commission in time for the Easter holiday (April 18th). "Sonia" has a cabin with two bunks. The jib and the main have roller reefing gear, making it an easy boat to handle. A notice has been put up in the A.R.

J. HOPTON.

HOCKEY CLUB.

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

February 8th, at Camberley.

Sandhurst started by scoring from the bully-off; the whole of the defence seemed to be taken unawares. The Hospital settled down after this, but Sandhurst had the better of the play till half-time, and some very hard shots only just missed going into goal.

In the second half the Hospital had the better of the game, and by scoring a goal made the scores equal. The defence managed to keep their opponents out for the rest of the game. Iliff deserves special mention for his excellent work at back. A very fast and enjoyable game thus ended in a draw.

ST. BARTHOLOMEW'S HOSPITAL *v.* KEBLE COLLEGE, OXFORD.

February 12th, at Oxford.

Keble were not so strong as they were last year, and throughout the game the Hospital team were, individually and collectively, superior to their opponents. The forwards made use of the even fast ground and were well supported by the backs. The result was a win for the Hospital by 8 goals to *nil*.

ST. BARTHOLOMEW'S HOSPITAL *v.* ROYAL ENGINEERS.

February 15th, at Chatham.

The Royal Engineers got the ball from the bully-off, and after a round of passing amongst the forwards scored almost in the first minute. Bart.'s settled down after this, but the long passes and more accurate stick-work of our opponents gave them the advantage, and they scored 4 times before half-time to our 2 goals.

In the second half the Bart.'s forwards adopted the tactics of our opponents in sending long passes, and it proved successful, for they added 3 more goals, whereas our opponents only increased their score by one. The final score was 6—5 in our opponents' favour.

Goals for the Hospital were shot by White 2, Jamesen Evans 2, Symonds 1.

REVIEWS.

NOTES ON PRACTICAL NURSING. By E. MAUDE SMITH, R.R.C. (London: Faber & Gwyer, Ltd., 1929.) Pp. 128. Price 3*s*. 6*d*.

Lectures instil principles, details are learnt best by practice. "Art is long, life is short," and practice and lectures can seldom cover the whole range of a subject, especially in the earlier years of studentship. The text-book fills the gap and plays its part in reference and revision. It is difficult to revise from a large text-book, and the limitations of the small text-book are overborne by its usefulness before examinations and also in the first approach to the subject. The book under review provides such an approach and would be found useful in revision. It is written in the form of a series of notes, based on lectures delivered by the author between 1904 and 1927. There are a few points which might bear alteration. The temperature chart in typhoid fever is wrongly described, but this is probably due to misprinting. It is a pity that there is a page on nutrient enemata—seldom if ever used in modern practice—and nothing said of the preparation and the giving of glucose and saline. It is a dangerous practice to guess the potential capacity of the urinary bladder, and the rate and amount suggested in the giving of intravenous saline might prove too much for the patient. Benedict's test is easier to interpret than Fehling's in testing urine for sugar. But there are many excellent chapters and notes which far outweigh such points as these. The notes are necessarily short; they seldom pause to explain, but for the probationer nurse they are admirable in their conciseness, in the field which they cover and above all in their practical nature. The author was trained in St. Bartholomew's Hospital and the notes follow the present practice in the Hospital.

AIDS TO PHARMACEUTICAL LATIN. By G. E. FREASE, Ph.C. (London: Baillière, Tindall & Cox, 1929.) Pp. 168. Price 3*s*. 6*d*.

Gone are the days when a study of the classics was looked on as being all-important and, in this clipping age, few are the students who can translate into grammatical Latin the abbreviations of the directions of a prescription. Often now is found that ignorance has led to a clumsy mixture of the Latin with English—surely a loss to the patient who feels he is getting his full money's worth if he can understand nothing of what has been written on the paper he takes to the chemist. Latin is an international language. The reviewer had occasion once to send a prescription to a friend to be made up in Kiev. Alas, Kiev was unable to rise to the occasion, as there was lacking in the town every drug except the vehicle, but the prescription and directions written out in full Latin were understood easily.

For those who would preserve the older traditions in the writing of prescriptions, who would wish to know exactly from what they abbreviate, and who would save themselves from a display of ignorance before their chemist, this book is to be heartily recommended.

THE MIDWIFE'S ANTE-NATAL CLINIC. By LELIA PARNELL, Matron, British Hospital for Mothers and Babies, Woolwich. With an Introduction by J. S. FAIRBAIRN. (London: Faber & Gwyer, Ltd., 1928.) Pp. 74. Price 2*s*. 6*d*.

If a midwife lives up to her French reputation of being a wise woman, doctors may go to school with her. Half an hour spent with this charmingly written book may reveal to the busy medical man much that he never troubled to think about. The author, who knows and minds her business, reminds the midwife that she is dealing with a human being and not with a collection of symptoms. It is regrettable that the author relies on the liquor potassæ test for pus. "Benedict's Fehling solution" is clearly a misprint; the method recommended of adding to one and a half drachms of urine eight drops of Benedict is clearly a mistake.

THERAPY OF PERSONAL INFLUENCE. AN A.B.C. OF TREATMENT BY PERSONAL INFLUENCE, SUGGESTION, MEDICAL HYPNOSIS, AND PSYCHO-MAGNETIC METHODS. By EDWIN HOPEWELL-ASH, M.D. (Published privately at BM/ELHA, London, W.C. 1, 1929.) Pp. 96. Price 2*s*. 9*d*. post free.

To the general practitioner the chronic cases which obstinately resist his routine treatment by medicine, rest and sympathy must be as the sands of the sea. Face to face with the grossness of what he may even look upon as a personal injustice he often retreats behind Hughlings Jackson's comforting advice, "The only thing to do is to say a great big damn, and have done with it." In the 90 pages of the well printed booklet for review the author enshrines the gracious wish that his twenty-five years' experience of mind-healing may be a guide and friend to students of psycho-therapy, and may stimulate the practitioner to take up the practice of treatment by personal influence. Twenty-eight pages of the book are devoted to an account of cases of noises in the ear, colitis, stammering bladder, alcoholism, nocturnal enuresis, railway-carriage phobia, and countless other complaints which the author successfully and often dramatically healed by personal influence, suggestion, hypnosis, and rays psycho-magnetic, ultra-violet and infra-red. The book, written in an easy, clear and vivid style, may be found helpful by those who are fascinated by what the author calls the "hypothetical energy of personality." Others, though anxious to work deliverance to all, mindful of Hippocrates' warning that experience is deceitful and judgment difficult, will use this new weapon delicately lest it change in their hands into the Egyptian reed.

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

AINSWORTH-DAVIS, J. C., M.B., F.R.C.S. "Renal Calculus with Solitary Cyst of Left Kidney." With a Note by T. P. Dunhill, M.D. *British Medical Journal*, January 4th, 1930.

ANDREWES, C. H., M.D. "Immunity to the Salivary Virus of Guinea-Pigs Studied in the Living Animal and in Tissue-Culture." *British Journal of Experimental Pathology*, February, 1930.

BURT-WHITE, H., M.D., F.R.C.S. (and COLEBROOK, L., M.B., MORGAN, GERTRUDE, M.B., JERVIS, BEATRICE, M.B., and HARRE, GERTRUDE, M.B.). "Cutaneous Sensitiveness to Scarlatinal Toxin in Pregnancy and the Puerperium." *British Medical Journal*, February 8th, 1930.

CARMICHAEL, E. ARNOLD, M.D., F.R.C.P.Edin. "? Lead Myositis." *Proceedings of the Royal Society of Medicine*, February, 1930.

CHANDLER, F. G., M.A., M.D., F.R.C.P. "A New Thoracoscope." *Lancet*, February 1st, 1930.

DAVIES, J. H. TWISTON, M.B. "? Psoriasis; ? Pityriasis Rubra Pilaris; Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, February, 1930.

——— "Parapsoriasis: Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, February, 1930.

DONALDSON, MALCOLM, F.R.C.S. "The Early Diagnosis and Treatment of Cancer." *British Medical Journal*, January 4th, 1930.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D. "Lymphadenoma with Involvement of the Larynx." *Proceedings of the Royal Society of Medicine*, February, 1930.

——— "Swelling Above Right Vocal Cord; Outgrowth on Left Vocal Cord: Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, February, 1930.

——— "Reticulo-Sarcoma, Formerly Left Tonsillar Region, Lately Right Tonsillar Region; Radium Treatment; Recovery." *Proceedings of the Royal Society of Medicine*, February, 1930.

——— "Epithelioma of the Larynx." *Proceedings of the Royal Society of Medicine*, February, 1930.

DUNHILL, T. P., C.M.G., M.D., Ch.B. *See* Ainsworth-Davis.

——— "Toxic Goitre." *British Journal of Surgery*, January, 1930.

ELLIOT, R. H., D.Sc., M.D., F.R.C.S. "Some Points in Connection with Cataract Extraction." *British Medical Journal*, December 21st, 1929.

EVANS, GEOFFREY, M.D., F.R.C.P. "Essential Constipation." *Clinical Journal*, February 20th, 1929.

——— "Dietetic Treatment of Spastic Constipation." *St. Bartholomew's Hospital Reports*, 1929, lxii, p. 70.

FINZI, N. S., M.B., M.R.C.S., L.R.C.P. *See* Harmer and Finzi.

GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S. "Contributions to the Study of the Treatment of Epithelioma of the Tongue by Radium." *Lancet*, February 1st, 1930.

GOW, A. E., M.D., F.R.C.P. "Treatment of the Typhoid Fevers." *Lancet*, January 4th and 11th, 1930.

GROVES, ERNEST W. HEY, M.S., M.D., B.Sc., F.R.C.S. "A Reversible Bed Frame for Spinal and other Cases." *British Medical Journal*, January 11th, 1930.

——— "Hunterian Oration on Hero-Worship in Surgery." *Lancet*, February 22nd, 1930; *British Medical Journal*, February 22nd, 1930.

HALL, PERCY, M.R.C.S., L.R.C.P. *Ultra-Violet Rays in the Treatment and Cure of Disease.* London: William Heinemann, 1929.

HARMER, W. DOUGLAS, M.A., M.B., M.C., F.R.C.S., and FINZI, N. S., M.B., M.R.C.S., L.R.C.P. "Radium Treatment of Intrinsic Carcinoma of the Larynx." *Practitioner*, January, 1930.

HARRIS, C. F., M.D. *See* LINDER and HARRIS.

HORDER, Sir THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "More Medical Notes." *Clinical Journal*, January 22nd and 29th, 1930.

LINDER, GEOFFRY C., M.D., M.R.C.P., and HARRIS, CHARLES F., M.D. "Calcium and Phosphorus Metabolism in Chronic Diarrhœa and Tetany." *Quarterly Journal of Medicine*, January, 1930.

MCCURRICH, H. J., M.S., M.B.(Lond.), F.R.C.S. "Retention of Urine." *British Medical Journal*, February 1st, 1930.

MORLOCK, H. V., *M.C.*, M.D., M.R.C.P. (A. J. SCOTT-PINCHIN, M.D., M.R.C.P., and H. V. M.). "Atelectatic Bronchiectasis." *British Medical Journal*, January 4th, 1930.

——— "Familial Acohluric Jaundice (Son, Mother and Grandmother)." *Proceedings of the Royal Society of Medicine*, February, 1930.

NIXON, J. A., C.M.G., M.D., F.R.C.P. "Advantages to the Diabetic of a Diet Rich in Carbohydrates." *British Medical Journal*, February 22nd, 1930.

PARAMORE, R. H., M.D., F.R.C.S. "Eclampsia Treated with Special Anæsthesia." *British Medical Journal*, January 4th, 1930.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Epoch-making Books in British Surgery. XI. 'My Book,' by John Abernethy." *British Journal of Surgery*, January, 1930.

PYBUS, F. C., M.S., F.R.C.S. "The Injection Cure of Hydrocele." *British Medical Journal*, February 8th, 1930.

ROCHE, ALEX F., M.A., M.D., M.Ch.Cantab., F.R.C.S. "Strangulated Obturator Hernia." *Clinical Journal*, January 29th, 1930.

ROSS, J. PATERSON, M.S., F.R.C.S. "Uterus with Fibromyoma, from which Hæmorrhage Occurred into the Peritoneal Cavity." *Proceedings of the Royal Society of Medicine*, February, 1930.

ROXBURGH, A. C., M.D., M.R.C.P. "Some Cutaneous Syphilides." *Clinical Journal*, February 19th, 1930.

RYLAND, ARCHER, F.R.C.S.Ed. "Fibrous Stricture of the Œsophagus caused by Swallowing Lysol Five Years Ago." *Proceedings of the Royal Society of Medicine*, February, 1930.

SAXBY-WILLIS, F. E., M.D. (and JEWELL, J. W. F., M.D.). "Laudry's Paralysis of Descending Type." *Lancet*, January 18th, 1930.

——— "Tumour of Lung; Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, February, 1930.

SHARP, B. BUCKLEY, M.D., B.S., M.R.C.P. "Some Effects of Methyl Chloride Gas." *British Medical Journal*, February 22nd, 1930.

SHORE, L. R., M.A., M.D., M.R.C.P., D.P.H. "Abnormalities of the Vertebral Column in a Series of Skeletons of Bantu Natives of South Africa." *Journal of Anatomy*, January, 1930.

THEOBALD, G. W., M.D., M.R.C.P., F.R.C.S.(Edin.). "Two Cases of Eclampsia Developing without Albuminuria, and one Fatal Case of Hydatidiform Mole without Albuminuria." *Journal of Obstetrics and Gynæcology of the British Empire*, Winter No., 1929.

WEBER, F. PARKES, M.D. (and SCHOLTZ, M., M.D.). "Combined Degeneration of Spinal Cord without Blood-Picture of Pernicious Anæmia." *Proceedings of the Royal Society of Medicine*, February, 1930.

WHARRY, H. MORTIMER, F.R.C.S. "Aids for the Deaf." *Practitioner*, January, 1930.

EXAMINATIONS, ETC.

University of Cambridge.

The following degrees have been conferred:

M.D.—Parsons, F. B.

M.B., B.Chir.—Gordon, J. C.

Conjoint Examination Board.

Pre-Medical Examination, January, 1930.

Chemistry.—Moynahan, D. J. M.

Physics.—Hill, R. L., Moynahan, D. J. M., Neill, I. D.

Elementary Biology.—Fletcher, C.

First and Second Examination.

Part I. Anatomy.—Bamford, J. B., Clark, E. M., Epstein, M., Morris, D. S., Turner, R. E. S., Wilson, J. S. H., Zeidenfeld, G.

Physiology.—Bamford, J. B., Clark, E. M., Edwards, D. H., Ford, A. R., Morrison, R. J. G., Turner, R. E. S., Wilson, J. S. H., Zeidenfeld, G.

Pharmacology and Materia Medica.—George, C. A., Sherman, I.

Final Examination.

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

Apthorpe-Webb, H. F., Barber, A., Burgess, W. J., Caplan, A., Carter, C. L., Dalliwall, R. E. S., Davies, H. L. G., Duncan, C. M., Lannaman, L. J., Lloyd, W. E. B., McGregor, H. A., McKee, G. K., MacVine, J. S., Matheson, I. W., Page, A. P. M., Rerrie, J. I., Segalov, S., Silverstein, H., Thorne Thorne, V., Ward, E. M.

L.M.S.S.A.

The Diploma of the Society has been granted to the following:

Mailer, W. A. R.

CHANGES OF ADDRESS.

ARCHER, C. W., "White House," Hythe, Hants.

ARTHUR, G. K., Tunstall Road, Biddulph, Stoke-on-Trent. (Tel. Biddulph 29.)

BARNES, D. T., 8, Holywell, Oxford.

DONALDSON, E., 52, Cromwell Road, Queen's Gate, S.W. 7.

GARROD, L. P., Bankcroft, Douglas Road, Harpenden. (Tel. Harpenden 230.)

SMYTH, Major F. G. A., R.A.M.C., R.A.M.C. Officers' Mess, Grosvenor Road, S.W. 1.

WATERFIELD, N. E., Foulis, Great Bookham, Surrey.

APPOINTMENTS.

DONALDSON, E., M.D., D.P.H., appointed Medical Officer in the Ministry of Health.

DONELAN, C. J., M.R.C.S., L.R.C.P., D.P.H., appointed Medical Officer in the Ministry of Health.

ROBERTSON, I. M., M.B., B.S., appointed Clinical Assistant to the Ear, Nose and Throat Department, The Royal Infirmary, Sheffield.

SMITH, N. F., M.D.(Oxon.), appointed Medical Officer in the Ministry of Health.

BIRTHS.

AINSWORTH-DAVIS.—On January 4th, 1930, at Kevinside, Amersham, Bucks, to Mr. and Mrs. J. C. Ainsworth-Davis—a daughter.

BAIRD.—On December 8th, 1929, to Dr. and Mrs. J. C. H. Baird, of 80, Southampton Street, Reading—a daughter.

BALL.—On November 4th, 1929, at "Redcroft," West Wickham, Kent, to Dr. and Mrs. Harold C. J. Ball—a daughter.

BATTERHAM.—On February 21st, 1930, at Keyberry House, Newton Abbot, Devon, to Thelma (*née* Rundle), wife of Dr. Douglas Batterham—a son.

BURROWS.—On January 27th, 1930, at 6, Holly Lodge Gardens, Highgate, to Gwendoline, the wife of Harold Burrows—a son.

ECCLES.—On January 7th, 1930, at a nursing home at Hove, to Dr. and Mrs. Karslake Eccles—a son.

FRANCE.—On January 23rd, 1930, at Ludlow, Bromley Common, to Eileen, wife of Francis France, M.B.—a daughter.

FRASER.—On February 18th, 1930, at "Mountains," Hildenborough, to Gladys (*née* Thomson), wife of D. Beaufort Fraser—a son.

STRETTON.—On February 2nd, 1930, at Westwood, Kidderminster, to Mary, wife of John W. Stretton, F.R.C.S.—a boy.

VINER.—On January 29th, 1930, at Chorley Wood, Herts, to Mona, wife of Geoffrey Viner, F.R.C.S., of 4, Harley Street, W. 1.—a daughter.

MARRIAGES.

ALLOTT—KYDD.—On January 29th, 1930, at St. Paul's Presbyterian Church, Birkenhead, by the Rev. John Goudie, M.A., Eric Newmarch Allott, B.M., M.R.C.P., elder son of Mrs. Allott and the late Henry Newmarch Allott, of Stretford, to Edith Mary, younger daughter of Mrs. Kydd and the late William Kydd, of Birkenhead.

FRANCIS—STEWART.—On February 1st, 1930, at Holy Trinity Cathedral, Guildford, by the Rev. Canon Kirwan, Dr. C. A. Francis, 56, Queen Anne Street, W., to Patricia Marion Margaret, only child of the late Charles J. Stewart and Mrs. Stewart, Cluaran, Guildford, and granddaughter of the late Colonel W. T. Stuart, Bengal Staff Corps.

DEATHS.

BRIGHT.—On January 25th, 1930, at 3, Royal Crescent, Brighton, of heart failure, Archibald Leonard Bright, M.R.C.S., L.R.C.P.

CLAPP.—On January 27th, 1930, at his residence, Downside, Whitchurch, Tavistock, Devon, Robert Clapp, M.R.C.S., L.R.C.P.

DAVIES.—On November 24th, 1929, Arthur Templer Davies, M.D., F.R.C.P., of Hornbeams, Welwyn, Herts, late of 3, Bank Buildings, E.C., second son of the late Herbert Davies, M.D., 23, Finsbury Square, E.C., aged 71.

ELLIS.—On January 23rd, 1930, at Bulawayo, Francis Heygate Ellis, M.C., M.R.C.S., L.R.C.P.(Lond.), S.G.M.O. Rhodesian Medical Service, beloved husband of Muriel Floyd Ellis (*née* Andrews), and youngest son of the late Colonel Fairfax Ellis, Royal Artillery, and Mrs. Fairfax Ellis, of Blackheath, London, aged 52.

GREEN.—On February 5th, 1930, at Queen Alexandra's Military Hospital, Millbank, S.W., Major-General Sebert Francis St. Davids Green, C.B., C.B.E., M.D. (late R.A.M.C.), aged 62.

HURRY.—On February 13th, 1930, at "Hinton Firs," Bournemouth, Jamieson Boyd Hurry, M.A., M.D., J.P., late of "Westfield," Reading, aged 72.

ROSS.—On August 6th, 1929, at Sherborne, Philip Hedgeland Ross, M.R.C.S., L.R.C.P., D.P.H.(Camb.).

SCOTT.—On January 28th, 1930, at Saskatoon, James Matthews Duncan Scott, M.D.(Edin.), D.Ph.(Camb.), Professor of Physiology in the University of Saskatchewan, Saskatoon.

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, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *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.1. Telephone: National 4444.*

St. Bartholomew's Hospital Journal.

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

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CALENDAR.

Tues., April 1.—Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty.
Fri., " 4.—Prof. Fraser and Prof. Gask on duty.
Tues., " 8.—Sir Percival Hartley and Sir Holburt Waring on duty.
Fri., " 11.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Tues., " 15.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Fri., " 18.—**Good Friday.** Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty.
Sat., " 19.—**Last day for receiving matter for the May issue of the Journal.**
Mon., " 21.—**Bank Holiday.**
Tues., " 22.—Prof. Fraser and Prof. Gask on duty.
Fri., " 25.—Sir Percival Hartley and Sir Holburt Waring on duty.
Mon., " 28.—Special Subject: Clinical Lecture by Mr. Rose.
Tues., " 29.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.

EDITORIAL.

GLASGOW VISITS BART.'S.

THE great work of the Hospital Appeal in bringing the history, the achievements and the aspirations of St. Bartholomew's before the intelligent and benevolent newspaper public is already bearing fruit. Attracted by the alluring announcements in our leading daily and weekly papers, no less than sixty-seven medical students from Glasgow University paid a visit to the Hospital on Tuesday, March 18th—having taken the Rugby International on their way. Through the kindness of the College Council a day was arranged for them, on which they were able to sample the life of the Bart.'s student. A trip round the Surgery, operations with Prof. Gask, out-patients with Mr. Girling Ball and Dr. Hilton and a tour of the Museum with Mr. Hume occupied the morning. Before lunch Prof. Gask displayed some of the treasured Archives of the Hospital and spoke of the pictures, which have recently been mounted on screens in the Great Hall. A visit to the tomb of Rahere came as an unexpected interlude. At lunch it was the turn of Glasgow to perform, by singing their warsong, "Yegorah," in honour of Bart.'s, and to the surprise of the other guests at the Manchester.

A characteristic clinical lecture by Sir Thomas Horder upon "Some Cases of Swellings in the Neck," followed by ward rounds with Sir Percival Hartley, Dr. Langdon Brown and Dr. Gow, and a tour of the new Surgical Block with Mr. Girling Ball ended the day, and Glasgow departed, weary, grateful, and, we think, amazed.

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TENTH DECENNIAL CLUB.

The Annual Dinner of the Tenth Decennial Club will be held on Friday, May 9th. Wing-Commander Scott will be in the chair. Further particulars will be published in the May issue. The secretaries of the Dinner are Mr. Reginald M. Vick and Dr. A. W. Stott.

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ELEVENTH DECENNIAL CLUB.

The Second Dinner of the Eleventh Decennial Club will be held at the Holborn Restaurant (Crown Room), on Friday, May 9th, at 7 for 7.30 p.m., with Dr. E. S. Vergette in the chair. Those who entered the Hospital as students between January 1st, 1915, and December 31st, 1925, and who have since qualified are eligible for membership. Those wishing to join the Club should make application to either of the Hon. Secretaries, F. C. W. Capps, or Wilfred Shaw, at St. Bartholomew's Hospital.