

## Reviews—continued.

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## St. Bartholomew's Hospital



## JOURNAL.

"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

VOL. XXXVIII.—No. 1.]

OCTOBER 1ST, 1930.

PRICE NINEPENCE.

## CALENDAR.

Wed., Oct. 1.	—Old Students' Annual Dinner in the Great Hall, 7.0 for 7.30 p.m.
Fri., " 3.	—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Sat., " 4.	—Rugby Match v. Rosslyn Park. Away. Association Match v. St. Thomas's Hospital. Away.
Mon., " 6.	—Special Subject: Clinical Lecture by Mr. Just.
Tues., " 7.	—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.
Wed., " 8.	—Surgery: Clinical Lecture by Sir Holburt Waring.
Fri., " 10.	—Dr. Gow and Mr. Harold Wilson on duty. Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., " 11.	—Rugby Match v. Old Alleynians. Home. Association Match v. R.M.A. Woolwich. Away. Hockey Match v. Beckenham II. Home.
Mon., " 13.	—Special Subject: Clinical Lecture by Mr. Russell.
Tues., " 14.	—Prof. Fraser and Prof. Gask on duty.
Wed., " 15.	—Surgery: Clinical Lecture by Mr. Harold Wilson.
Thurs., " 16.	—Abernethian Society: Inaugural Address by Dean Inge, 8.30 p.m.
Fri., " 17.	—Sir Percival Hartley and Sir Holburt Waring on duty. Medicine: Clinical Lecture by Dr. C. M. Hinds Howell.
Sat., " 18.	—Rugby Match v. Old Haileyburians. Home. Association Match v. Emmanuel College, Cambridge. Away. Hockey Match v. Woolwich Garrison. Away.
Mon., " 20.	—Special Subject: Clinical Lecture by Mr. Elmslie. Last day for receiving matter for the November issue of the Journal.
Tues., " 21.	—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Wed., " 22.	—Surgery: Clinical Lecture by Mr. Harold Wilson. Rugby Match v. Cambridge University. Away.
Fri., " 24.	—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty. Medicine: Clinical Lecture by Sir Thomas Horder.
Sat., " 25.	—Rugby Match v. Old Leysians. Home. Association Match v. Caius College, Cambridge. Home. Hockey Match v. Sittingbourne. Home.
Mon., " 27.	—Special Subject: Clinical Lecture by Mr. Russell.
Tues., " 28.	—Dr. Gow and Mr. Harold Wilson on duty.
Wed., " 29.	—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
Fri., " 31.	—Prof. Fraser and Prof. Gask on duty. Medicine: Clinical Lecture by Dr. C. M. Hinds Howell.

## EDITORIAL.

1930-1931.

THE new Academic Year has opened, unheralded and un-introduced.

The Hospital, with its long tradition of "feasts," has, it is true, an Old Students' Annual Dinner; but the New Students are flung into the midst of their work, to find their breathless way to shore themselves. This reticence concerning so important a moment in the life of the College is reminiscent of an earlier epoch, before Rahere took the City streets by storm, and that strange nurse in blue cried "Help for the Hospital" from every hoarding.

The latest figure in the Hospital tryptic— that white-clad amphibian, prepared alike for the dry land of medical speculation as for the rosy deeps of surgical inquiry—the Freshman may take as his own simile. In time he will lose his lost look, and he will find out the people who do *not* matter. But he has been a freshman before; he knows what to expect of us, as we of him. Good luck to him!

\* \* \*

There was a time when St. Bartholomew's, too, had an Introductory Address, ready for October 2nd's morning papers. Whereby hangs the tragic tale which was told by Sir William Church in his memoir of Sir Thomas Smith (*St. Bartholomew's Hospital Reports*, 1910, xlv, p. xxxvii).

"In 1868 Sir Thomas Smith was deputed by his colleagues to deliver the last introductory address at the commencement of the Winter Session given at the Hospital. . . . A very considerable amount of licence was allowed to the students on the occasion of the introductory address, and they somewhat freely

expressed their opinion of their teachers and others who might be present. In the preceding year this licence had exceeded reasonable bounds; for some reason or other the Treasurer had rendered himself unpopular with the students, and, in addition to the general uproar and disorder, one man armed himself with a pea-shooter and a supply of ammunition, with which he amused himself and his friends by peppering the bald head of the Treasurer, who was not a little indignant at the treatment he received, and declared that he would never attend another meeting of the School. The Staff, although very willing to drop the introductory address, thought it would be ignominious to retire when defeated as it were by the students in keeping order, and after due consideration it was decided that of the younger men Smith alone was likely to be given a respectful hearing. Their action was successful; Smith gave an excellent address amid perfect order and has had no successor."

\* \* \*

#### THE ABERNETHIAN ROOM.

By the time these words are in print the Abernethian Room will be once more in full use. Those who were driven from the "A.R." into the Library by the painters and panellers, from the Library into the Square by the polishers, and from the Square by the weather, will have no further excuse for frequenting the less formal houses of the neighbourhood.

For the benefit of those who will not see for themselves, we have obtained details of the improvements. The olive-green tiles—perpetual reminder to the student in his leisure hours of the beauties of the Surgery—have been torn down and their place taken by oak panelling, above which the walls have been painted a stone colour. Four new chesterfields for the alcoves on the corridor side of the room have been purchased, and what is to be retained of the old furniture has been renovated. All the furniture is covered in brown "leather." Oak bracket lights, two lamps in each, have been fitted, two in each alcove, and one between each window. A new grate and fender have been put into the main fire-place.

There will be a special attendant to tidy the room, to reassemble the newspapers and journals, and—*O tempora, O mores!*—to remove hats and coats which have been thoughtlessly left there.

The Room at last will have an appearance worthy of its name and of the School. It is for its inhabitants to prove themselves worthy of its appearance.

#### THE ABERNETHIAN SOCIETY.

The Very Rev. W. R. Inge, K.C.V.O., D.D., Dean of St. Paul's, will deliver the Inaugural Address on Thursday, October 16th, at 8.30 p.m. in the Medical and Surgical Theatre on "Racial Decay and Regeneration."

All members of the Students' Union are members of the Abernethian Society without payment of further fee. During the year three evening meetings are held, at which the Inaugural, the Mid-Sessional and the Summer Sessional Addresses respectively are delivered. On Thursday, April 30th, a special meeting will be held, to be addressed by Sir Arthur Keith in commemoration of the centenary of the death of the Founder, John Abernethy.

The Society meets also on Thursday at 5.30 p.m., after due notice has been given by the Secretaries, for Clinical Evenings, at which short papers are read and cases are shown for discussion. The year's programme will be published in the November issue and will be posted in the Abernethian Room.

\* \* \*

#### THE JOURNAL.

The JOURNAL was founded in 1893 as the official organ of the Students' Union, for the publication of papers of medical interest, of notes of cases, of the reports of the athletic clubs and of the Hospital societies, and of Hospital news. A copy is given each month to every member of the Students' Union, and is sent to those who, after qualification or at the termination of their resident appointments, pay the subscription which then becomes due.

An Index is included in the November issue, and a special binding, for one volume or for three, is obtainable through the Printers.

Articles of a literary character, poems, satires and Humour, the rarer produce of Hospital leisure, are welcomed by the Publication Committee. A select and humorous volume culled from old numbers was recently published under the title, *Round the Fountain*. Copies may still be had at the College Office.

\* \* \*

#### DR. LEONARD MARK.

We regret to announce the death of Dr. Leonard Mark, which occurred on September 5th at the age of 75. Always a lover of St. Bartholomew's, he took a lively interest in its history, compiling in 1907 a *Catalogue of a Collection of Prints and Drawings* and other historical objects connected with it. He was an occasional contributor to the JOURNAL on subjects

linking medicine and art, and lately he wrote an article on his work as Pathological Draughtsman to the Hospital. His two personal studies of acromegaly have aroused the wide attention not only of the profession, but of the general public; and he wished that the study of his case should be completed by a post-mortem examination at St. Bartholomew's. We hope to publish in our November issue an account of the findings.

In this connection we would deplore the fact that more doctors do not leave their bodies for post-mortem examination. There is at the present time a great reluctance on the part of the members of the public to allow examinations of the bodies of their relatives. It is for the doctors to provide a salutary example.

We publish, on p. 4, an obituary of Dr. Mark.

\* \* \*

#### MR. H. W. CARSON.

We regret to announce the death at the early age of 59 of Herbert W. Carson, Surgeon to the Prince of Wales's Hospital, Tottenham. An obituary notice will be published in November.

\* \* \*

Mr. Norman Capener, F.R.C.S., has been appointed Assistant Professor of Surgery (Orthopædics) at the University of Michigan.

\* \* \*

#### E. W. HALLETT.

The Secretaries of the Students' Union have received a letter from Mr. Hallett, thanking them for their trouble in arranging the testimonial that was presented to him, and "thanking all those gentlemen who subscribed to it, and wishing them all the best of luck in their forthcoming examinations."

\* \* \*

It is very unfortunate that we should lose the services of one of our best forwards at the very beginning of the Rugby season. W. M. Capper is at present in Bowly Ward. The offending ilium has been successfully dealt with, and the patient is now complaining of nothing except the incessant and manifold noises of the New Block. It is hoped that he will be able to play again in about a couple of months.

## OBITUARIES.

### SIR FRANCIS H. CHAMPNEYS, Br., M.D.

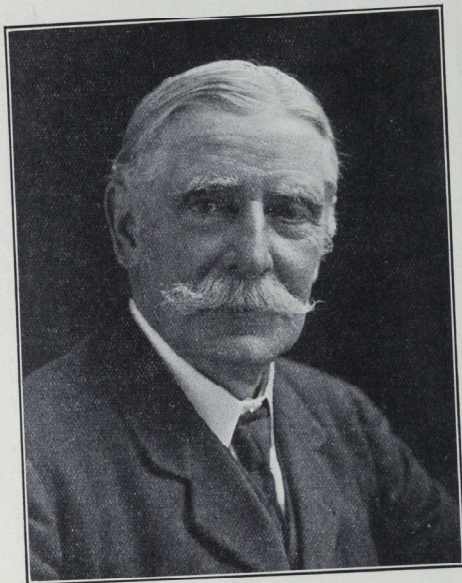
THE death of Sir Francis H. Champneys on July 30th removes almost the last of the Oxford medical graduates educated between 1860 and 1870 under the old system, which first made them gentlemen and scholars, afterwards distinguished physicians or surgeons. Amongst them were Dr. Bridges the Poet Laureate, who remained at Oxford; Sir Seymour Sharkey and George Gulliver of St. Thomas's; Pridgin Teale at Leeds; G. A. Wright at Manchester; Sir William Church, Samuel West and William Bruce Clarke at our own Hospital.

Champneys was a son of the Church in which his great grandfather, his grandfather and his father were dignitaries, and throughout life maintained the faith, being a devout worshipper at St. Alban's, Holborn, where he numbered Father Stanton and Father Russell amongst his friends. He was passionately fond of music from his school-days onwards, and was known as a composer of anthems which are frequently sung, as the mainstay of a society for the revival of Church music, as the author of articles in Stainer's *Dictionary of Musical Terms*, and as a member of the Executive Committee of the Royal College of Music.

Born on March 25th, 1848, he entered Winchester College as a scholar in 1860, and matriculated from Brasenose College, Oxford, in 1866. Four years later he graduated B.A. after gaining a first class in the Honours School of Natural Science. He rowed bow at Henley in 1868 on the occasion of the historic race for the Stewards Cup. The boat was designed especially for a coxwainless four, but the stewards insisted on a cox being taken. A man was therefore made to sit across the canvas when the start was made from the island and was dropped overboard immediately after the start. Brasenose won easily and was disqualified, but in the following and subsequent years a prize was given to the winning coxwainless four.

In 1872 Champneys was elected to a Radcliffe Travelling Fellowship, having received his medical education at St. Bartholomew's, and as Radcliffe Fellow studied at Vienna, Leipzig and Dresden. He acted for a time as Assistant Physician at the Dresden Lying-in Hospital and had determined to devote himself to midwifery as his life's work. On his return to England he was appointed Medical Tutor in our School and Assistant Physician at the General Lying-in Hospital, York Road. Shortly afterwards he was elected Obstetric Physician and Lecturer on Midwifery at St. George's Hospital and here he remained until 1890, when he was chosen to fill

similar positions with us which had become vacant by the sudden and unexpected death of Dr. Matthews Duncan. As a lecturer and teacher Champneys confined himself to the obstetrical side of his subject, and so long as he remained Physician-Accoucheur all operations were performed by his surgical colleagues. He resigned on attaining the age of 65 in the year 1913.



*F.H. Champneys.*

Many honours came to Champneys: a baronetcy in 1910; President of the Obstetrical Society in 1895-6; President of the Royal Society of Medicine 1912-14; a Crown Nominee at the General Medical Council; President of the General Lying-in Hospital. In all he performed the duties courteously, pleasantly and with dignity. He married Virginia Julian (d. 1922), daughter of Sir John Warrender Dalrymple, seventh baronet, of North Berwick. His elder son died of wounds received in action in 1915; his second son, Weldon Dalrymple-Champneys, of Oriel College, Oxford, who served as a Captain in the Grenadier Guards, and is now engaged at the Ministry of Health, succeeded to the title. His only daughter Margaret, well known as

an interpreter of Bach's contralto solos, is married to the Rev. Eric Southam, Vicar of St. James's, Bournemouth.

Champneys carried on the great midwifery tradition brought from Edinburgh by Dr. Matthews Duncan—a tradition of absolute truthfulness, sound knowledge, sturdy common sense and a freedom from the petty jealousy which so often beset his predecessors and led to unseemly quarrels. He deliberately modelled his teaching upon that of Dr. Matthews Duncan, and even when he was Obstetric Physician at St. George's Hospital would go down daily to his master's lecture and take copious notes of what was being said. To the end of his life he took a lively interest in his profession, and was helpful in the foundation of the College of Obstetrics and Gynaecology.

D'A. P.

#### LEONARD PORTAL MARK.

Leonard Portal Mark had a long connection with the Hospital, beginning on October 1st, 1875, when he entered as a medical student, because Dr. Patrick Black, who was then the senior physician, had married his aunt. He passed through the ordinary course without any special distinction, and as soon as he had received the College Diploma he filled the post of Assistant House Surgeon at the Sussex County Hospital, Brighton, and House Surgeon at the Richmond Hospital, Surrey. He then obtained the I.R.C.P. and the L.S.A., and became House-Physician at the York Road Lying-in Hospital. Subsequently he was Resident Clinical Assistant at Bethlem Hospital. He made a voyage before settling down in general practice, visiting Australia, and he even thought for a time of practising at Calcutta.

Returning to England he began to practise in Sydenham, but he soon moved to London. Eventually he obtained a share in the partnership of Cripps, Lawrence and Cosens, to fit himself the better for which position he took the M.D. degree at the University of Durham in 1899. Having time on his hands, for patients were not numerous, and being known as a skilful painter in water-colours and somewhat of an etcher, Mark accepted an invitation to become Pathological Draughtsman to the Hospital, when Thomas Godart, who had held the post for many years, went to Australia. The duties were ill defined and the times of attendance erratic. An unusual case in the wards or the out-patient room or something of interest in the post-mortem room caused the Curator of the Museum to telegraph, and in a short time Mark had arrived to draw what was wanted; otherwise he came down two or three afternoons every week to see if there was anything to be done. This post

he held from about 1885 until the time of his death, though of late years it was a sinecure.

So far Mark's life was uneventful. His health was not very good; he suffered from headaches which, he was told, were due to eye-strain, and he had difficulty in making his jaws meet. The friends with whom he worked—notably Sir Archibald Garrod and Sir D'Arcy Power—noticed as early as 1892 that his facial appearance was changing, and that his hands were altering in shape. Apparently they did not speak of the matter to him, for he says that it was not until November, 1895, that it suddenly dawned upon him as he was walking across Cavendish Square that he was becoming acromegalic. The symptoms became gradually more marked and the disease ran its course, crippling him and making him an invalid, but seemingly without shortening his life, for he died at the age of 75. His mental faculties were unimpaired, and he studied his own case with care, publishing the results at which he had arrived in *Acromegaly: A Personal Experience*, which appeared in 1912, and supplementing the volume with *The Apologia of an Acromegalic* in 1927.

Within the last month he sent to his friends a small, privately printed volume, entitled *More Reminiscences of Boyhood spent at Marseilles*. Completely bilingual, for he was born and educated in France, Mark's services were called upon at the International Congresses and other polyglot gatherings. They were always given cheerfully and usefully.

#### CHARLES BUTTAR.

##### AN APPRECIATION.

I'm afraid "Charles" was the last person in the world to like an obituary notice of himself; his last conscious words might have been, "Don't write any such balderdash; no biographer can tell what I really was. I've tried to be useful and that's that"; and he would say, "If I have helped anyone to sift wheat from chaff, or to get pompous asses to see what asses they are, or if I have got to understand my own littleness, I shall not have lived in vain."

We, whom he has left, like to think that somewhere and somehow he may not mind our expressions of love and respect for him, that somewhere in that Valhalla of great Bart.'s men there may be his great, genial laugh; that now he may know the truths he was ever so valiantly striving after, waiting for us to join him, anxious to tell us what he has found. Who knows?

Buttar indeed was a great man—perhaps too great to become well known to the public. He was one of those sons of St. Bartholomew's working for others behind the scenes, like some village Hampden steadying folks from

pettiness and silliness. No cynic he, only terse and straight. If he laughed at others he also laughed at himself. His "Tosh" meant, "don't grouse, don't gas; look for the true inwardness of things." His article, "Medicine and Religion," in the book *Medicine and the Church* deserves a separate issue. It shows the calm reasoning and clarity of view characteristic of him. How wistfully he would wait to be convinced that idealism was sufficient, yet that aspiration was often as valuable an attainment. What a good all-round man he was—a good classical scholar, a sound physician, the safest of anaesthetists, a motorist who helped the public and fellow motorists; what a friend he was to poor patients, what a vast amount of work he did in medico-politics, how valuable on his many committees!

Charles Buttar died before he had to suffer the grievousness of illness and old age. Of him it may be said, as Tacitus wrote of Agricola—if, as wise men believe, noble souls do not perish with the body, rest in peace. Let us honour thee not so much with transitory words but with our reverence; and if our powers allow, with our emulation. That will be the true respect, that the true token of love.

W. H. MAIDLAW.

#### SPONTANEOUS PNEUMOTHORAX.



PONTANEOUS pneumothorax, though not a rare condition, is perhaps sufficiently uncommon for the following four cases recently in the wards under the care of Dr. Hinds Howell to prove of some interest.

This thoracic accident is usually regarded as one of the medical emergencies, yet only one of these four cases required emergency treatment, which unfortunately was unavailing.

CASE I.—E. H., boy, *et.* 15. Complained of cough and pain in the chest. History of present condition: Cough without sputum for three weeks. On day of admission, sudden onset of severe dyspnoea and pain over the lower part of the sternum after a fit of coughing. There was a very strong family history of tuberculosis. Condition on admission: The patient was orthopnoic and cyanosed, with an anguished expression and cold, clammy perspiration. Temperature 98.8° F.; pulse, 116; respirations, 44. Chest: area of cardiac dullness not definable. Heart-sounds best heard to the right of the sternum. On the left side, greatly diminished movement, absent vocal fremitus, hyper-resonance, absent breath-sounds and feeble vocal resonance. There were showers of crepitations over the right side. No bell sound and no metallic tinkling. The patient was put to bed and given a hypodermic injection of morphia (gr. ½). Progress was very favourable for four days, when he had a sudden attack of urgent dyspnoea with cyanosis whilst at stool. He became very restless and was given oxygen whilst a morphia injection (gr. ½). His chest was needled on the left side and air could be heard coming out. Within an hour he had settled down. On the following day he had a similar attack and similar treatment, except that on this occasion

air was withdrawn with the aid of an artificial pneumothorax apparatus. Unfortunately, surgical emphysema appeared, which rapidly spread over the entire body and he died five hours after the onset of the attack. Permission for an autopsy was refused.

CASE 2.—M. H.—, girl, *et. 16*. Complained of cough. History of present condition: Cough and hoarseness of voice for four months, worse during the last six weeks after onset of pain in the right side of the chest. Nine days before admission pain became very severe and she coughed continuously for two hours. Family history: Father with phthisis at home. Condition on admission: Temperature, 100° F.; pulse, 110; respirations, 25. In obvious respiratory distress, *ala nasi* working. Chest: Apex-beat beyond left anterior axillary line, right border to left of sternum. Sounds natural. The right side of the chest looked fuller than the left, but moved much less. On the right side, percussion note "boxy," breath-sounds very faint, but amphoric, and the bell-sound positive. The left side of the chest was apparently normal. The liver was displaced downwards. A week later a succussion splash was obtained. Tubercle bacilli were found in the sputum. The right lung slowly re-expanded, but was not completely so by the time she went to a sanatorium six weeks later.

CASE 3.—G. M.—, man, *et. 49*. Complained of cough and shortness of breath. History of present condition: Chronic bronchitis for twelve years, with moderate sputum. Ten weeks ago, while putting on his braces, he suddenly became very dyspnoic. There was no pain and no increase in his sputum. Later he was seen at the Royal Chest Hospital, where a diagnosis of right-sided pneumothorax was made. Past history: Bilateral pleurisy in 1928. Condition on admission: Patient was a pale, thin man without dyspnoea or cyanosis. Temperature, 100° 8' F.; pulse, 98; respirations, 20. Chest: The heart was slightly displaced to the left, but otherwise normal. On the right side, diminished movement, markedly diminished vocal fremitus, percussion note impaired at the base, hyper-resonant above, breath-sounds faint vesicular. The bell-sound was audible in the interscapular space, but there was no metallic tinkling. Succussion splash was not attempted. The liver was not displaced. The right side was explored and a clear fluid obtained. Sputum, examined for tubercle bacilli, was negative. He gradually improved and was discharged three weeks later. At present he has no physical signs and is gaining weight.

CASE 4.—S. G.—, man, *et. 21*. Complained of shortness of breath and pain in the chest. History of present condition: Sudden stabbing pain in the left side of the chest whilst walking one week ago. It had eased since then, but he had become very breathless. He had a slight cough without sputum after any exertion. For two years he had felt run down with lassitude, anorexia and vague dyspepsia. Past history and family history were negative. Condition on admission: A thin, weakly individual, dyspnoic and slightly cyanosed. Temperature, 98° 4' F.; pulse, 96; respirations, 34. Chest: Symmetrical shape. Apex-beat in fourth right space,  $\frac{1}{2}$  in. from right border of sternum. Sounds natural. Left side of chest, greatly diminished movement, absent vocal fremitus, hyper-resonant note and absent breath-sounds. There was an amphoric quality to the voice-sounds and metallic tinkling was heard. The coin sign, though quite different on the two sides, did not yield a true bell-sound. No succussion splash. Progress was satisfactory, except for an attack of pleurisy without effusion on the right side a month after admission. Within six weeks the lung had completely re-expanded and he now awaits sanatorium treatment.

It will be seen that these four cases vary in a great many respects, and that each individually differs in some degree from the typical text-book case either in regard to the history, physical signs or both. To take only one physical sign—breath-sounds. These we expect, typically, to be absent, yet in two of the above cases breath-sounds were present—vesicular in Case 3, amphoric in Case 2. Text-books lead us to believe that the bell-sound can nearly always be obtained, but it was absent in two of these cases although frequent attempts were made to elicit it. Case 1, alone, had a really acute onset with urgent

respiratory distress, the others showing varying degrees of severity of onset.

Therefore the liability of spontaneous pneumothorax to present marked variability of physical signs must be remembered, and then, when the occasion arises, the condition can be fearlessly diagnosed even though the percussion-note be dull, the breath-sounds present and the bell-sound absent, but always using the position of the apex-beat as a valuable guide.

*Causation.*—The causes of spontaneous pneumothorax will not be fully considered here as any text-book gives an adequate list, but there are two causes which should be emphasized. Experts hold tuberculosis responsible for 80–90% of cases, and in this connection it is interesting to see that there is some factor in each of these four cases, either in the physical findings or in the history, personal or familial, suggestive of a tuberculous origin. In Case 1 the suggestive factor is the family history; in Case 2 tubercle bacilli were actually found; in Case 3 there was a history of pleurisy, and the presence of a hydro-pneumothorax is an additional point; in Case 4 a history of two years' lassitude and dyspepsia, the attack of pleurisy on the opposite side whilst in the ward adding weight to the supposition. The other cause is one which is not mentioned in most of the text-books of general medicine. It is also one which may likely become an even commoner cause owing to the increasing employment of artificial pneumothorax.

Spontaneous pneumothorax may follow or be superimposed upon an artificial one in one of two ways: (1) as a result of puncturing the visceral pleura during an induction or refill, or (2) as a result of the rupture of an adhesion producing a laceration of the visceral pleura and underlying lung substance. In (1), if the needle lacerates the pleura during an induction of artificial pneumothorax the consequences may be serious—from the immediate shock and the later effusion, which frequently becomes purulent. If, on the contrary, the laceration occurs during a refill, subsequent events are likely to be less dramatic as the injured lung is partially or completely collapsed and the wound is smaller. In (2), the tearing of an adhesion, resulting from increased intrapleural pressure during the act of coughing, may lay open a cavity or caseous focus in the lung. If this occurs a fatal pyopneumothorax is probable.

Spontaneous pneumothorax, if due to tuberculosis, is followed in the majority of cases by a hydro-pneumothorax, but only rarely so if of non-tuberculous origin. Only two of the four cases detailed here developed an effusion, but Case 1 died before the time at which one expects an effusion to occur.

## INFANT FEEDING SIMPLIFIED.

Reference to a simple method of infant feeding in an article on "A Year in an American Medical School," published in the September JOURNAL, has aroused considerable interest. The author, Dr. Gaisford, who is Resident Medical Officer at the East London Hospital for Children, Shadwell, has contributed the following notes in response to numerous inquiries as to the exact methods of preparing acid milk.—Ed.



giving somewhat fuller details of the feeding methods employed at the East London Children's Hospital, may I state at the outset that "lactic acid milk" is not regarded as the only form of feeding on which babies will thrive successfully? It was used this year at first as an experiment, and later as a routine, and the results have been eminently satisfactory.

### Essentials for a Successful Formula.

For artificial feeding to succeed, certain essentials must be observed, and failure of any one of these leads to failure of the feeding as a whole.

These essentials may be stated briefly as follows:

1. 50 calories per lb. of expected body-weight per day.
2. 1½ oz. of cow's milk per lb. of expected body-weight per day. (This provides the optimum quantity of protein, and a sufficiency of mineral salts and vitamin B.)
3. Water equivalent to 15% of the actual body-weight per day.
4. Sufficient vitamin A, C and D.
5. Added carbohydrate (of which the optimum is 1 oz. to every 10 oz. of milk).
6. Freedom from harmful bacteria.
7. Digestibility in the quantities given.

Whole lactic acid milk, prepared from pasteurized or boiled milk, with 3 oz. of carbohydrate added to each quart plus a sufficiency of cod-liver oil and fruit-juice fulfils all these essentials, and is therefore a perfectly good formula for the artificial feeding of any normal infant.

Failure to gain weight on an adequate quantity of such a formula nearly always means infection, and should lead to a prompt inspection of the ears, nasopharynx and urine.

### Advantages of Acidifying the Milk.

1. The curds are small, and no further curdling occurs after ingestion.
2. The buffer substances which normally render cow's milk less digestible than breast-milk are neutralized and the digestibility becomes equal to that of breast-milk.
3. The milk keeps better in hot weather.

*Treatment.*—In the milder cases, putting the patient to bed and a hypodermic injection of morphia is all that is required as immediate treatment. In those cases where dyspnoea and cyanosis are more marked intranasal oxygen may be beneficial. In the acutest cases, with a rising intrapleural pressure and increasing mediastinal displacement aspiration of the affected sides is definitely indicated. These cases usually have a valvular opening in the visceral pleura, whereby gas enters the pleural cavity during inspiration but cannot be expelled during expiration. The treatment then is to insert a medium-sized exploring needle into the pleural cavity, having the needle attached to a piece of rubber tubing which is dipping into a bowl of water, placed for preference on the floor or on a low stool. This will act as a safety-valve and air will not be sucked into the pleural cavity during inspiration.

A possible complication is that the second spontaneous pneumothorax closely following the first may be on the opposite side, and in this eventuality immediate diagnosis and treatment is more than ever urgently called for. As with fluid in the chest, the gaseous effusion should be gradually and slowly withdrawn, otherwise severe dyspnoea, paroxysmal cough and frothy expectoration may occur, in addition to the possibility of the wound in the visceral pleura reopening as a result of the sudden fall in intrapleural pressure.

The diagnosis of spontaneous pneumothorax may be a simple or an exceedingly difficult matter, owing to the variability in physical signs and in the immediate effects on different individuals. As happens in pulmonary tuberculosis, the condition may be latent, and only revealed by a careful routine examination or by an X-ray. On the other hand, where the diagnosis is obvious, it may be so catastrophic in onset that minutes wasted may mean a life thrown away.

Finally, if this condition is borne in mind during the examination of the chest, and especially where there are anomalous signs present, the diagnosis of spontaneous pneumothorax would be more frequently, yet correctly, made.

I wish to express my thanks to Dr. Hinds Howell and to Dr. Chandler for permission to publish the notes of these cases, also to Dr. Maxwell for much helpful advice and criticism. R. D. ROBINSON.

4. The acid inhibits the growth of harmful organisms in the milk.

5. Because of the increased digestibility whole milk may be given at any age, thereby increasing the caloric value of the feed and diminishing its bulk.

#### Methods of Acidifying the Milk.

(a) *Cultural*.—By inoculating the milk with a culture of *Streptococcus acidilactici* (or *B. bulgaricus*). This method is not yet generally practicable, though the United Dairies prepare such a milk for the Hospital, and it is hoped that it may soon become a commercial product.

(b) *Chemical*.—One quart of boiled or pasteurized milk is placed in a sterile basin. The milk must be cold.

One teaspoonful of B.P. lactic acid is diluted with an ounce of water and this is slowly poured into the milk with continuous stirring.

To get a uniformly fine curd this procedure takes about ten minutes.

#### Choice of Carbohydrate to be Added.

In adding such a high percentage of carbohydrates it is necessary to employ a mixture of two or more to prevent the occurrence of diarrhoea. To those who can afford it, a proprietary dextrimaltose will do satisfactorily.

Instead of this we have used (a) commercial glucose (which costs about 2½d. per lb.). This consists of a mixture of dextrin, maltose and dextrose in varying proportions, usually with about 35% of dextrin, and does excellently. The syrup is poured into a tablespoon and six spoonfuls mixed with an equal quantity of hot water to lessen the viscosity, and the resultant mixture added to one quart of the acid milk and well stirred.

(b) a powder composed of—

Dextrin	50%.
Dextrose	} aa 25%.
Cane-sugar	

This costs about 9d. per lb.

An equivalent quantity is used (3 oz. by weight to each quart), and when mixed into a paste with a little milk can be rapidly added to the bulk, and then merely requires to be thoroughly stirred in with a spoon or fork.

The formula so prepared is then bottled and kept till required. Before feeding it has simply to be warmed to body temperature.

*Notes*.—Before feeding, the milk must be thoroughly shaken to ensure uniformity of consistence.

The nipple will have to have its hole enlarged till the

thickened mixture flows through at the usual rate. (This may be done with a red-hot needle.)

#### Routine of Feeds.

Lactic acid milk should usually not be fed other than on a 4-hourly schedule, and 5 feeds a day are ample after the third month, except in cases of extreme malnutrition.

a.m.	6. Formula.
	8. 3ss-5j cod-liver oil.
	10. Formula.
p.m.	12. 3ss-5j fruit-juice.
	2. Formula.
	4. Water offered if awake.
	6. Formula.
	8. 3ss-5j cod-liver oil.
	10. Formula.

The antiscorbutic vitamin may be supplied in the form of orange-juice, tomato-juice, or cabbage-water. The juice from tinned tomatoes does excellently and is used as a routine at the Hospital, as it is cheaper than oranges and more palatable than cabbage-water.

The formula described may be used unchanged throughout the first year, though with the addition of other forms of carbohydrate after the sixth month the quantity added to the milk may be decreased to 2 oz. per quart at six months, and 1 oz. per quart at the ninth month. It may be used for all "well babies" and a great many ill ones. To those who say it is impossible to feed all babies on any one stereotyped formula and that every baby is a law unto himself the uniformity of composition of breast milk must take some explaining, for breast-feeding is successful in something like 85% of cases.

#### Volume of Feeds.

Acting on Dr. Marriott's advice we have allowed all "well babies" to take as much of this formula as they will. This, after all, is but common sense, for who are we to decide arbitrarily how much a baby shall have? His appetite will vary from feed to feed, according as he has slept or been active or hot or cold since his last feed. A breast-fed baby seldom takes the same quantity at two successive feeds, and our aim in artificial feeding is to get as near as possible to the conditions existing in the naturally fed baby. The first feed offered is usually 2 oz. more than the age of the infant in months—i. e., a 3-month infant is started on a 5-oz. feed. Subsequent feeds are dictated by appetite; I have seen a baby of 4 months take a 16-oz. feed and go to sleep happily for the first time for weeks! Many of the nutritional

disorders are due to underfeeding—certainly many more than are due to overfeeding.

The formula may be used by itself, or for complementary or supplemental feeds. Babies are perfectly willing to take it immediately after the breast, or before it, or instead of it.

Usually after the sixth or seventh month a baby has acquired a taste for sweet milk, and then the introduction of acid milk meets with some opposition. This is overcome in most cases after starvation for 6-8 hours, when acid milk is taken with avidity.

#### Indications for Altering the Formula.

In cases of diarrhoea of enteral origin the milk should be skimed before adding the acid, and 5% dextrin substituted for the usual carbohydrate mixture.

In parenteral diarrhoea (e. g. that due to acute otitis) there is no indication for any radical change in the formula, but the quantity of feed offered should be diminished on account of the lessened gastric juice secreted. With the subsidence of the primary infection the diarrhoea will cease spontaneously.

In Canada many paediatricians prefer to use orange-juice to acidify the milk, and a favourite routine formula (for use specially in complementary feeds) is—

Milk	. . . . . 7 tablespoonfuls.
Water	. . . . . 3 "
Sugar	. . . . . 2 teaspoonfuls.

Mix and boil. When cool add 3 teaspoonfuls of orange-juice and stir thoroughly. We have found this to be well taken but to cause rather coarser curds than the lactic acid.

To those interested in the subject of infant feeding may I commend Marriott's *Infant Nutrition* (Kimpton) and Goldbloom's *Care of the Child* (Longmans, Green & Co.)?

In concluding these brief notes I should like once more to acknowledge my great indebtedness to Prof. Marriott, Chief of the Children's Hospital in St. Louis, where the essentials of the technique outlined above originated, and to express my thanks to the Staff of the East London Hospital for Children for having allowed some 150 infants to be fed by his methods.

WILFRID GAISFORD.

#### ACKNOWLEDGMENTS.

*The British Journal of Nursing—The Clinical Journal—Les Echos de la Médecine—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital—The Kenya and East African Medical Journal—The League News—The Medical Journal of Australia—The Nursing Times—The Post-Graduate Medical Journal—The Queen's Medical Magazine—St. George's Hospital Gazette—St. Mary's Hospital Gazette—The Speculum (Melbourne)—University College Hospital Magazine.*

## SCHLATTER'S DISEASE BEFORE AND AFTER SCHLATTER.

AN EPONYMIC NOTE.

**T**HE fascinating rarity of Schlatter's disease ensures for its proprietor a conscientious biography from his orthopaedic surgeon, a delighted welcome from the careworn examiner, and the speculative interest of the philosophically-minded student. Knowledge of its natural history remains nevertheless as meagre and conjectural to-day as it was twenty-seven years ago, when the first account of the disease was published.

What is known in this country as Schlatter's disease was independently described in the early part of 1903 by Robert B. Osgood of Boston and by Karl Schlatter of Zürich. Osgood's paper, dated January 29th, appeared in the *Boston Medical and Surgical Journal* (1903, cxlviii. 114) under the title "Lesions of the Tibial Tubercle Occurring during Adolescence," the article being illustrated by a series of radiograms. The author's conclusions were as follows:

"The adolescent tibial tubercle, from its situation and mode of development, is susceptible to injuries, especially in athletic subjects. These lesions are usually caused by a violent contraction of the quadriceps extensor. Fracture and complete avulsions of the tubercle are rare, cause loss of function, and are easily diagnosed, usually clinically and always by means of the X-ray. Avulsions of a small portion and partial separation of the tubercle are more common. They do not cause complete loss of function, but without treatment, long continued, serious annoyance. The diagnosis should be made by a combination of the clinical and X-ray pictures, and before the latter are accepted both knees should be skiagraphed and accurate technique observed."

Schlatter's paper appeared in May of the same year in the *Beiträge zur klinischen Chirurgie* (1903, xxxviii. 874) with the title "Verletzungen des schnabelförmigen Fortsatzes der oberen Tibiaepiphyse," and was also illustrated by X-ray photographs. Schlatter showed that the date of appearance and of fusion of the epiphysis varies greatly with the state of development, constitution, and race of the individual. In the majority of cases the epiphysal process originates in a bony nucleus lying upon the tuberosity. The point of junction with the epiphysal plate forms a *locus minoris resistentiae* where negligible violence may produce a solution of continuity. The disease affects chiefly males between the ages of twelve and seventeen, and in the author's cases the right knee was involved in seven cases, the left only in one. The disease is produced by a fall on the knee or by indirect violence such as the muscular pull of the quadriceps. Pain in the knee, long-lasting rather than intense, may at first be negligible, so that the patient has difficulty in dating the onset of the disease. Functional disturbance is only slight,

although muscle atrophy may result from disuse. Pressure on the tubercle, which may be very prominent, produces pain.

In a second paper, published five years later in the same journal (1908, lix, 518) under the title "Unvollständige Abrissfrakturen der Tuberositas tibiae oder Wachstumsanomalien?" Schlatter confirms his earlier view of the traumatic nature of the lesion, while carefully disowning cases of complete separation of the epiphysis. The gross physical signs and the dramatic history of these latter cases had already in the pre-Röntgen days attracted the study of surgeons, headed by Müller in 1888 and duly chronicled by Poland in 1896 (*Traumatic Separation of the Epiphyses*, London, 1898, ch. vi, 816).

While both Osgood and Schlatter favour trauma as the main aetiological factor, others have invoked the influence of an inflammatory process, or of a constitutional disturbance showing itself in a tendency to spontaneous incomplete fracture and epiphysis—"lockerung," most frequently of the tubercle of the tibia.

The credit for the classical description of the disease as a clinical entity belongs to both Osgood and Schlatter, wherefore the name Osgood-Schlatter's is preferable to Schlatter's disease, and this name, dictated by historical and alphabetical justice, has been adopted by the *Quarterly Cumulative Index Medicus*.

The history of Osgood-Schlatter's disease began in 1903, the history of "strain or partial separation of the tubercle of the tibia" at an earlier date. An intelligent search through the records of surgery would inevitably yield some hint of a description. The casual reading of *Studies of Old Case-books*, published in 1891, on the evening of seeing a case, revealed that Paget at least had not failed to observe it.

"Much more common," he writes in the chapter on 'Periostitis following Strains,' "are the enlargements of the tubercle of the tibia which are often seen in young people much given to athletic games. They complain of aching pain at and about the part, especially during and after active exercise, and the tubercle may be felt enlarged and is often too warm. The pain often continues, more or less, for many months, and there may be enlargement of the bursa under the ligamentum patellae, and the tubercle may remain too prominent; but common as are these cases, especially in our public schools, I have never known grave mischief ensue in any of them, and they get well of themselves. They may represent one of the least degrees of periostitis due to strain; the increase of the prominence of the bone is only just beyond that which may be deemed the normal limit for the attachments of vigorous muscles."

Paget clearly knew the condition well. Perhaps a little leisure, or the call of an editor for an article, certainly the sight of a radiogram, would have linked yet another disease with his illustrious name.

By such threads of circumstance hangs eponymic immortality.

W. R. BETT,  
ALFRED FRANKLIN.

## MUSEUM MUSINGS.

**I**N the course of a medical career many sights and experiences imprint themselves indelibly on one's memory, but perhaps one of the most vivid is one's first glimpse of the Pathological Museum. It is difficult to forget how (having recently crossed the Rubicon of the Second Examination, or even having deserted, out of curiosity, the mysterious organization of the batrachians and lower mammals) one stole diffidently into the vast building and stood and gasped in sheer wonder. That first glimpse is apocalyptic. With exactly such breath-taking awe do people gaze, for the first time, at the mighty waters of Niagara, or the ice-bound peaks of the Himalayas.

What an epic of disease! What an apotheosis of human suffering—of pain and fear and despair; of lonely vigils in the night; of the anguish of suspense—a tale of woe surely Dantesque in its magnitude!

Where also is the mighty statistician to record the leagues of catgut used in countless operations, or the sea of flavine and paraffin, the number of square miles of gauze, or the volume of invective shed by how many perspiring surgeons?

One can but sit and ruminate (instead of diligently applying oneself to one's work) on the manifold aspects of human joy and sorrow. One is struck by the fact that there is immortality—of a kind. There is no such thing here as total extinction, although, maybe, it is chiefly our weaknesses which are perpetuated. Here, for example, is a monument (in the shape of a "hob-nailed" liver) to a man who loved strong drink, and here an aortic aneurysm of a man who lived not wisely but too well. Here, too, is the gall-bladder of a famous surgeon in which was found the greatest number of stones ever recorded! Mankind longs for immortality. It is a fundamental aspiration which is forever at the back of human consciousness in all its phases. Thus, the poet sings:

"We seek the City of God and the haunt where beauty dwells,  
And we find the noisy mart and the sound of burial bells.  
" . . . Friends and loves we have none, nor wealth nor blessed abode,  
But the hope of the City of God at the other end of the road."

Even the lurching inebriate, responding to the last faint urge of a rapidly-dimming consciousness, must faint sing:

"And when I die, don't bury me at all;  
Just pickle my bones in alcohol."

And what cares Nature for the sanctity of human life? Alas, poor foetus! Perhaps, had the Fates been more propitious, the world would have gained a great

warrior or a great poet. Let us indeed mourn thee as a "mute inglorious Milton," or a "Cromwell guiltless of his country's blood!"

Sooner or later in one's passage to Olympus, one realizes that one is not so much in a Museum as in an art gallery. Who has not seen a learned pathologist crooning over his favourite specimen, or shedding maudlin tears over a beautiful infarction of the spleen or rare psammoma of the brain (whatever that may be)? And I believe that people have come great distances to see the original specimen of carcinoma of the nipple, described by Paget, in exactly the same way that others travel to Italy to see the exhibition of the great Italian Primitives! Thus is a horrid cankerous growth metamorphosed into a thing of great beauty when removed, covered with alcohol, and "hung" in its appropriate corner. For does not the very essence of all beauty lie in appropriateness in time and space? The Museum further resembles an art gallery in its general atmosphere of quiet and repose. If only those hard stools could be replaced with something more comfortable! Ah! how one could sit and meditate to one's heart's content, and what refreshing intervals of sleep . . . !

The Museum is also a memorial to the never-ending progress of the Science of Medicine. One cannot, for instance, help comparing the extremely primitive truss (shown in one case) "used by Arabs on the White Nile" with the highly efficient appliance of to-day; while such archaeological relics as cupping glasses, and "bongies consisting of waxed paper rolled on a central core," fill us with reverent but unmistakable mirth. So also do such exhibits as "Bone Surgical Syringes (circa 1550, dug up in Shoreditch)" and "portable candlesticks for ward use."

It is interesting to note that although times and methods change, pathology changes but little, and medical students not at all. Thus, we are told, the monaural wooden stethoscopes, still used occasionally, evolved gradually from the Laennec type, which was cylindrical. The gradual "slimming process" was the result of successive scrapings with pocket-knives while students were waiting for tardy lecturers. In these days of binaural stethoscopes this is no longer possible, and so the restless, slightly destructive energy which every medical student possesses in some degree is utilized in carving initials and caricatures on the benches of the Anatomical and Medical and Surgical Theatres. Perhaps here, too, one may discern that longing for immortality aforementioned! How one's bosom swells with pride on moving to the opposite side of the Museum to behold the imposing array of electric ophthalmoscopes and specula shown by courtesy of the House of Arnold!

The Pathological Museum contains many such fascinating little corners if one chooses to go a little off the beaten track. It is a positive treasure-house for those interested in materia medica, while for the would-be comparative anatomist there are skeletons of cormorants, pelicans, alligators and orang-outangs. However, there are still those who cling to the old-fashioned belief that the primary use of the Museum is to gain a knowledge of pathological processes sufficient to satisfy an obsessed but, alas! omnipotent Board of Examiners.

JOHN LANDON.

## PLARR'S LIVES.\*

"Each man according to his capacity or understanding may reap commodit' out of it." *Montaigne*.

**A** NEW book has got itself somehow on to our bookshelf of late, having sidled its way into a space that we had hardly noticed between Munk's *Roll of the Royal College of Physicians* and the long, scarred regiment of the D.N.B. *Plarr's Lives of the Fellows of the Royal College of Surgeons of England* is its imposing title; *Plarr's Lives* will be its name.

It is fitting that Victor Plarr should be thus commemorated. As Librarian to the College he had begun in 1912, at the suggestion of Sir John Bland-Sutton, to collect material for a biographical record of the Fellows, and had continued in this enterprise until his death early in 1929. His notes have been revised, his references amplified, his manuscript re-arranged, yet the spadework and the credit remain essentially his. This by no means belittles the reviser's work; it is as true to say that without the long and careful labour of Sir D'Arcy Power, present Honorary Librarian at the College, and of his assistants, Mr. Walter G. Spencer and Prof. Gask, the manuscript would have remained unpublished.

The Order of the Fellows owed its institution in 1843 to Sir Benjamin Brodie, who, in the second generation of the Hunterian tradition, was "great enough to combine the science with the art of surgery." The Order, as its founder intended, has ensured "the introduction into the profession of a certain number of young men who might be qualified to maintain its scientific character." Some of these "young men" cast their shadows—should it be their light?—over two or three

\* *Plarr's Lives of the Fellows of the Royal College of Surgeons of England*. Revised by Sir D'ARCY POWER, K.B.E., F.R.C.S., with the assistance of W. G. SPENCER, O.B.E., M.S., F.R.C.S., and Prof. G. E. GASK, M.C.G., D.S.O., F.R.C.S. Thelwall Thomas Memorial. Printed and published for the Royal College of Surgeons by John Wright & Sons, Ltd., Bristol, 1930. Two volumes, pp. xxvi+752, 596. Price: Cloth 42s. net; half bound, 57s. 6d. net.

pages, just measure of their influence in life. Some are consigned by hard fate to a six-line summary, for the price of the four letters after their names and the sake of completeness. Yet, great and small, they had the bond of the Fellowship in common; and whether they practised surgery with success or failure, or whether they forsook her utterly, between them they have achieved a high and honourable record. The history of the lives and the achievements of the Fellows is the history of modern British Surgery.

Such a book as this, difficult as its begetting must have been, presents its problem also for the reader. A dictionary or a catalogue decently reposing on the shelf marked "for reference" is a simple matter. This is a catalogue and dictionary that is also a book. Should you, in Samuel Butler's analogy, "eat grapes downwards—that is always eat the best grape first"? Or should you with an air of politeness chew through the cluster in the order in which Nature (the nature of the alphabet) has disposed them? It is as though you should arrive in some foreign city, knowing a few inhabitants, bent on knowing all. Shall you haste to call upon your old friends first, or march along the main highway, solemnly knocking at each door in turn? The temptation to be polite and solemn—a grave one in this matter of distinguished surgeons—must be overcome. It is best to wander through the noisy thoroughfares or the back alleys of history, with your inclination as your guide.

Here you will find the noble figure of Sir James Paget, who still holds the greatest fascination for the students of his School; Sir Thomas Smith, the hero of a hundred quips; Bowlby, whom all men delight to honour. Leave your Chauvinism, and here you can con the great ones of other schools—Brodie, Pridgin Teale of Leeds, Syme of Edinburgh, and, above all, Lister, of whose work there is a useful summary. Here the student can learn the recent history of his craft. Names, which are for him the names of instruments, will expand into the personalities of those who made them. The routine practice of the day takes on fresh interest and loses its rigid hold for him, who knows of the battles fought and won for its establishment. Here in this assemblage of medical fates you will read your own: you may well wonder on which page.

History repeats itself, quotes Philip Guedella, historians repeat each other. The Royal College of Surgeons has provided a dangerous weapon for historians in publishing a book so eminently quotable. In future every nineteenth century surgeon will have about him the touch of Plarr. It was inevitable that in the telling of these tales of men so lately dead, some inflection of the obituary manner should be audible.

Yet what distinguishes the work is the fact that so much of the writing is based on personal knowledge. The personalities of the Fellows are allowed to stand out in a way unusual in biographical dictionaries. This is the secret of the book's success. A. F.

## STUDENTS' UNION.

### ASSOCIATION FOOTBALL CLUB.

At the Annual General Meeting held on May 16th, 1930, the following officers were elected for the season 1930-31:  
*President.*—W. H. Hurlley, Esq., D.Sc.  
*Vice-Presidents.*—Sir Charles Gordon-Watson, F.R.C.S., R. Foster Moore, Esq., F.R.C.S., A. E. Gow, Esq., M.D.  
*Captain.*—C. A. Keane.  
*Hon. Secretary.*—H. J. Roache.  
*Captain 2nd XI.*—R. E. Owlett.  
*Hon. Secretary 2nd XI.*—D. R. S. Howell.  
*Captain and Hon. Secretary 3rd XI.*—H. Kassim.  
*Committee.*—R. G. Gilbert, W. Hunt, A. W. Langford.  
 Honours for season 1929-30 were awarded to—  
 R. A. Wenger, J. Shields, R. MacGladdery, F. E. Wheeler, C. A. Keane, H. J. Roache, A. W. Langford, R. Shackman, R. G. Gilbert, C. M. Dransfield, W. Hunt.

### HOCKEY CLUB.

We welcome all freshmen and ask those who would like to play hockey this season to sign the paper on the notice-board in the Abernethian Room. There will be a trial game at Winchmore Hill on Saturday, October 4th. Full fixture lists have been arranged for three teams, so it is hoped that everyone who wants to play—including those who would like to begin—will be able to get a game at least once a week. E. W. Burstal and C. Fletcher are Hon. Secretaries of the 2nd and 3rd XI's.

In the 1st XI we shall still have with us eight members of last season's team, including H. L. Hodgkinson (captain), P. M. Wright (match secretary), and F. C. H. White and L. P. Jameson Evans, who are on the selection committee. We shall sadly miss W. F. Church, who has played for us at centre half for the past three years, and to whose unselfish play and leadership we owe so much, and also E. J. Neil and A. G. Williams, who have both been in the team since 1926; we shall indeed be fortunate if we can find three players worthy to take their place, to help us keep the cup they won last year. J. H. H.

### UNITED HOSPITALS HARE AND HOUNDS.

Now that the athletic season has drawn to a close, it is not inappropriate to say a few words about that rather underrated pastime cross-country running. Year after year, on the track, our team always seems to be relatively weak in the longer distances—1 mile and 3 miles. Of course one obvious reason is, that it is so much more tedious running twelve times round a cinder track, than sprinting 300 yards. But in spite of this, there are many men who would take up these races were it not that they find they cannot last the distance, even though they have trained the twelve circuits. They then assume that they will never make long-distance runners, go in for the shorter distances for which they are less suited and never excel in any.

The truth of the matter is that the necessary stamina for 2, 3 and 4 miles cannot be picked up on the track—track training is rather to acquire speed. A good season of cross-country running would give these people all the stamina they require. All the best long-distance track runners of to-day run over the country during the winter.

As an essentially winter sport it is not to be beaten in England. One never has to scratch a run because the ground is too hard, while

the heaviest rains or snows make it all the more enjoyable. There is no other way of making oneself so physically fit, if one trains judiciously and steadily. Finally, added to all are the rural surroundings. The United Hospitals Hare and Hounds course, at Hayes, Kent, is one of the prettiest, right away from houses, arterial roads, etc. It follows the classical description—blackberries in the early season, occasional rabbits, and a liberal sprinkling of "plough," while the "hot baths" at the finish are unique.

To the prospective beginner it all sounds very fatiguing and monotonous, but this is not so. In the runs at the beginning of the season, when no one is fit, the pace is never too fast for the slowest, and all run at their own speeds. Cross country running should never be fatiguing when one is just training. It is only when one races that one becomes exhausted, and no one need race for the club who does not want to do so. Training runs are always held, whether there is a race or not.

Finally, very little equipment is necessary. A pair of plimsoles and rugger shorts and vest are all that are required. There is no subscription of any sort, and the fares are cheap—6s. 10d. return. Every Wednesday about 1.30 p.m. a party of us meet in the Abernethian Room and usually catch the 2.1 p.m. train from London Bridge. There is an excellent return service from Hayes. All those men at all interested in cross-country running are asked to get in touch with either H. B. Lee or J. K. Strong. All details of fixtures and trains will be put up on the Athletic Board in the Abernethian Room. J. R. S.

### AMATEUR DRAMATIC SOCIETY.

The Amateur Dramatic Society will present their annual entertainment in the first week in January.

All members, and others who are interested, should watch the notice-board for announcements of meetings and rehearsals. C. K. V.

## CORRESPONDENCE.

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

### FIFTY-THREE YEARS AGO.

DEAR SIR,—Recent articles on 50 years ago at Bart.'s stir my own recollections.

I had taken my B.A. and M.A. in Science—in the Queen's University, Ireland, in 1875 and '76—but I could find no employment worth having. It was pointed out to me that I had amply covered all the early scientific courses in medicine and had better take my M.D. I had also been Captain of the XV and of the cricket XI for three years, and a new sphere seemed desirable. So I went to Bart.'s.

I arrived late one night and made my way to the Dean's house. Soon there appeared a figure in a long robe and a pair of high furred boots. This was Norman Moore, with whom I eventually became very friendly. He found my head reeling from sea-sickness I had fought down—knowing no better. So he gave me the pill that is blue and a shake down. But I had then to go into rooms at Islington—none empty in Bart.'s—and of these rooms I recall parties in which the Lintys (later I.M.S.) and Dorman (A.M.S.) joined. And of my landlady a notable saying. It had been snowing and this good cockney said: "Oh, Sir! the hicc his hover the 'orses 'ooofs." But that's merely by the way.

In the surgical theatre one day there appeared a distinguished Frenchman. He was introduced to Smith on Bart.'s Staff. "Oh," said he, "I do know de name of Smid." Said our man—"Yes, that's Smith of London. I'm Tom Smith of Bart.'s."

At one time I was P. M. Clerk to Wickham Leggs—a good-looking man with a splendid set of teeth. It was my duty to make a record of a certain suicide who had jumped from the Whispering Gallery in St. Paul's. I was looking at the place a few days ago and an old verger recalled the incident. This poor man had landed on the centre one of three chairs, the two others being occupied by dear old ladies. One can realize their shock! I found one of the upright pieces of the back of the chair had gone through his heart, but curiously enough he didn't seem very much broken up otherwise. Another of my preceptors was Morant Baker. I was quite fond of him and his geniality. His *Physiology* was a delight to me, and

when I had mastered it I spent the whole of one night in a run over, going to my bed about 6 a.m.

In those days, '77 to '79, we had three XV's, and I was full back of the first. Before crossing from Ireland I had played for Munster and Ulster. My badge lately turned up in an old box—three golden crowns on a blue shield and this on a white jersey. I looked double the size that I did in black, and our badge was then of wire that tore our adversaries' faces sadly. Against a team called the "Wasps" I had a curious experience. I tackled the enemy on the goal line and we had a "Maul in goal"—which I was told I won. I say "I was told." The game stopped a few minutes later. In the dressing-room I suddenly stood up and said, "Where am I?" Taylor our captain got up and put his hand on my chest and I hit him nothing much—and he told me I had been hurt, and the cold tap was brought into action. I never could recall the maul, nor our leaving the field. Consciousness was in abeyance, and it is a nice point as to what happens in brain-cells in such cases. Their action in recording as they do a multitude of trifles we are not "conscious" of must be temporarily suspended. I had no subsequent trouble except that exactly a week later I was suddenly and violently sick.

In 1879 I took my M.D. in the Queen's University—now extinct as such—and then joined the A.M.S. under a new warrant that seemed to promise everything. Norman Moore warned me against it, but I had had at least eight years' very stiff brain work, in spite of lots of football and cricket. As to the A.M.S., now termed R.A.M.C.\* I will merely say this: If you desire to join the Army, do so as a combatant officer and never get trapped in a department. If you desire to add professional study to the heroic scenes of war, then join a firm that will allow you to go off to every war everywhere. Except that I try and follow the leading ideas in professional work—as a scientific pleasure—as in reading Langdon Brown's *Physiological Principles*—I now seldom see a ward. But of this I feel sure. Were I, in my next incarnation, to be put to medicine, I would ask (if I remembered) to be allowed into the wards from the very outset. I am a firm believer in subconscious cerebration, and I should like that, from the first day, practical work should sink into my mind, to be read up later. It is more akin to the old apprentice system. I will not argue on the point and take up your space further than this—that it is "thinking" and not parrot knowledge that serves the mind. One half hour a day—perhaps one case only. Another half hour in note-making and reference. In my opinion this is of inestimable value at the outset. I am aware it is not the present system, but I claim support from an recent article in Bart.'s JOURNAL. It says Dr. Langdon Brown believes medicine to be an art best practised at the bedside.

I think I may permit myself to add that my marks at the Entrance Examination for the A.M.S.—ninth place out of 80—were the same as those of the first place for the I.M.S.—on the same paper in November, 1879. So Bart.'s must have taught me something!

Yours etc.,  
 T. M. CORKER.  
 London, W.;  
 September, 1930.

## REVIEWS.

CONGENITAL CLUB-FOOT (TALIPES EQUINOVARUS). By E. P. BROCKMAN, M.Ch., F.R.C.S. (Bristol): John Wright & Sons, Ltd., 1930. Pp. viii + 110. With 92 illustrations. Price 10s. 6d. net.

The history of congenital club-foot is a curiously erratic chapter in the story of medical endeavour. Never at any time has it seemed quite able to make up its mind between half-hearted manipulation and destructive or constructive surgery. The immense literature of the subject (of which the author gives a pleasing and admirably critical survey) goes back to Hippocrates, who formulated the mechanical theory which has hypnotized the profession. In 1839—pre-Listerian days, when open operations jeopardized limb and life alike—W. J. Little, himself a victim of the deformity, introduced into this country subcutaneous tenotomy of the tendo Achillis as a method of treatment. The reputation of this operation soon became tarnished, for enthusiastic surgeons carried it to extremes. In 1864

\* Those who desire to know my views as to the R.A.M.C. may deduce them from my letters to the *British Medical Journal*, published May 2nd, 1925, p. 881, August 8th, 1925, and July 31st, 1926.

the Royal College of Surgeons stimulated new and important research by choosing as the subject for its Jacksonian Prize Essay, "Club-foot: Its Causes, Pathology and Treatment." The prize was awarded to William Adams for his now classic essay.

The position of congenital club-foot in the enlightened days of modern surgery is hardly one of confident esteem or well-merited glory. For its aetiology is as obscure as its pathology and to our therapeutic contributions to our knowledge of its pathology and to our therapeutic armamentarium are welcomed. The monograph for review presented is agreeable to the eye and worthy of its publisher. It represents work done by the author in the Orthopaedic Department at St. Thomas's Hospital. Its value was appreciated by the British Orthopaedic Association, which awarded it the Robert Jones Medal in 1928.

The author recognizes three varieties of the deformity: a common variety occurring in otherwise normal infants; a rarer type in which there is failure of development of the limbs; and a very rare and exaggerated variety associated with absence of the tibia and some of the toes (arthrogryposis multiplex congenita of Stern). His new aetiological theory of the deformity is interesting, for it links congenital club-foot and congenital dislocation of the hip in one category; the deformity is caused by a failure in development of their normal state of all the tissues of the foot, independently of any intrinsic influences, resulting in congenital subluxation of the head of the astragalus in an imperfectly formed acetabulum. The scaphoid and sustentacular portions of the socket are normal, but the portion formed by the inferior and internal calcaneo-scaphoid ligaments is deficient.

The chapter on treatment is well and incisively written. In infants repeated manipulation combined with fixation of the foot in plaster in the intervals should be started seven to ten days after birth. The author deprecates the custom indulged in by many surgeons of allowing mothers to manipulate their children. After six months, the manipulation should be done under anaesthesia, if necessary with the Thomas wrench. If manipulation fails to cure the deformity, open operation (lengthening of the contracted muscles and enlarging the acetabulum) is preferable to subcutaneous tenotomy. Bone operations are confessions of failure. Mr. Brockman has produced a work which will take high rank in the literature of the subject. The value of the book lies in its critical evaluation of existing theories and opinions, its interesting suggestions evolved from a careful comparison of normal and abnormal conditions, and the number and beauty of its illustrations. The book will prove popular with students, housemen and orthopaedic surgeons.

**INSOMNIA: AN OUTLINE FOR THE PRACTITIONER.** By H. CRICHTON-MILLER, M.A., M.D. (Edin. and Pavia). (London: Edward Arnold & Co., 1930.) Pp. xi + 172. Price 10s. 6d.

This is a book which should well repay the attention of both student and practitioner. After dealing briefly with the general considerations of insomnia, the author very soon commences to bring home to the reader what so many realize in a vague way and so few act upon in a practical manner, namely, the importance of the psychological side of insomnia. In dealing with the general treatment of insomnia Dr. Crichton-Miller stresses the great value of muscular relaxation and of attention to the circulatory system. As regards diet, the author ridicules the idea of a special diet for the insomniac; he also writes with no little sarcasm on an old friend, the glass of hot milk, in its time-honoured rôle of soporific. The chapter on Medicinal Treatment is most valuable. The method of administration of hypnotics is a matter that rarely receives more than scant consideration, yet the importance of this side of treatment is clearly shown. The advice to have a thorough knowledge of a few drugs is good, especially as the advent of a new hypnotic is now an event of almost daily occurrence.

The remainder of the book deals with the psychological side of insomnia. The author does not approach the subject biased by any particular school of psychological thought, but gives a general consideration to the views of each school. In a book of this nature, intended as it is for the busy practitioner with little enough time for reading, the subject cannot be treated in detail, but for those who desire to pursue the subject further a carefully considered bibliography is provided. The author deals with psychotherapy, but only with its possibilities, and few would care to adventure into the wide fields of psychotherapy having only such brief instruction as is provided here. Nevertheless this chapter should achieve the author's purpose, namely, to stimulate the general practitioner to

a more thorough and sympathetic consideration of what may be accomplished by the use of psychotherapy.

The book concludes with outline records of nine illustrative cases. It is pleasing to see that the cases are selected at random, and do not present a series of nine miraculous and instantaneous cures by the use of psychotherapy.

**MODERN INFANT FEEDING.** By BERNARD MYERS, C.M.G., M.D., M.R.C.P. (London: Jonathan Cape, "The Modern Treatment Series," 1930.) Pp. 160. Price 5s.

Although the results obtained by breast-feeding are far better than those of any artificial method, it appears that the emancipation of women has been accompanied by an increasing inability or psychological unwillingness to adopt the better method. There is, therefore, a real need for sound knowledge of the best artificial methods. This little book is clearly and concisely written; it deals fully with the normal child as well as with the commoner digestive upsets of infancy. The practical side of the matter is always kept in view, and the book will prove particularly useful to the general practitioner.

**THE TREATMENT OF CHRONIC ARTHRITIS.** By A. H. DOUHWAITTE, M.D., F.R.C.P. (London: Jonathan Cape, "The Modern Treatment Series," 1930.) Pp. 127. Price 5s.

This volume contains within small compass an admirable review of the present state of knowledge and opinion concerning this difficult subject. Osteo-arthritis, rheumatoid arthritis, infective arthritis and gout are dealt with in turn, the treatment being in each case preceded by a brief account of the pathology and clinical features. The degree of importance which is to be assigned to focal sepsis in each of these conditions has been the subject of a good deal of controversy in recent years. It is recognized that focal sepsis may produce multiple arthritis without any additional factors. This type is labelled "chronic infective arthritis" and is cured by eradication of the offending teeth or tonsils. In rheumatoid and osteo-arthritis metabolic and degenerative factors are respectively described as primary, and focal sepsis, which often coexists and certainly aggravates the condition, is regarded as subsidiary and incidental to the main condition. The pendulum seems to be swinging back to the "rheumatic diathesis." It also appears that we are again beginning to regard gout as a common disease. The chapters on treatment are explicit, and will amply repay careful study. The publishers are to be congratulated upon the attractive appearance of this series. The price we regard as reasonable.

**THEORY AND PRACTICE OF NURSING.** By M. A. GULLAN, Sister Tutor, St. Thomas's Hospital. Third edition. (London: H. K. Lewis & Co., Ltd., 1930.) Pp. xvi + 246. Price 9s.

This book gives a condensed and accurate summary of the elements of physiology, dietetics, administration of drugs, gynaecology, fevers, and heart and lung diseases, as well as a concise but very complete account of medical and surgical nursing. Blank pages for additional notes are provided at the end of each chapter—a useful feature. Metabolism of proteins, carbohydrates and fats is made clear by three coloured diagrams, which greatly simplify this complicated subject. The book can be confidently recommended to nurses, and the chapters on baths, spongings, packs, enemata, artificial feeding and lavage contain much information which the student who intends to take up general practice would do well to master.

**THE DIAGNOSIS AND TREATMENT OF HEART DISEASE: PRACTICAL POINTS FOR STUDENTS AND PRACTITIONERS.** By E. M. BROCKBANK, M.D. (Vic.), F.R.C.P. Sixth edition. (London: H. K. Lewis & Co., Ltd., 1930.) 35 illustrations, including 3 plates. Pp. xiii + 235. Price 7s. 6d. net.

The sixth edition of this little book contains alterations and additions to the chapters on clinical examination and added chapters on angina pectoris and aneurysm. The arrangement of the headings is particularly clear, and the style all the way through is refreshingly lucid. The final-year man may be a little impatient of passages such as the rather naïve explanation of polyuria in granular kidney—that "the . . . excreting cells are inefficient and have to work during the night as well as the day in order to get rid of the urea"; but there is little that cannot be followed with advantage by the average student who has attained his "stethoscope ears," and some value of news and value to the practitioner of several years' standing.

There are one or two particular criticisms that occur to one, such as the omission to mention the occasional "silent gap" in blood-pressure recording, and the failure to stress the disappearance of the presystolic murmur during auricular fibrillation in mitral stenosis.

The chapters on treatment and on examination for life assurance are of value; the latter may be considered as a dissertation on prognosis in heart disease, and as such will be welcome to those who find this the most difficult aspect of cardiology, as indeed it probably is.

On the whole, the book is perhaps most suitable for those who are as yet not far advanced in their clinical studies.

**COTTAGE HOSPITALS.** By F. M. DUPLAT-TAYLOR, M.Inst.C.E., JOHN COLERIDGE, F.R.I.B.A., and J. J. ABRAHAM, M.D., F.R.C.S. (London: Ernest Benn, Ltd., 1930.)

Many things are claimed to "supply a long-felt want," but this book does really give us something we have needed for some time, although we may not have been conscious of any particular "want."

The modern cottage hospital is often quite an imposing building, equipped with all modern requirements and capable of carrying out a vast amount of vitally important work. But only those who have been through it know the amount of toil and trouble that the planning and establishment of a cottage hospital entails. To give all interested people a basis for discussion and for making plans, this book has been compiled jointly by a surgeon, an architect and an engineer, and the result is a small compact volume which will serve admirably as a book of reference upon practically every point concerning cottage hospitals. The questions of sites and buildings, water supply, sewage disposal, lighting, heating, cooking and general planning are dealt with in a series of useful notes. A special chapter is devoted to X-rays. Surgical equipment, the operating theatre and its accessories, with lists of instruments and other requirements, make up another chapter, and the book concludes with "general equipment," among which there is found room for useful notes upon "food waste" which every member of a hospital committee will appreciate. An adequate index and several plates giving clear plans of typical hospitals complete a book which should attain a wide sphere of usefulness.

**ROSE AND CARLESS' MANUAL OF SURGERY.** By C. P. G. WAKELEY, F.R.C.S., and J. B. HUNTER, M.Chir., F.R.C.S. (London: Baillière, Tindall & Cox, 1930.) Pp. 590. Illustrated. Price 30s. net.

This edition, the thirteenth, decked in letters of gold, instead of the sombre black of its predecessors, has been thoroughly revised by its band of contributors, which includes Dr. Carnegie Dickson on Pathology, Mr. Negus on Ear, Nose and Throat work, Mr. Eardley Holland on Gynaecology, and Dr. Hadfield on Anaesthetics; Mr. Bishop Harman has written on Affections of the Eye. Tropical Surgery, by Sir Frank Powell Connor, is given a chapter to itself—an innovation which we feel will be popular with its readers. The illustrations, on the whole, are good, especially the coloured plates of bacteria; but while we dislike parting with old friends, we feel that many might have been replaced by more modern drawings with advantage.

The text indicates truly the modern trend of surgical opinion on most subjects, but many urologists would disagree with the authors when reading that *tuberculosis testis* usually begins in the *globus major*, and no mention is made of "excretion urography." Perhaps the authors feel that this advance in methods of investigation is, as yet, unproven. The section on Blood Transfusion is good; that on the treatment of Varicose Veins is decidedly scanty, insufficient detail being supplied to be of any practical use. The *pros* and *cons* in the use of radium and X-rays for cancer have been carefully dealt with, and the authors may be congratulated upon giving a reasoned statement of modern views. The method of treatment of carcinoma of the breast, rectum and tongue by radium needles is outlined and illustrated by simple but clear diagrams. The radiographic supplement has been cut down to forty-three plates, and although their excellence of reproduction has been maintained, we feel that they would serve a more useful purpose if they were included in the text itself.

The index is both full and accurate, and references to original papers are scattered throughout the work.

While this seems an excellent book for students as a manual of surgery, its appeal to practitioners would be greatly increased if more detail as to treatment and prognosis had been included.

**A SHORT PRACTICE OF GYNAECOLOGY.** By HENRY JELLETT, M.D., F.R.C.P.I., and RICHARD TOTTEHAM, M.D., F.R.C.P.I. Sixth edition. (London: J. & A. Churchill, 1930.) Pp. x + 525. Four plates, 360 illustrations. Price 32s.

This is an attractive and well-written text-book, up to date and beautifully illustrated. Clinical features and treatment are fully described, but the more academic points are abbreviated or omitted. Nearly a third of the book is devoted to the description of operative technique and the illustrations here are particularly good, every step being made clear. Pre- and post-operative treatment are well dealt with.

Certain terms, such as leucorrhoea, relative sterility, and secondary haemorrhage are used not in accordance with the usual definitions. The menstrual cycle is counted as beginning on the first day of the resting stage. We cannot agree that radium has little or no effect on the ovary, nor that the endometrium remains intact during menstruation, nor that chronic endometritis is a very common disease. Apart from these points, however, the teaching contained in this book corresponds closely with that given in this Hospital. The radium treatment of carcinoma is outlined, and some details are given of the Donaldson technique. The lead treatment of carcinoma is also described, and an interesting account is given of the use of vaccines as adjuvants in the treatment of chronic infections of the genital tract and of puerperal infection. A brief summary of Wilfred Shaw's account of metropathia haemorrhagica is included in the chapter on uterine haemorrhages. The subject of endocrinology receives scant attention. Here the practitioner is so entirely at the mercy of the manufacturer that we think some guidance should be given as to which (if any) of the innumerable endocrine preparations on the market are of value in treatment. No account is given of the functions of the corpus luteum. Fletcher Shaw's views on chronic metritis are omitted.

We think that this is in many respects the best of the smaller text-books of gynaecology, and that it is likely to prove popular with students and practitioners.

**GENERAL PRACTICE (SOME FURTHER EXPERIENCES).** By ERNEST WARD, M.D., F.R.C.S. (London: John Bale, Sons & Daniels, Ltd., 1930.) Pp. 108. Price 3s. 6d.

This book, appearing as a sequel to *Medical Adventure* cannot help being a little disappointing. It is less entertaining than its predecessor, but it contains a great deal of advice of a practical kind. Everyone who intends taking up general practice will be well advised to read it. It will take less than a couple of hours and the time will be well spent. Dr. Ward evidently knows a few jokes against the consultant. We wish he had told us more of them.

## ERRATUM.

**INJURIES TO JOINTS.** By SIR ROBERT JONES.

The price of this book is 6s., not 7s. 6d., as announced in our last issue.

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

AINSWORTH-DAVIS, J.-C., M.B., F.R.C.S. "Painless Haematuria." *British Medical Journal*, August 2nd, 1930.

BEHRMAN, S., B.Sc., M.R.C.S. "Non-spinous Psoas Abscess: Four Cases at a Children's Hospital." *Lancet*, August 9th, 1930.

CAMMIDGE, P. J., M.D. (and HOWARD, H. A. H., B.Sc.). "The Hereditary Transmission of Hypoglycaemia in Mice." *Proceedings of the Royal Society of Medicine*, July, 1930.

CHRISTOPHERSON, J. D., C.D.E., M.D., F.R.C.P. "New Pattern Lipiodol Trocar and Cannula." *Lancet*, August 2nd, 1930.

COCHRANE, K. G., M.D., M.R.C.P., D.T.M.&H. "Classification and Routine Treatment of Leprosy." *Leprosy Review*, July, 1930.

CORSI, H., F.R.C.S. See ROXBURGH and CORSI.

CULLINAN, E. R., M.R.C.P. (C. F. T. EAST, F.R.C.P., and E. R. C.). "Nirvanol in the Treatment of Chorea." *Lancet*, July 26th, 1930.

FEILING, ANTHONY, M.D., F.R.C.P. "Old Injury of the Brachial Plexus." *Proceedings of the Royal Society of Medicine*, July, 1930.



- HIGGS, S. L., F.R.C.S. "Two Cases of Dislocation of Carpal Scaphoid." *Proceedings of the Royal Society of Medicine*, July, 1930.
- HILL, NORMAN H., M.D., M.R.C.P. and MELLOR, A. W. C. "Protein Milk in Infant Feeding." *Lancet*, August 23rd, 1930.
- HORDER, SIR THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "More Medical Notes." *Clinical Journal*, July 30th, 1930.
- KEYNES, GEOFFREY, F.R.C.S. *Reviser of Bowley and Andrewes' Surgical Pathology and Morbid Anatomy*, 8th edition. London: J. & A. Churchill, 1930.
- MCCAY, F. H., M.B., B.Chir. "Gall-stones passed through a Sinus in the Back." *British Medical Journal*, July 26th, 1930.
- MARK, L. P., M.D. *More Reminiscences of Boyhood spent at Marseilles*. Privately printed.
- MAXWELL, JAMES, M.B., M.R.C.P. "Intradermal Tuberculin Test." *Lancet*, August 9th, 1930.
- "Bronchial Carcinoma." *Clinical Journal*, September 3rd, 1930.
- MELLOR, A. W. C., M.B. See HILL and MELLOR.
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- PARAMORE, R. H., M.D., F.R.C.S. "Eclampsia treated with Spinal Anæsthesia." *Lancet*, August 23rd, 1930.
- POWER, SIR D'ARCY, K.B.E., F.R.C.S. "Some Bygone Operations in Surgery. I, Cutting for the Stone." *British Journal of Surgery*, July, 1930.
- ROXBURGH, A. C., M.D. and CORSI, H., F.R.C.S. "Discussion on the Therapeutic Value of Gold Compounds (Sanocrysin, Krysoglan, etc.)." *Proceedings of the Royal Society of Medicine*, July, 1930.
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- SAXBY-WILLIS, F. E., M.D. "Diaphragmatic Hernia." *Clinical Journal*, July 23rd, 1930.
- STONE, G. KENNETH, D.M., M.R.C.P. "A Study of Yeasts by the Complement-Fixation Test." *Lancet*, September 13th, 1930.
- SYKES, W. STANLEY, M.A., M.B., B.Ch., D.P.H. "An Improved Open Ether Inhaler." *Lancet*, August 2nd, 1930.
- VERRALL, P. JENNER, F.R.C.S. "Two Cases of Coeliac Rickets." *Proceedings of the Royal Society of Medicine*, July, 1930.
- "Discussion on Amputations and their Relation to the Artificial Limb." *Proceedings of the Royal Society of Medicine*, July, 1930.
- WALKER, KENNETH M., O.B.E., F.R.C.S. "Discussion on the Technique and Results of Prostatectomy." *Proceedings of the Royal Society of Medicine*, July, 1930.
- WARD, R. OGIER, D.S.O., M.Ch., F.R.C.S. "A Radium Needle Introducer." *Lancet*, July 20th, 1930.
- (and HERITAGE, KENNETH, F.R.C.S.). "Some Examples of Excretion Urography." *Proceedings of the Royal Society of Medicine*, June, 1930.
- WEBER, F. PARKES, M.D., F.R.C.P. (and HELLENSCHMID, R., M.D.). "Telangiectasis Macularis Eruptiva-Perstans." *British Journal of Dermatology and Syphilis*, August-September, 1930.
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- WILLOUGHBY, HUGH, M.R.C.S., L.R.C.P., D.T.M.&H. (PHILIP MANSION-BARR and H. W.). "Studies on Sprue, with Special Reference to Treatment based upon an Analysis of 200 Cases." *Quarterly Journal of Medicine*, July, 1930.
- WOOLLARD, H. H., M.D. "The Cutaneous Glands of Man." *Journal of Anatomy*, July, 1930.

## CHANGES OF ADDRESS.

- BRAIMBRIDGE, C. V., The Native Hospital, Nairobi, Kenya.
- BROOKE, C. O. S. B., County Court-House, Belfast.
- CANE, A. S., Willingham, Cambs. (Tel. Willingham 30.)
- CLAXTON, E. E., The First House, Radnor Park, Folkestone. (Tel. Folkestone 1924.)

- GARROD, SIR ARCHIBALD, K.C.M.G., 1, Huntingdon Road, Cambridge.
- HIGGINS, A. G., The Lych Gate, Henleaze, Bristol.
- HORWOOD, F. L., 41, Chandos Avenue, Whetstone, N. 20. (Tel. Hillside 2085.)
- KINDERSLEY, C. E., 11, The Circus, Bath. (Tel. 3097.)
- KNIGHT, R. H., The Grange, Crawley, Sussex. (Tel. Crawley 37.)
- LONDON, J., Springfield, Castleford, Yorks.
- LEVITT, W. M., 2, Stone Buildings, Lincoln's Inn, W.C. 2. (Tel. Holborn 6095.)

## APPOINTMENTS.

- BACH, F., M.D.(Oxf.), appointed Medical Registrar to the British Red Cross Society's Clinic for Rheumatism, Peto Place, N.W. 1.
- BROOKE, C. O. S. B., M.R.C.S., L.R.C.P., D.P.H., appointed Chief Tuberculosis Officer for County Antrim.
- SHORE, T. H. G., M.D.(Cantab.), F.R.C.P., appointed Physician to the South Devon and East Cornwall Hospital, Plymouth.

## BIRTHS.

- CURRIE.—On August 20th, 1930, at 107, Eastbourne Road, Darlington, Co. Durham, to Mary Campbell Vickers, wife of Dr. John Currie, D.S.O.—a daughter (Winsome).
- GILLBARD.—On September 14th, 1930, at Sherfield, Hants, to Mary, wife of Dr. Windham Gillbard—a daughter.
- POWELL.—On August 29th, 1930, at Earlsridge, Redhill, to Thelma (née Faraday), wife of Dr. Ronald R. Powell—a daughter.
- YOUNG.—On August 27th, 1930, at 1, Titchfield Road, N.W. 8, to Stella (née Robinson), wife of Dr. Frederick H. Young—a daughter.

## MARRIAGES.

- CULLINAN—HORDER.—On September 17th, 1930, at St. Etheldreda's Church, Ely Place, E.C., by Father O'Connor, Edward R. Cullinan, M.D., M.R.C.P., to Dorothea Joy, elder daughter of Sir Thomas and Lady Horder.
- DURDEN-SMITH—NEILL.—On September 20th, 1930, at the Church of St. Bartholomew-the-Great, Smithfield, Anthony James, only son of Mr. and Mrs. H. W. Smith, of Lee, to Grace Yvonne Elizabeth elder daughter of the late Mr. Samuel Neill and Mrs. Neill, of Sherborne, Dorset.
- FRANCIS—JOLLANDS.—On September 17th, 1930, at St. Mary's Church, Chiddingfold, by the Rev. E. P. Pelloe, Reginald Harvey Francis, M.R.C.S., L.R.C.P., third son of Dr. and Mrs. Harvey Francis, of Ashton Lodge, Woodthorpe, Nottingham, to Mary Aylmer, elder daughter of Mr. and Mrs. Cecil Jollands, of "The Old Forge," Chiddingfold.

## DEATHS.

- AUBREY.—On September 22nd, 1930, at 3, The Parade, Cowes, Dr. John Bates Aubrey, second son of the late Sir William Hoffmeister.
- BUTTAR.—On August 31st, 1930, following an operation, Charles Buttar, M.D., of Limecroft, Guildford, and formerly of 41, Inverness Terrace, W. 2.
- CARSON.—On August 21st, 1930, Herbert W. Carson, F.R.C.S., of 111, Harley Street, W. 1, aged 59.
- FINIGAN.—On August 29th, 1930, after a long and severe illness, Daniel O'Connell Finigan, M.D., of Woodlands, Stourwood Avenue, West Southbourne, formerly of Fordingbridge, aged 55.
- MARK.—On September 5th, 1930, at 49, Oxford Terrace, W. 2, after a long illness bravely borne, Leonard Portal Mark, M.D., son of the late Edward W. Mark, late Consul of Marseilles.

## 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. WILLIAMS, 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.

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

VOL. XXXVIII.—No. 2.]

NOVEMBER 1ST, 1930.

PRICE NINEPENCE.

## CALENDAR.

- Sat., Nov. 1.—Rugby Match v. Pontypool. Away.  
Association Match v. Keble College, Oxford. Away.  
Hockey Match v. R.N. and R.M., Chatham. Home.
- Mon., „ 3.—Special Subject: Clinical Lecture by Mr. Scott.
- Tues., „ 4.—Sir Percival Hartley and Sir Holburt Waring on duty.
- Wed., „ 5.—Surgery: Clinical Lecture by Sir Holburt Waring.
- Fri., „ 7.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.  
Medicine: Clinical Lecture by Sir Percival Hartley.
- Sat., „ 8.—Rugby Match v. Moseley. Away.  
Association Match v. Caius College, Cambridge. Away.  
Hockey Match v. Keble College, Oxford. Away.
- Mon., „ 10.—Special Subject: Clinical Lecture by Mr. Elmslie.
- Tues., „ 11.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.
- Wed., „ 12.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
- Fri., „ 14.—Dr. Gow and Mr. Harold Wilson on duty.  
Medicine: Clinical Lecture by Dr. Gow.
- Sat., „ 15.—Rugby Match v. Old Cranleighans. Home.  
Association Match v. Old Merccers. Home.  
Hockey Match v. Old Cranleighans. Away.
- Mon., „ 17.—Special Subject: Clinical Lecture by Mr. Scott.
- Tues., „ 18.—Prof. Fraser and Prof. Gask on duty.
- Wed., „ 19.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.  
**Last day for receiving matter for the December issue of the Journal.**  
Hockey Match v. Gloucestershire Regiment. Home.
- Fri., „ 21.—Sir Percival Hartley and Sir Holburt Waring on duty.  
Medicine: Clinical Lecture by Dr. Gow.
- Sat., „ 22.—Rugby Match v. Torquay. Away.  
Association Match v. Old Citizens. Home.  
Hockey Match v. Emmanuel College, Cambridge. Away.
- Mon., „ 24.—Special Subject: Clinical Lecture by Dr. Cumberbatch.
- Tues., „ 25.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
- Wed., „ 26.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.
- Fri., „ 28.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  
Medicine: Clinical Lecture by Sir Percival Hartley.
- Sat., „ 29.—Rugby Match v. Devonport Services. Away.  
Association Match v. Old Brentwoods. Away.  
Hockey Match v. Trinity College, Cambridge. Away.

## EDITORIAL.

## THE OLD STUDENTS' DINNER.



THE Old Students' Annual Dinner was held on Wednesday, October 1st, in the Great Hall. After "The King," Mr. Rawling, from the Chair, described the progress of the Hospital during his thirty-six years' association with it. He remembered coming down from the premier college at the premier University to see Bart.'s with no fixed intentions. Dr. Shore, then Dean, soon had his name on the books. His subsequent career had given him the opportunity, for which he was truly grateful, of passing on the traditions of Alfred Willett, Lockwood, D'Arcy Power and Anthony Bowlby. Inevitably he had to occupy the Chair at the Old Students' Dinner. If allowed to choose the year, he himself would have selected 1930; there was so much to talk about.

In 1898, when he was a House Surgeon, there was no electric light, no telephone, and only one operating theatre. Operations were sometimes carried out in the wards behind screens; dressings were done by candle-light. The R.S.Q. was beastly, and the incidence of pulmonary tuberculosis among its inhabitants was high. Somewhere between 1910 and 1914 a certain restlessness had shown itself, and the pioneer in the movement towards reconstruction was C. B. Lockwood. The war and the post-war years of undiscipline had not favoured any further development, but in 1920 things began to move. In 1926 the Nurses' Block was started, and now the New Surgical Block had been opened. The moving spirit in all this was Sir Holburt Waring, who had travelled far and wide to pick out the best that the world had to offer for the equipment of the New Block. In commemoration of his work a ward had been named after him.

Mr. Rawling then described the rosy prospect of the future. The Maternity Block, the rebuilding of a Medical Block, a Paying Patients' Block, Residential

Quarters for Students, an X-Ray Block, the enlargement of the Special Departments, all would come in time. The justification of the Hospital Appeal was the work that would be done in the next eight hundred years.

Sir Charles Gordon-Watson proposed the health of the Lord Mayor, which was drunk with musical honours. The Lord Mayor replied briefly, acknowledging his great interest in the success of the Hospital Appeal and in the further development of the Hospital.

Surgeon-General Percy Benson, in a short speech, made allusion to Bart.'s in the early 'seventies, when he had been a student.

Coffee in the Library brought a pleasant conclusion to an exceptionally pleasant evening.

#### SIR D'ARCY POWER.

The good wishes of all Bart.'s men will go with Sir D'Arcy Power on his journey to America, whither he sails on November 1st. As we announced in September, he is to be Visiting Professor at the new School of the History of Medicine at Johns Hopkins University. The plan to honour him by presenting him with a copy of his own "Selected Writings" on his seventy-fifth birthday is generally known, although it has not been publicly announced. Unfortunately he will be in America on November 11th. We are asked to state that the book will be published at the beginning of December, but that the formal presentation of Sir D'Arcy Power's specially printed copy will be deferred until an official birthday, to be appointed early next year.

#### CAMBRIDGE UNIVERSITY MEDICAL SOCIETY.

Dr. Langdon Brown is to address the Cambridge University Medical Society on November 19th on "The Return to Æsculapius." Among the other lectures in the exceptionally good programme arranged for the Michaelmas Term by this Society is one on "Plastic Surgery in War and Peace" (November 26th). The lecturer is Sir Harold Gillies, whose great services to humanity and to the profession have been acknowledged this year by a knighthood conferred by H.M. the King, and by his appointment as the first Plastic Surgeon to St. Bartholomew's.

As we go to Press comes the tragic news of the death on November 2nd of Cecil Francis Watts. He had just been appointed Junior Demonstrator of Pathology. We extend our heart-felt sympathy to his mother and father on their sad loss.

Prof. Gask will deliver the Thomas Vicary Lecture on "Vicary's Predecessors" at the Royal College of Surgeons on Thursday, November 6th, at 5 o'clock.

Congratulations to Mr. F. W. Capps, who has been appointed Assistant Throat Surgeon.

Congratulations to Mr. S. L. Higgs on his appointment as First Assistant Orthopædic Surgeon to the Hospital.

#### CAMBRIDGE GRADUATES' DINNER.

The Fifty-fourth Annual Dinner of the Cambridge Graduates' Club of St. Bartholomew's Hospital will take place on Wednesday, November 19th, at 7.15 for 7.30 p.m. at the Mayfair Hotel. Mr. R. Foster Moore (Christ's) will be in the Chair. The price of the dinner is 12s. 6d., exclusive of wine. No tickets are required. Hon. Secs.: H. N. BURROUGHS and REGINALD M. VICK.

#### THE STUDENTS' UNION DANCE.

The Students' Union will hold its Annual Dance at the Savoy Hotel on Thursday, November 20th. Vale Lane's Dance Band has been engaged to play. The Ball begins at nine o'clock, and is announced as ending at three. Single and double tickets, 21s. and 35s. each respectively, may be had from Messrs. Briggs, Furber, Ellis, McBride and Nicoll.

The following gentlemen have been nominated to House Appointments from November 1st, 1930:

<i>Junior House Physicians—</i>	
Sir Percival Hartley . . . . .	R. E. M. Fawcett.
Prof. F. R. Fraser . . . . .	B. C. Nicholson.
Sir Thomas Horder, Bart. . . . .	W. H. McMenemy.
Dr. Hinds Howell . . . . .	T. H. N. Whitehurst.
Dr. A. E. Gow . . . . .	W. J. Walter.
<i>Junior House Surgeons—</i>	
Sir Holburt Waring . . . . .	K. W. D. Hartley.
Mr. L. Bathe Rawling . . . . .	E. C. Sugden.
Prof. G. E. Gask . . . . .	J. S. MacVine.
Sir C. Gordon-Watson . . . . .	H. L. Hodgkinson.
Mr. Harold Wilson . . . . .	G. K. McKee.
<i>Intern Midwifery Assistant (Resident)</i>	V. C. Thompson.
<i>Intern Midwifery Assistant (Non-Resident)</i>	I. E. Phelps.
<i>Extern Midwifery Assistant</i>	(R. M. S. Cross.*
<i>H.S. to Throat and Ear Departments</i>	W. D. T. Brunyate.†
<i>H.S. to Ophthalmic Department</i>	H. J. Burgess.
<i>H.S. to Venereal and Skin Departments (Non-Resident)</i>	H. P. Hutchinson.
	(C. N. Evans.*
	A. H. T.
	Robb-Smith.†
<i>H.S. to Orthopædic Department</i>	J. C. Nicholson.
<i>H.P. to Children's Department</i>	R. K. Price.
<i>Junior Resident Anæsthetists</i>	(K. M. Ross.
	R. E. Angel.
<i>Non-Resident Anæsthetist</i>	J. E. S. Stephens.
	(W. D. T. Brunyate.*
	C. H. Devin.*
	N. Kramer.*
<i>Casualty House Physicians</i>	R. M. S. Cross.†
	J. Q. Evans.†
	R. S. Risk.†
	(A. H. T.
	Robb-Smith.*
<i>Casualty House Surgeons</i>	(D. A. Beattie.†

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

## IN MEMORIAM.

HERBERT WILLIAM CARSON.

October 9th, 1870—August 31st, 1930.

**B**y the passing of Herbert William Carson, Bart.'s has lost one of her loyal sons, who went forth to carry the traditions and inspirations of his *Alma Mater* to a struggling hospital on the outskirts of London, and by his energy and enthusiasm was one of those who helped to raise it from comparative obscurity to a well-recognized position among the general hospitals of London.

Carson entered at St. Bartholomew's Hospital in October, 1888. He used to say that he never did any real work until after he was qualified. This statement is, I think, unfair to himself. He was one of my dressers in 1894, and I well remember his keenness and thirst for knowledge. During our "taking-in" week he used to remain at the Hospital until a late hour in order not to miss an interesting case, and if an emergency operation were in prospect, he was wont to sleep on the sofa in my sitting-room, so as not to miss being present at the operation. With our association at this time began a friendship which continued uninterruptedly until his death.

Soon after he became qualified, in 1895, he was appointed House Surgeon at the Tottenham (now the Prince of Wales's Hospital), becoming Assistant Surgeon in 1897 and full Surgeon in 1904. At first his intention was to specialize in the surgery of the ear, nose and throat, so that after becoming a Fellow of the Royal College of Surgeons in 1899, he was appointed to take charge of this department at Tottenham. After twelve years he resigned the charge of this department and devoted himself to general surgery.

In 1900 Carson and Dr. A. J. Whiting inaugurated the North-East London Clinical Society, of which he was President twice. This led, in 1902, to the foundation of the North-East London Post-Graduate College, which has been a flourishing centre of post-graduate education, not only for the north of London, but for students from a wider area.

The foundation of the Fellowship of Medicine in 1919 gave a great impetus to post-graduate teaching in London, and led to a considerable increase in the number of students enrolled at the North-East London Post-Graduate College. Into this work Carson and his colleagues threw themselves wholeheartedly, and students, not only from this country, but from overseas, attended the courses given at the College.

For the long period of thirty-three years Carson served the Hospital of his adoption with unstinted energy and untiring devotion. At all times his first thought was, "What can I do for my Hospital?" He was proud of it, and it was proud of him.

With his long-standing interest in post-graduate teaching it was natural that he should become associated with the Fellowship of Medicine, to the Executive Committee of which he was elected in 1923, and except for an interval of one year, he remained on that committee until the end, being Chairman at the time of his death. In this work he assisted with his customary vigour and earnestness of purpose the "fathering" of post-graduates from overseas being his especial care.

Among other distinctions he was one of the Honorary Librarians of the Royal Society of Medicine, and a former President of the Medical Society of London and of the Hunterian Society. He was a highly successful teacher, stating his views with deliberation and lucidity, and a certain dogmatism reminiscent of our old teacher Harrison Cripps, who was wont to say, "To teach, one does not need to know much, but one must know it thoroughly and well."

Carson was not a prolific writer. He was the Editor of *Modern Operative Surgery*, to which he contributed several articles on abdominal surgery, and at an earlier date published a small volume on *Surgical Diagnosis*. At the medical societies, however, he was a frequent speaker, his utterances being characterized by the same clearness and lucidity as his teaching. Dialectical exercises did not interest him. He stated his views, but rarely argued.

Tall, of athletic build, with a pleasing, soft voice and ever cheery greeting, his was a personality which made many friends. His aim was always to please, never to antagonize. During all the years I knew him I never saw him ruffled or put out. Although he lived a strenuous life he never became one-sided, and had many interests outside his profession. He was a first-class chess player and a keen lover of cricket, and in the summer might be seen at Lord's snatching respite for an hour or two from professional work. In his younger days he was a wicket-keeper quite up to county cricket form, but curiously, he regarded batting as a waste of time. In later years he played lawn tennis well, and also attained a certain proficiency at the Royal and Ancient game, but games he played for the sake of the game, rather than with the aim of achieving particular excellence. He had a passionate love of the sea, and was never so pleased as when enjoying a holiday on the ocean.

It is interesting to reflect how often apparently trivial circumstances may determine the whole course of a

man's life. Carson's career might have been very different had it not been for his love of the sea and his skill as a chess player. Soon after he was qualified he went on a trip to the Mediterranean. During his absence he was offered a post at a provincial hospital. The return of the ship on which he sailed was delayed, and so the opportunity was lost. A year later he applied for an appointment at a hospital in a county town. On the day before he was to be interviewed by the selection committee he went down to stay with a friend. His host happened to be a chess player, and arranged that in the evening Carson should play twenty of the local players simultaneously. He had little difficulty in winning most of his games, but fortunately for him, although it seemed unlucky at that time, one of his victims was so enraged that he declined to play any more, and left the club in high dudgeon at being "made a fool of by a beardless boy." This irascible old gentleman turned out to be the chairman of the selection committee, and Carson failed to get the appointment!

To me the most striking and most-to-be-prized tribute to our departed friend is that of one of his nurses: "His place will never be filled at the Prince of Wales's. He was so kind, and interested in everything—all our studies, our social affairs here—nothing was too small for him, and we all knew he was our friend." No surgeon can have greater honour than to win the respect and affection of those among whom his daily work is done. No surgeon can have a greater privilege than to give the utmost of his help to those of "the most gentle profession" who are associated with him in his daily round. Of Carson it may be said with truth, and one could wish for no finer epitaph, "He was a friend of Nurses." "The sound of a voice that is still" will long be a fragrant memory at the Hospital to which he gave such long and loyal service.

No memorial to Carson would be complete without reference to the helpmeet who shared so fully in his work and in his play, and to whom no small part of his success was due. To her in her sorrow will go out the sympathy of all Bart.'s men, and her consolation will be that in his devotion to duty he proved himself a worthy son of the great Hospital where he qualified for his life's work.

His passing came with tragic unexpectedness. At the end of July he was at a reception for the members of the American Society of Clinical Surgery, apparently in his usual health and cheery spirits. Two weeks later he underwent a serious operation, pneumonia supervened, and he passed away on August 31st, within a few weeks of his sixtieth birthday.

H. J. P.

## OBITUARY.

DR. E. D. WHITEHEAD REID.

The death of Dr. E. D. Whitehead Reid, of Canterbury, on October 20th last, at the early age of 47 years, has caused the greatest grief to his many friends, and has brought to a close a life of intense activity and interest. He was piloting his own Westland Widgeon monoplane from Shoreham to Canterbury on the evening of October 19th when he had the ill-luck to run into bad-flying weather. The ground mist was gathering fast, so he decided to land before completing his journey. The tops of the trees were hidden in the mist and the monoplane failed to clear them, with the result that one wing was torn off and the machine went into a spin and crashed. Dr. Whitehead Reid was rendered unconscious and received severe head injuries, from which he died eighteen hours later in the West Kent General Hospital at Maidstone. He was a pilot of long experience and had been a private owner for ten years, being one of the first owner-pilots in this country.

Edward Douglas Whitehead Reid was born in Canterbury forty-seven years ago. He came of a medical family, with a long medical tradition—his father was Dr. Thomas Whitehead Reid, who practised in Canterbury for many years, and his grandfather was Dr. James Reid, who founded the practice at St. George's House, just before the Crimean War. Dr. Whitehead Reid was educated at Tonbridge School and Christ's College, Cambridge. At School he shot in the Bisley VIII, and at Christ's he was President of the College Athletic Club and rowed in the College boat. At St. Bartholomew's he was distinguished in athletics, and it was largely owing to his prowess that the Shield came back to the Hospital in 1909. He qualified in 1909, and took his degree at Cambridge the following year; he was then appointed House Surgeon to the London Temperance Hospital, and later House Physician to Dr. Norman Moore at Bart.'s. Owing to the death of his father he had to relinquish the latter appointment early in order to take up the practice at Canterbury. Though young for such responsible work, he rapidly gained the confidence of patients and made many friends. He was soon appointed to the Surgical Staff of the Kent and Canterbury Hospital—at the time of his death he was Senior Surgeon to that institution. He was medical officer to the King's School at Canterbury, Consulting Surgeon to the Herne Bay Hospital, and held other important appointments. During the war he held a temporary commission in the R.A.M.C., and was attached for a time to the Staff of No. 1 Red Cross

(Duchess of Westminster) Hospital at Etaples Base. Later he went to Egypt, and whilst there he learnt to fly, becoming a certificated pilot before he left the unit to which he was attached. On returning to England after the war Dr. Whitehead Reid at once took steps to become enrolled as a private owner. He was a Flight-Lieutenant in the Auxiliary Air Force Service, being attached to No. 601 (County of London) Bombing Squadron, and took part in the night "raid" over London last summer. He was a careful and enthusiastic pilot, who did all that was humanly possible to eliminate risk. It was characteristic of him that he never persuaded his friends to fly with him, though if they wished to do so he gave him the greatest pleasure. There are few among us who get through more in twenty-four hours than did Douglas Whitehead Reid. He was a man who lived intensely—worked hard, played hard, and never wasted a moment. Those who knew him in his professional life could not fail to be struck with the careful and detailed notes he kept of his cases. He was exceptionally well informed, and being equipped with first-class faculties he made the fullest use of his knowledge. His ability was recognized and widely appreciated. In spite of his many activities he found time to keep in touch with his *Alma Mater* and with various special hospitals. He was ever punctual and business-like in arranging his day.

The people of Canterbury and East Kent have lost a valued medical and surgical adviser. His many friends at Cambridge, Bart.'s and elsewhere will feel his loss, and will always remember him as one who was keen and enthusiastic both in work and play, an attractive, loyal and lovable friend. He leaves his wife, his mother, a sister and a brother to mourn his loss.

A memorial service was held in Canterbury Cathedral on Friday, October 24th. The Cathedral was filled with mourners without distinction of class or creed. The Royal Air Force was fully represented. It was a day of mourning for Canterbury. Business premises were closed during the time of the service and burial. We leave him at the Lychgate of St. Martin's churchyard, safe in the memory of his friends. The rest of that sad day is the private concern of those who are nearest to him, and must not be written. Those who watched and waited heard, after a time, the strains of the Last Post followed by—Reveille.

H. P.

DR. ADOLPHE ABRAHAMS writes:

I am glad of the permission to add a personal note to any which a more detailed biographer may contribute in memory of Whitehead Reid.

§

I cannot believe that he ever had an enemy. His strikingly handsome features, perfectly groomed appearance, his air of breeding and yet easy, friendly manner made an immediate impression on a stranger. Nor was that preliminary impression reversed or reduced by subsequent experience; his charm and courtesy were invariable. I never saw him at work as a House-Physician among the out-patients, but I know how they must have worshipped him.

Whilst never really distinguished in any branch of sport, Whitehead Reid was good at, as we used to say in the sporting parlance of those days, useful at everything. And this was characteristic of the man, that he really enjoyed sport as sport, and not for any distinction which might result from exceptional success. So he was never intrigued by the meticulous attention to details which specialization demands, but wisely preferred a versatility with moderate success but far greater enjoyment. He was a good oarsman and, as I knew to my cost, a formidable sculler. He was one of the best high jumpers at Cambridge, and though he just failed to get his Blue he was the prettiest jumper I ever saw, and would have taken first place in any competition for style. He was almost as good a hurdler and a fair runner up to half a mile. But more than all, he was an enthusiast. We won the Inter-Hospital Athletic Shield in 1908 because Reid was our Hon. Secretary. We were not a strong lot; true, we had the present Throat Surgeon, then the finest middle distance runner in the country, but one great runner does not make a team, and the rest of us were but small fry. Reid's efforts on our behalf were unremitting and his determination made defeat impossible.

Such a man was, as would be expected, an out-and-out patriot. His school, his college, his university, his Hospital, his country were all always beyond criticism. Living sixty miles from London, he nevertheless set an example by attending meetings and functions often shirked by those of us who lived round the corner, and I never met him without a feeling of intense admiration and of shame that in similar circumstances not two men in a thousand would take so much trouble. Somebody once said in my hearing, "Whitehead Reid could not possibly have come from any other hospital than Bart.'s"—a compliment, I venture to believe, equally acceptable to both the man and the Hospital which deploras his loss.

## DR. LEONARD MARK: A POST-MORTEM ABSTRACT.

**THE** late Dr. Leonard Mark, who had suffered for many years from acromegaly, desired that when he died an autopsy should be made at this Hospital. By this generous act he hoped that the morbid changes found would be of help in studying the pathology of the disease. In this he certainly would not have been disappointed, and a detailed study of the valuable material, retained at his own request, is being made, and will be reported at a later date.

Meanwhile, however, many people have asked for a short outline of the gross changes found post-mortem. The extent and variety of these findings are a tribute to the vitality of the late doctor, who lived a vigorous life to the time of his death at the age of 75, on September 5th, 1930.

ABSTRACT OF POST-MORTEM NOTE (SEPTEMBER 8TH, 1930).

### External Examination:

The body of a largely-built, thin man, showing *rigor mortis* and hypostasis. The chest is barrel-shaped and sunken on the right side. The right leg is cedematous.

### Skeletal System:

The body shows the changes of acromegaly in a moderate degree.

*The skull.*—The vault is enlarged (25 in. circumference), and both the inner and outer tables are greatly thickened (in parts 1 in. thick). On the base the pituitary fossa is somewhat enlarged and the posterior wall of the fossa softened. The mandible is larger and thicker than normal.

*The arms.*—The radii and ulnæ are enlarged and the hands typically acromegalic.

*The legs.*—The tibiæ and feet show enlargement.

### The Ductless Glands:

*The pituitary gland* is slightly larger than usual, especially in the downward direction. It has a soft consistency, but no other macroscopical abnormality.

*The thyroid gland* is enlarged.

*The suprarenals and testes* appear natural.

*The thymus* is not seen.

### The Central Nervous System:

Apart from the pituitary gland (see above) and the cerebral vessels (see below), nothing abnormal is noted in the brain.

### The Respiratory System:

There are old pleural adhesions over both lungs and recent pleurisy over the right base. Both lungs are congested, emphysematous, and show the changes of chronic bronchitis. In addition, the right lower lobe is consolidated and has the appearances of confluent broncho-pneumonia.

### The Alimentary Canal:

This shows nothing abnormal.

### The Liver:

The liver is congested. The gall-bladder is natural. The pancreas is natural.

### The Spleen:

This is large and there is perisplenitis.

### The Cardio-Vascular System:

*The heart.* The pericardium contains a few ounces of clear fluid. The whole heart is enlarged, both hypertrophied and dilated. The mitral and aortic valves show some atheromatous thickening.

*The arteries.*—There is a generalized state of advanced atheroma.

The aorta: Atheroma is present in the aorta, commencing in the first part of the arch, which is somewhat dilated, becoming progressively more severe, and reaching a maximum at the bifurcation into the common iliacs. At this point the disease is very advanced.

The common iliac arteries: The right common iliac artery is almost completely occluded by a partially organized ante-mortem clot, which is evidently of some great age. The left artery is occluded by a more recent, soft, almost unorganized ante-mortem clot, which is, however, adherent in a few places.

The popliteal artery (right): This feels like a "clay-pipe stem" and is thrombosed.

The circle of Willis: There is an advanced degree of atheroma.

### The Urinary System:

*The kidneys.*—Both kidneys are enlarged. The capsules strip with difficulty, leaving a granular surface with many small cysts. The left kidney is hydro-nephrotic and the right pyonephrotic. Both contain gravel and small mixed stones. In addition to these changes the cortices are diminished and contain several cysts, and the line of demarcation between the cortices and medullæ is blurred.

*The bladder* is not infected.

*The prostate* is not enlarged.

### Pathological Diagnosis and Lesions found:

Acromegaly. Enlargement of the pituitary and thyroid glands. Advanced atheroma (with thrombosis of the common iliac and right popliteal arteries). Chronic interstitial nephritis (arterio-sclerotic type), hydro-nephrosis, pyonephrosis and renal calculi. Emphysema, chronic bronchitis and terminal confluent broncho-pneumonia.

EDWARD R. CULLINAN.

## CLINICAL RESEARCH IN MEDICINE: POSSIBILITIES AT ST. BARTHOLOMEW'S.

**RESEARCH!** A word to conjure with! There's a vogue for "Research" at the moment, and the fashionable brand this season is to be "Clinical Research." Bartholomew's must follow the fashion or be rated out-of-date.

What is Clinical Research and who are the researchers?

In plain fact, every member of our profession is engaged in research, for all alike are daily called to study new problems of infinite variety. Bartholomew's Hospital and Bartholomew's men by training and by inclination have ever been engaged in clinical research, in the widest sense though without realizing the fact.

How may we win due credit for our good works?

Conventionally speaking, the term "medical research" connotes investigations conducted largely in the laboratory, and so far as these activities go, it is true enough that the practical application of many of the investigations published to-day is far to seek. A cult of pure research has arisen with men devoted to its service. Those who engage themselves in this branch of natural science may even be classified in systematic groups.

Thus we recognize—Group 1: heaven-born geniuses. Group 2: professional researchers. Group 3: amateurs of research.

No one shall deny that Bartholomew's has had and still enjoys more than a full share of representatives of Group 1, amongst the most illustrious of whom we rejoice to number men at work amongst us this very day.

Of Group 2, the "professional researchers," there are more than enough elsewhere. It seems that these make a livelihood from their investigations, and so it must often happen that the ideal of original inquiry becomes a means to their end rather than their guide and inspiration. It is surely because of such that

"research" is in danger of becoming a byword in public esteem.

Thirdly, there are the amateurs, to which group the whole body of the profession belongs to a greater or less degree. I particularly wish to be associated with this honourable body and to be counted of their number. The idea is in my mind that the amateur devotes himself to his task as much for the love of it as for any other reason. No amateur rides his hobby long unless he possesses some aptitude in its management.

So let us comfortably agree that we at St. Bartholomew's are already immersed and engrossed in Clinical Research, each and all of us, and let us accept as a first principle that Bartholomew's men in general owe their fine professional aptitude to their proficiency in this branch of medicine, just as it cannot be denied that the crown of research owes laurels to Bartholomew's men. Then how does it come about that the outside world demands to know:

"What clinical research is going on at Bart's?" and seemingly asks in vain!

We do not lack "professors" in the van of progress, and the serried phalanx of our "units" ever fronts the fight against disease!

Is it, in Yankee phrase, that we fail to "tell the world" sufficiently of our doings? Is our accursed modesty our bane?

It has always seemed to me that an immense amount of good work is done year by year in the wards and laboratories of the Hospital which, in our unassuming way, we have labelled routine investigation, but which, with a little direction and arrangement, might have been put into a form suitable for publication and much useful information made accessible. All my professional life I have been at a loss to find an answer to questions the reply to which could be furnished by any general practitioner of experience. I am constantly questioning myself as to the significance of this or that abnormality. How is life to be lived by my patient? What will be its duration, and how will it end? The answer to these questions is scarcely to be found in print, yet generations of men before me have held this knowledge in their hearts and died without revealing it.

It seems, then, that the material is at hand, the observations made and usually recorded, but the analysis is lacking. The final stages of co-ordination and publication are seldom completed. We are, in the main, poor historians of our own deeds, and it is to be observed, without cynicism, that by a trick of fate those whose writings are most readable seldom write anything worth reading. In other words, a graceful literary style and the capacity for first-class original work do not often go together, or we should have libraries full of

much needed information and medical science would be half a century ahead of to-day.

The germ of my idea for the further development of clinical research at St. Bartholomew's begins now to appear. All we need is a little systematization, a little more co-ordination, and a great deal more help and encouragement for men who would like to do some original work, but don't know what subject to choose or how to begin.

Some humble fellow might be found, dressed in the sackcloth of our common garb rather than the flowing academic robes which drape the chairs of Universities, in whom those unhappy men, the chief assistants in medical wards, might confide. I picture them unhappy and I believe my estimate is just—there seems so little for them in their lives when the brief irradiation of their chief ceases to shine and his ward-round is ended.

How may we set our house in order and produce better work to the honour and glory of the Hospital, which is our duty, and to satisfy popular demand, which is expedient?

Sir Thomas Lewis would have it that we should specialize further, and set aside men to be trained in research to the exclusion of every other interest. It seems to the writer that Lewis is unduly influenced by his experience with heart disease. It is exceedingly doubtful whether the disorders of other systems of the body are susceptible to the methods of investigation employed in the study of the almost purely mechanical problems afforded by the heart. Far better to follow Moynihan's counsel to the physiologists and promote a closer union between the practical and theoretical aspects of medicine, by insisting that every investigation shall begin at the patient and be directed to the solution of practical problems. Thus the fine old Bart.'s tradition is maintained, that experience must be gained by study at the bedside and by no other means.

It were easy to follow other schools, and appoint a senior official in charge of a special research department of the Hospital. This entails new buildings, new staffs, new equipments and new costs. Those of us who know the Hospital would question the desirability of "multiplication of mandarins" in the comparatively restricted compass of a single medical school. Moreover, the constitution of a separate "unit" smacks altogether too much of that odious thing, research to order. The Hospital is already rich in talent and neither needs nor seeks another director. But it is not to be expected that men preoccupied with advanced research will spare time to organize and direct the first steps of beginners, however generously they are prepared to give advice and assistance at a later stage. The soil must be prepared on which such priceless seeds are sown.

In ancient days the first care of the Hospital was to heal the sick within its walls; to-day the education of students to become first-rate doctors is a duty of almost equal importance.

There can be no question of the value of original work in teaching a man to think for himself, to make proper use of the work of others and to express himself intelligibly. The status of the medical chief assistants would be enormously improved and the interest of their work greatly increased if the conduct of a piece of original work were made a necessary condition of their appointment. The subject for inquiry might either be suggested by the physician concerned or by the assistant himself, to be submitted to his chief for approval.

The actual conduct of the work and the details of experiment would call for the supervision of a competent senior, below the rank of professor but of the status of senior demonstrator or lecturer, who would also be responsible for preparing the work for publication either in the *Hospital Reports* or, if suitable, in the general medical press.

So far from being deplorable, as Sir Thomas Lewis urges, publication affords the only legitimate means for recording original work, for it must be remembered that the profession of medicine does not permit the "patenting" of new discoveries. At the same time, the need for more conciseness and logic in the writing of scientific papers is clear to anyone who cares to scan the pages of current periodicals.

It would be no bad thing if the *St. Bartholomew's Hospital Reports* included each year a very brief statement of research in progress within the Hospital walls, with a summary of results, if for no other purpose than to let men know where they may look for collaboration and to increase their respect for their colleagues.

In this way it would not be long before lines of research would develop, to be followed up by successive holders of a particular clinical post, so that work on certain special subjects would become identified with the Hospital rather than, as heretofore, with the names of particular individuals.

Mayhap in the fullness of time men may be found, gifted with special genius for original work, competent to devote their whole time to discovery and even worthy to hold permanent office on the Hospital Staff. For in truth the ability to undertake original work and produce results of value can neither be bought nor sold and, like all artistic achievement, is largely a fortuitous outcome of circumstances over which the worker himself has only limited control. Hence many a man does but one good piece of original work in a lifetime and no more.

It is so important at the moment that enthusiasm and ideas should be encouraged. Repeated sterilization

of hope leads in the end to cynicism, and thence by way of indifference to nullity. Wilfred Trotter rightly questions if scepticism be indeed the highest flower of the scientific spirit. "Let us not shun," he says, "the painful irruption of new ideas. . . . The truly scientific mind is altogether unafraid of the new . . . it will not grudge to any unfamiliar conception its moment of full and friendly attention."

How much does the physician at a teaching school owe to the stimulus and original ideas of the students he instructs, who force him to review every problem from other angles than his own? Only one thing is precious in science—original thought. There are a thousand operatives who can undertake the mechanical study of a stereotyped problem.

The Department of Pathology at Bart.'s has just been re-partitioned; there has been a re-shuffle of titles amongst the permanent officials. Suppose, before things settle down again, a sign-writer could be bribed to inscribe the magic legend, "Clinical Research Laboratory," over the room in which the medical chief assistants now work. Let this room become the rallying-ground for these men, and for all those holders of scholarships and grants for research whose studies embrace laboratory investigations as well as ward work. Some lowly shepherd glad to guide their first uncertain steps could find a corner in the same humble setting, and lo! a miracle! a clinical research scheme for which all the elements are already in being would become, without loss of time, accomplished in the sight of all men!

A final word, this adumbration is labelled "Clinical Research in Medicine." There is no message for the Surgeons—has not Lord Moynihan himself declared that the great Art of Surgery has attained perfection?

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RICHARD ARMSTRONG.

## ACKNOWLEDGMENTS.

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## FAMILIAL ACHOLURIC JAUNDICE.



FAMILIAL acholuric jaundice is a disease known to most medical students by name, and as the disease is not a rare condition, several examples each year are seen in this Hospital.

Acholuric jaundice occurs in two big groups—the familial and the acquired varieties. The causation of both types is obscure. The symptoms and signs in the individual are fairly similar, and the only differences are often that in the acquired form there is a lack of family history, a later age of onset, a greater anaemia, and a less marked fragility of the red blood-corpuscles.

## CHARACTERISTICS OF THE FAMILIAL JAUNDICE.

The disease is characterized by a mild jaundice which varies slightly from month to month, by an enlargement of the spleen, as a rule by the absence of bile from the urine, and by an increase in the fragility of the red blood-corpuscles.

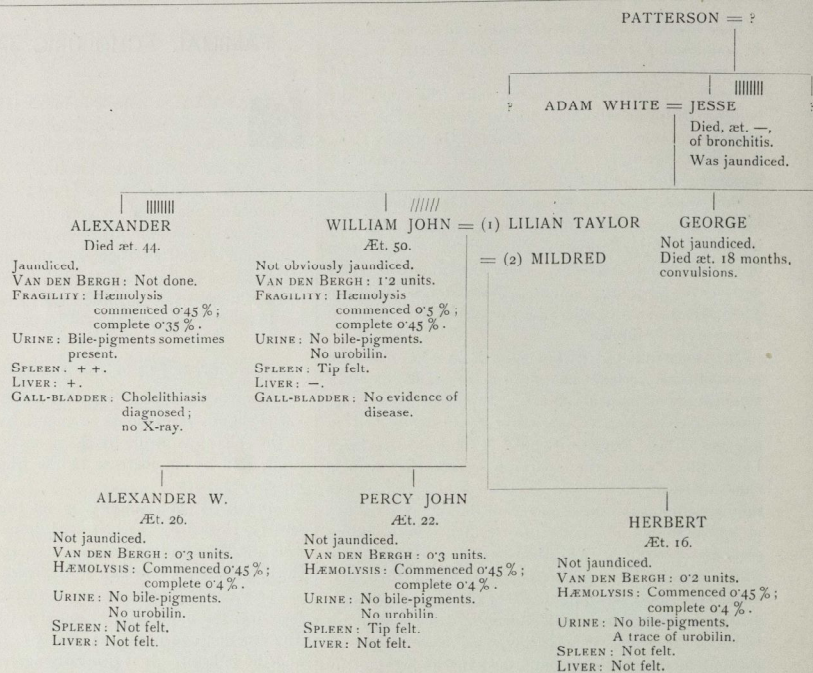
*Jaundice.*—The jaundice is of the hæmatogenous variety, caused by the increased destruction of the red cells and the resulting presence of more bile-pigments in the blood stream, bilirubin and biliverdin compounds.

The Van den Bergh reaction detects the presence and measures the amount of bilirubin in the blood-stream. The reaction consists of at least two forms—the direct and the indirect. It is generally agreed that the direct reaction indicates the presence of bilirubin, serum and the diazo-reagent alone being necessary for the test. For the indirect reaction, serum, 95% alcohol, saturated ammonium sulphate solution and the diazo-reagent are required. The indirect may be present when the direct reaction is negative. It is believed that a precursor of bilirubin occurs in the blood stream, perhaps a bilirubin protein compound which is split by the hexagonal cells of the liver into bilirubin and some other substance. This compound is also acted upon by the alcohol and split into bilirubin and possibly protein.

In acholuric jaundice it is the unsplit compound which is present in excess in the blood stream. The Van den Bergh reaction is therefore of the indirect type, and varies from 2 units or less to 4 or 7 units.

The jaundice has not the same characteristics as in obstructive jaundice; there is no pruritus, no increased liability to hæmorrhage, no bradycardia, no xanthoma.

*Spleen and liver.*—Enlargement of the spleen may be to one finger's breadth, or to as much as five or six fingers' breadths below the costal margin. Enlargement of the liver, which is not usual, was present to a marked degree in one of the cases.



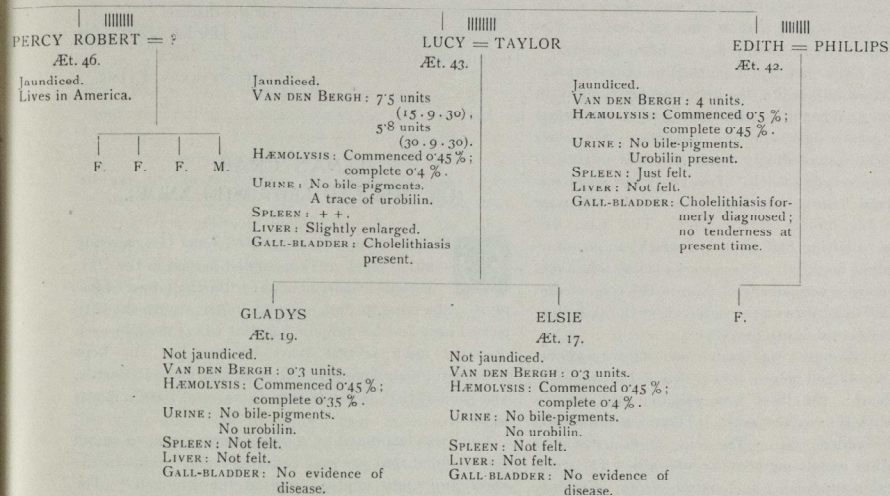
*Fragility.*—The fragility of the corpuscles is increased as a general rule. Normal red blood-corpuscles commence to be hæmolyzed in 0.42% saline, and are completely hæmolyzed in 0.35%. In acholuric jaundice hæmolysis may commence in 0.6 or 0.7% saline, and be complete in 0.5%. In the family to be described the fragility was only very slightly raised—a rather unusual feature. It is said that patients may have “crises” in which the fragility rapidly increases, and this may be associated with an increase in the jaundice.

*Urine.*—The kidney threshold for bilirubin is normally 4 units, but in acholuric jaundice 7 units have been present in the blood-stream without bilirubin being present in the urine, indicating that the threshold has been raised. Though urine is generally free of bile-pigments, occasionally bile may appear for short periods as the icterus waxes, to disappear again as the icterus wanes. It must, however, be borne in mind that an associated cholelithiasis may be the cause in some cases of this bilirubin excretion.

The urine does, on the other hand, often contain

urobilin in increased amounts. Bile-pigments in the large intestine are reduced by putrefactive organisms into a pigment which is partly excreted in the fæces as stercobilin and partly reabsorbed into the portal circulation and stored in the liver. Some urobilin is excreted into the urine as urobilinogen. In insufficiency of the liver and in other diseases in which liver insufficiency is probably not present, *e. g.* acholuric jaundice, urobilin enters the systemic circulation and is readily demonstrated in the urine. A saturated solution of zinc acetate in absolute alcohol is added to the urine and the mixture filtered; the filtrate gives a green fluorescence, which may be accentuated by adding one drop of tincture of iodine.

*Gall-bladder.*—It has long been recognized that an associated catarrh of the bile-ducts and of the gall-bladder may occasionally be present. Many recent observers have found that cholelithiasis is almost the rule in patients with acholuric jaundice who live to middle life. The stones are probably compounds of cholesterol and calcium bilirubinate, and may show extremely well in X-ray photographs.



*Treatment.*—The disease has been treated successfully by removal of the spleen, the jaundice thereby disappearing, although it is reported that the fragility of the corpuscles remains unchanged. But as the jaundice may be slight and there is often no other disability, patients are frequently loath to subject themselves to an operation as severe as splenectomy. Treatment by tying the splenic vessels has been carried out in America with reported success. The anæmia nearly always present should be treated with arsenic and iron, and if necessary by blood transfusion before operative procedure.

#### A FAMILY INVESTIGATED.

The family whose genealogical tree is shown comes from Scotland. Two members of the family have been in St. Bartholomew's Hospital, both under the care of Sir Thomas Horder.

*Alexander White*, who died æt. 44, in 1923, had a large spleen and liver with no increased fragility of his red blood-corpuscles, and at one time had been thought to

have biliary cirrhosis. The cause of his death is not known; it is said to have been “wasting and anæmia.” While the patient was in Rahere Ward cholelithiasis was thought to be present, but no radiogram of the gall-bladder was taken. The Van den Bergh reaction is not recorded but the patient is stated to have been jaundiced, and on at least one occasion bile-pigments were present in the urine.

*William John White*, æt. 50, the next brother, is not obviously jaundiced, but has a Van den Bergh reaction of 1.2 units and a slightly raised fragility of his red cells.

*Percy Robert*, æt. 46, is in America, and is stated by his family to have been jaundiced since twenty years old.

*Lucy Taylor*, the eldest sister, is a patient in this Hospital now. The lady is jaundiced, and details concerning her will be given more fully at the close of this article.

*Edith Phillips*, æt. 42, the youngest child, is jaundiced and has an indirect Van den Bergh of 4 units and a slightly increased fragility of her red blood-corpuscles.

This woman has been yellow since birth, and when 33 years old had a sharp cutting pain in the right side of the abdomen; a diagnosis of cholelithiasis was made at the time. When aged 37 she went to live in the county of Norfolk, and since then has not been troubled with the pain. No tenderness was found in the gall-bladder region; the tip of the spleen was just felt. No radiogram of the gall-bladder was taken, as the woman was only staying a short time in London. The urine contained much urobilin but no bile-pigments.

Mrs. Lucy Taylor, æt. 43, the fifth child of this family, has been yellow all her life, the yellowness varying from time to time. When the yellowness was most marked there was greater lassitude and weakness. Six years ago she became exceedingly weak and was unable to continue her everyday work. Two years ago epigastric pain occurred half to one hour after meals, the pain passing to the middle of the back. This pain was relieved by vomiting half a pint of thick, unpleasant-smelling yellow material. Three weeks before admission she had a more severe attack of pain in the epigastrium which tended to localize on the right side of the abdomen. There has never been any pruritus.

On examination she was jaundiced, slightly anæmic, and had an enlarged spleen, which descended almost to the umbilicus; the liver was palpable one finger's breadth below the costal margin. There was tenderness in the gall-bladder region. The urine contained a trace of urobilin but no bile-pigments or bile-salts. The stools were normal in appearance and contained bile. Fragility of the blood corpuscles was very slightly raised; hæmolysis commenced in the 0.45% saline solution and was complete in the 0.4% saline. There was more hæmolysis in the 0.45% tube containing Mrs. Taylor's blood than in a similar tube of the controls. The Van den Bergh reaction was performed twice, the first time the indirect reaction being 7.5 units and on the second occasion 5.8 units. The direct reaction was negative.

The blood-count showed a secondary grade of anæmia, the hæmoglobin being 66%, with slight polymorph leucocytosis, 8000 cells per cubic millimetre. No myelocytes were seen. The Wassermann and Sigma reactions were negative. The radiogram of the gall-bladder demonstrated the presence of calculi.

The patient is about to undergo an operation for cholecystostomy, and if possible ligature of the splenic vessels will be performed at the same time. It was thought better to leave the question of splenectomy until after the patient had recovered from her first operation, and to wait and see what effect tying the splenic vessels has on the jaundice and spleen.

On examining members of the youngest generation no evidence of acholuric jaundice was found.

#### CONCLUSION.


The unusual feature of this family is that the fragility of the red blood-corpuscles is either normal or only very slightly increased in any of the persons suffering from the disease; but there can be no doubt that these cases described are true examples of acholuric family jaundice. It is of interest that so far no one in the youngest generation suffers from the disease.

I am indebted to Sir Thomas Horder, Bart., for permission to publish the notes of these cases.

COURTENAY EVANS.

### LENA'S CRAB

(OR, THE OLD LADY WHO KNEW).

N November 9th, 1929, Mrs. Lena C—, already in her 63rd year, presented herself in the Out-patient Department at St. Bartholomew's Hospital. She lived in Barking, and on her way to the City passed near another famous hospital where she had been operated upon several years before. But she kept steadfastly upon her way. She had heard about Bart.'s, and she felt that she *knew* something, and Bart.'s it was to be.

Lena was examined by a sympathetic clerk, to whom she confided that she was suffering from "pains in the chest and body, and a lump in the stomach." The pains might have been functional, but there was no doubt about the lump. It stuck out for 3 in. or more below her left ribs, and could not escape the most inexperienced fingers, hardly, even, the most unobservant eye, for Lena was terribly thin. She had "gone off her food" seven months before, after breaking her leg; for four months she had the aching pain in her stomach, which was made worse by food, and recently she had vomited her food occasionally. Altogether, she could find many reasons for not having any food at all, and only one, her determination to live, for swallowing it. Seven years or more ago she had had pain and vomited blood, and her first operation was done at the other hospital, so that the clinical picture was complete, and not even the most obtuse clinician could doubt that Lena had a cancer of the stomach. It was indeed a very large cancer, and being so easily felt might have been pronounced, by those of the dogmatic school, inoperable. ("All palpable cancers of the stomach are inoperable.") It was indeed an uncertain prospect, and the assistant surgeon put her name without enthusiasm on the admission list.

\* \* \*

A month later Lena found herself in bed in Bart.'s. She felt herself secure. She had reached the goal of her desires, and Something (so Lena thought) was going to be Done. Her faith in the Hospital of her choice—her second choice—was unbounded, and this crab that was gnawing so relentlessly at her vitals was going to be taken right away, and she was going to live for another twenty years contentedly and painlessly in Barking, gossiping about Bart.'s, and helping others to decide to try the healing waters of the Fountain. But, alas! Lena's luck was out. It was the 13th of December. She weighed only 76 lb. She coughed, and her lungs were full of crackles. True, she had not vomited for a month, but the crab had grown larger than ever, and Lena could almost feel his separate claws. The dresser, the house surgeon, the assistant surgeon looked at her with lack-lustre eyes. Death from acute bronchitis after a probably useless operation would not be euthanasia. Even a Christmas dinner would be no use to her. Lena was sent back to Barking on December 18th, and her end was confidently stated to be near. They knew—or thought they did; but so did she, and knew she did.

\* \* \*

Lena, in the face of Expert Opinion, could but accept their ruling, and for six miserable months she lived with her crab and tried to believe that they were right. More and more she vomited, less and less could she get anything to keep company with her crab. Even fluid took fright at the monster within her, and fled upwards with greater regularity than ever. But as she became thinner and feebler, yet the spirit within her remained undimmed. Suddenly, one day in the flaming month of July, she realized that for some time she had not coughed. Her lungs seemed to have dried up. Wonder indeed that she had not dried completely up, lungs and everything else! But at any rate the Experts had said they would do nothing because of her cough, and now she had no cough, so they couldn't refuse any longer. Lena pulled herself up into a chair at the table and proceeded to write a letter, a personal appeal, to the assistant surgeon. She was so feeble that she could hardly hold the pen, but she wrote, "I am *much better* than when I was in hospital in December. I have no cough, and I am quite sure that something can be done to help me at the hospital." She had to add, "I am vomiting so much that I have had practically no food or drink for more than three weeks, and I can't go on for long like this." When the surgeon read this appeal from someone who, according to all the rules of the game, ought to have been dead several months before, he felt that she must at any rate be seen, though of course it couldn't be of any real use, and he wondered

what he should say to her. A few days later Lena dragged herself to the Hospital. She didn't know, she said, how she got there. She lay upon a couch in the surgery, a little desiccated object, the skin hanging in folds round her small bones. She weighed scarcely more than 4 st., but still she was able to make an appeal that was almost fierce in its confident intensity. "I feel," she said, "that if only this lump were gone, I should be quite well," and as she spoke she made a movement with her hands as of tearing something from her stomach. "It's only my own spirit," she added, "that is keeping me alive." No refusal was any longer possible. The surgeon became filled with something of Lena's own confidence. There was no bed vacant at the moment, but no time was to be lost. She was sent home in a taxi, brightly assuring the surgeon that she would get to the Hospital somehow as soon as she was sent for.

A few days later, on July 16th, she was back again in the ward, and she seemed to irradiate confidence from her exhausted frame. She was put immediately on continuous rectal saline with 10% glucose, and her mucous membranes sucked it up like blotting-paper. In thirty-six hours she had absorbed 150 oz., but had taken nothing by the mouth. The operation was arranged to take place on July 18th. Anæsthesia was obtained with an injection of hyoscine A mixture, a mid-line and subcostal infiltration with 0.5% novocaine, and a minimal amount of gas and oxygen. The abdomen was then opened through a mid-line incision above the navel. The lower half of the stomach was found to be filled with a massive cancer, but in spite of its size, it was not adherent to surrounding viscera. Certainly it could be removed, but there must surely be secondary growths. Almost incredulously the surgeon searched Lena's inside, but her crab was clearly celibate; there was no offspring anywhere. Without waste of time it must be taken out, and the work immediately began. When the greater curvature of the stomach came to be freed it was found that the transverse mesocolon was caught up in the growth, and though the colon itself was free, the middle colic artery was deeply involved for a considerable distance. There was no time for regrets or timidities. The middle colic artery was clamped and divided, and the transverse colon was invited to turn blue. Two-thirds of the stomach was removed, and the stump joined to a short loop of the jejunum. The transverse colon remained a smiling pink.

\* \* \*

Lena was back in bed again, still too drowsy to be able to enjoy her triumph properly, but with an unmistakable air of complacency. During the stress of the

operation she had allowed her pulse-rate to rise from 70 to 80, but she soon brought it down again to 70. Her crab was gone, and now she was well. No more vomiting for her. She dismissed the pewter with a gesture of contempt. Six days later she announced that she felt hungrier than she had done for years, and on the 28th day after her operation she walked firmly out of the Hospital, undeniably weighing more than 5 st., and looking forward to a prolonged and triumphant convalescence. Two months later she had not completed her round of the available convalescent homes, and evidently Sister was being boundlessly indulgent. But by now she has tripped back to Barking, and the story that she has to tell is providing an endless source of satisfaction to the circles of her acquaintance.

Lena's brief history provides much material for reflection, but the outstanding question remains—how did she know? Apparently she knew quite positively—(1) that her crab could be removed, (2) that it was childless; (3) that her transverse colon didn't need a middle colic artery; (4) that whatever else happened she was going to get well. Probably the explanation is that she knew none of these things, but that she did know two others: (1) her own indomitable spirit; (2) the reputation of Bart.'s. St. D.

### A CASE OF VOLVULUS.

**B**G—, a young woman, aged 23, was admitted to Harley Ward in March, 1929. Since a child she had suffered from irregularity of her bowels and indigestion, being especially nauseated by any fat in her diet. Two years before admission she had an attack of severe pain relieved suddenly by treatment with enemata.

On March 21st, 1929, she had an acute attack of pain across the lower abdomen. The pain was spasmodic in character and accompanied by a continuous ache, but did not radiate. During the next forty-eight hours, before admission to the Hospital, the pain continued and she vomited eight times. Latterly the vomit was green and of a very foul odour, and her bowels had not been open since the attack of pain commenced. Two enemata were administered in Surgery Ward without the passage of faeces or flatus.

On admission the patient looked ill. There were sordes on the lips and the tongue was furred and dry. Temperature 99° F., pulse 88. The abdomen moved poorly, but was only slightly distended. There was some rigidity and tenderness, but no tumour was palpable and there was no visible peristalsis. Borborygmi

were present on auscultation. Examination of the rectum and the urine yielded no information.

On operation only small intestine was found in the right iliac fossa and this was plum-coloured. The caecum, appendix, ascending colon and half the transverse colon were found to be freely mobile and devoid of peritoneal attachments. They were engaged in a volvulus twisted counter clockwise through 520° and, in the original twist of 180°, the whole of the small intestine was also involved. The total length of the small intestine was found to be 7 ft. 7 in. and the base of the mesentery only 2 in. instead of the normal 6 in. The appendix was rather turgid and an appendicectomy was performed, followed by a colopexy, the parietal peritoneum over the right quadratus lumborum muscle being sutured in front of the ascending colon. The recovery of the patient was rapid, and when seen three months later she was in perfect health.

The points in the case that are typical of volvulus are the history of a previous attack which suddenly disappeared under treatment with enemata. There is the sudden onset and character of the pain, the constant ache due to the twist, and the colic due to peristalsis. The temperature and pulse-rate were neither very high, and the condition of the patient was not so grave as in strangulation.

The interest of this case lies in its relation to the mode of production of volvulus of the small intestine and caecum, and also on account of the extreme shortness of the small intestine.

Hutchinson records nine cases of volvulus involving the whole of the small intestine, caecum and ascending colon. In all these cases the volvulus took place in a counter-clockwise direction, and he suggests that it is due to a continuation of the developmental rotation of the intestines in the foetus, which is allowed to continue owing to the lack of attachment of the ascending colon.

As regards the length of the intestine, there is a case recorded of a girl who died following a resection of the small gut, the original length of whose small intestine was only 6 ft.

Marshall Flint, in experimental intestinal resection in dogs, found that after recovery there was an increase in diameter of the intestine with hyperplasia and hypertrophy of all its coats, but no change in length, and Sarnoff records an increase in gastric juice and decrease in peristalsis of the remaining gut. Flint discovered that the compensatory mechanism broke down on a diet containing much fat, protein appearing in the stools and the animals losing weight. This is of particular interest in view of the natural inclination of the patient under consideration to restrict so rigidly the fat in her diet.

I should like to express my thanks to Mr. Roberts for allowing me to publish notes of this case.

G. D. KERSLEY.

### SOME HISTORICAL ASPECTS OF RENAL TUBERCULOSIS.\*

**T**HE history of "renal phthisis" scarcely antedates the past century, but nevertheless the morbid appearances of the disease were recognized and described in ancient times.

One of the first to describe the post-mortem aspects of genito-urinary tuberculosis was Morgagni in his *De Sedibus et Causis Morborum*. In 1726 he performed an autopsy on a woman whose kidneys he describes as being "unequal in their surface and variegated with white spots where their surface subsided; the urinary bladder was internally red and in the thorax and belly there was some water which was very foul." This was apparently a case of miliary tuberculosis with secondary renal involvement.

In 1747 he performed an autopsy on a man, *et. 56*, "who gained a sorry sustenance in the streets by picking up melon rinds or anything else that could be found." This man was brought to the hospital on account of fever and a "sense of suppression" in his thorax. He at first got better, but again returned to hospital so emaciated and so broken down by disease that he soon passed away from this life. At the autopsy his kidneys were found to be eaten away and to contain cheesy material, while in his lungs were seen many tubercles.

Again, in Letter XXXXII of *De Sedibus et Causis Morborum* he describes a most interesting case: "A knight of six and forty years of age, who was formerly fat but was now slender and of a sallow complexion inclining to paleness, had begun to be troubled eight years before with many and various disagreeable symptoms on account of many and various errors in his diet, exercise, attention of mind, watchings and venery." Firstly he was infected with the lues venerea but was cured of this by a proper medical régime. He was, however, attacked a second time, more violently than before by the same disease. "For besides the pain in making water, an involuntary discharge of the urine, a purulent sediment therein, a pain in the stomach, he had vomitings, by means of which he threw up veal that had been eaten five days before without any change therein." This poor gentleman finally got weaker and weaker, his pulse being very quick and turgid, his pain in making water ever increasing and he had a viscid and tenacious spitting, till he finally died convulsed. At autopsy "the lungs appeared sound except for some stony concretions, but when the belly was opened the kidneys appeared to be less than their normal size and

\* Being the major portion of the historical survey from the Bentley Prize Essay, 1930.

of an unusual kind of figure and to have many protuberances here and there externally. These tubercles, when cut into, showed a sanious humour, for which a passage was opened into the pelvis. But in the urinary bladder, in which particularly about its neck the root of the disease was supposed to exist, by the unanimous consent of many learned men, nothing appeared in any parts that was worthy of remark except a slight erosion about the orifices of the ureters."

Valsalva supposed, and with very good reason, that this dissection might be a lesson of some importance to those present, as it might make them cautious in determining the seats of disease when they relate to the urinary parts.

The study of these cases is particularly interesting, for although phthisis of the kidneys was recognized at this period, yet, when we examine the modes of treatment of such a condition, we find that very little could be done. Patients were advised to take all sorts of herbs mixed with human or animal excreta.

The value of fresh air and exposure to the winds of heaven was recognized as being a factor in the treatment of all forms of phthisis by certain physicians, but beyond these simple measures there remained little hope for the patient with renal tuberculosis before the nineteenth century for whatever stage his disease had evolved.

We may say with confidence that the mortality of this disease before the middle of the last century was 100%. To-day it is about 35%, if taken as a figure to include all stages of the disease.

To what may we credit this outstanding drop in mortality but to the discoveries of the last century?

First and foremost to the invention of the cystoscope by Nitze, the story of which is full of interest and will be dealt with at a later stage; secondly, to Listerism accompanied by all the modern improvements in surgical treatment; thirdly, to Koch's discovery of the tubercle bacillus; and finally to the development of pyelography and radiography.

#### NITZE: THE CYSTOSCOPE.

The invention of the cystoscope takes first place, because without it, renal surgery, with all its aseptic methods, would be helpless to-day in diagnosis, and because the performance of a nephrectomy without ascertaining that the disease was unilateral would be courting disaster.

The first attempt at internal examination of the bladder (or endoscopy) was in 1805, when Dr. Bozzini invented an apparatus which he termed the "light conductor." This consisted of a hollow bone urethral tube through which the light of the sun was admitted; the instrument, when shown before the Medical Faculty



of Vienna, was condemned on the ground that it had insufficient illumination. The idea prepared the way, for several enterprising investigators attempted to improve upon the invention, and much literature was written on the subject at the time. New inventions were forthcoming, and in 1825 a certain John Fisher, of Boston, U.S.A., brought forward a hollow metal tube by which light could be reflected into the bladder. Two years later Paul Segalas devised an improvement on the existing

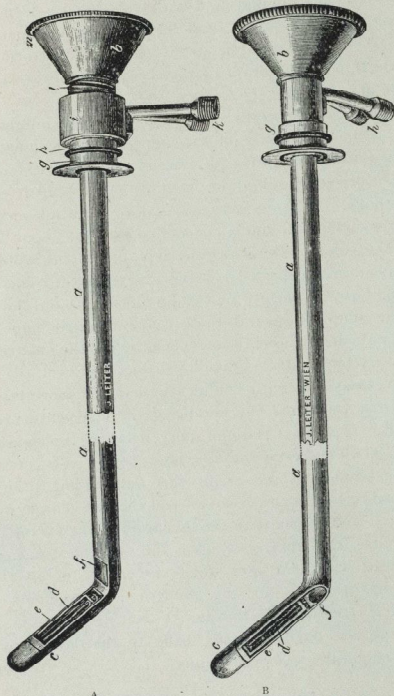


FIG. 1.—THE NITZE-LEITER CYSTOSCOPE OF 1879.

urethrovaginal speculum, which he demonstrated before the Academy of Science in Paris.

Desomeaux, who is known as "the father of endoscopy," opened the second great phase in the evolution of the endoscope, and to him may be credited the first practical instrument, which was produced in 1853. Twelve years later Cruise, of Dublin, made an important improvement in this endoscope, when he devised a method whereby the illumination from the edge of the flat flame of an ordinary paraffin lamp could be concentrated upon a reflector and thence conveyed through

a speculum to the parts to be examined. To prevent injury and discomfort from the great heat evolved by the powerful light the lantern was made of mahogany. The speculum resembled a Coudé catheter, with a little window of glass at the angle to permit the transmission of light.

This instrument found favour with a great many investigators, and Christopher Heath used it at the Lock Hospital and introduced it to the profession in England in 1866. A few improvements were added in the manner of light transmission, but the fundamental principles remained the same until the introduction of electrical illumination in 1879.

Nitze invented his first cystoscope in 1876, but nine years earlier there had been, in Breslau, a certain dentist, by the name of Bruck, who employed a platinum



FIG. 2.—A PORTER WITH A CYSTOSCOPE (Temp. 1879).  
(From Hurry Fenwick: *The Electric Illumination of the Bladder and Urethra*, London, 1888.)

loop, maintained at white heat by means of a galvanic battery, as a source of illumination for the examination of the mouth. He advocated that the same device might be applied with advantage to the examination of the rectum and bladder. The original Nitze cystoscope had many failings, and it was entrusted to those world-known instrument makers, Leiter, of Vienna, to be simplified and perfected. The main outcome of this was an improvement in the lighting and water-cooling arrangements, whereby the famous Nitze-Leiter cystoscope was produced in 1879. At first it was hailed all the world over by medical men as a gigantic step forwards in diagnostic methods, but alas, these praises soon turned to ridicule, for great as the step was, the instrument had many grave faults, so that for a time it fell into comparative disuse.

The instrument (Fig. 1) itself was constructed in the

form of a bladder sound of No. 21 French catheter gauge, with a sharp elbow and a longish beak. The window (*f*) was placed, depending on the part of the bladder to be examined, either in the cavity of the elbow (for the anterior wall, neck and sides [*A*]) or in the convexity (for the posterior wall and base [*B*]). The beak (*c*) carried the electric bulb, and the shaft (*aa*) contained the telescope, the water-cooling tubes and the insulated wire from the battery to the lamp. The obturator (*b*) end was furnished, with tubes connected with a water reservoir, so that a continuous stream of cold water could be kept running in order to absorb the great heat emitted by the platinum loop when in action; it was also furnished with a grip by which the connecting cords to the battery could be attached.

The heat emitted by this instrument when in action was so great that the water-cooling apparatus was indispensable; also to obtain a continuous illumination a constant current of a certain intensity was needed, which necessitated the use of a large and cumbersome battery. The ease with which the apparatus fused required the services of a skilled electrician to be handy at all times. Sir Henry Thompson, whilst demonstrating its use at the Royal Medical and Chirurgical Society in 1880, remarked that the instrument "should be under the care of a person well versed in the use of a galvanic apparatus and competent to adjust or repair, if necessary, the very delicate details which formed the essential parts of this somewhat complicated but very complete instrument."

It was too complicated, too cumbersome (Fig. 2), too unreliable and too costly to be of general service to the surgeon.

The next step in the evolution of the cystoscope was the invention by Edison in 1887 of the incandescent lamp, which replaced the platinum loop as a source of light. After this other improvements soon followed. Boisseau du Rocher in 1889 invented what he called a megaloscope, which was an instrument similar to the Nitze-Leiter cystoscope, but without a prism. This instrument also was very difficult to use and quite unsuitable for the required purpose.

Irrigation of the bladder was not possible when using the older Nitze cystoscope, and in 1888 an improvement was made whereby the process could be carried out.

The first direct catheterizing cystoscope was presented by Brenner to the German Surgical Congress in 1887; it consisted of a tube through which he attempted to pass catheters up the ureters of female patients. The performance of such a feat was accomplished by moving the whole instrument about into the required position. He succeeded in the case of one female, but entirely failed in the case of a male.

Five years later, however, James Brown, the predecessor of Young at the Johns Hopkins Hospital, modified the Brenner instrument, and had the honour of being the first to catheterize the male ureter through a cystoscope on June 9th, 1893.

In the following year Nitze, determined not to be outshone by the inventions of others, devised an indirect catheterizing cystoscope. In previous instruments the catheter emerged in the long axis of the instrument, which made it extremely difficult to direct it into the ureteral orifice, but Nitze's improvement provided a tube which came off at an angle and directed the catheter towards the ureter when the instrument was in position: therefore in spite of the fact that Nitze was not the first inventor to construct an instrument for ureteric catheterization, he was the first to construct one on the right principles.

Other modifications soon evolved, all of which are extremely interesting, but cannot be described in further detail. Of the part played by instrument makers in the evolution of the cystoscope one must mention the names of Leiter of Vienna, Wapple in America, Loewenstein and Wolf in Berlin, and Colin and Drapier in France; to them is much credit due for the co-operation which they gave in helping and developing the ideas of Nitze and others.

Of urologists and medical men who played an important part in this evolutionary process, the names of Gueterbock, Kollmann, Albarran, Pilchler, Buerger, Caspar, Young, Hurry Fenwick and many others must not be forgotten.

In conclusion it will not be out of place to quote the words of Andrew Fullerton,\* who says:

"Those who have grown up with the cystoscope can have no conception of the thrill experienced by one who, accustomed to older methods of examination, was privileged for the first time to obtain a view of the healthy bladder by the new instrument. As he viewed the mucous membrane and watched the rhythmic movements of the ureteral orifices, which from time to time drew themselves up and ejected a little stream of fluid from their open mouths and subsided gradually into the resting position, he felt that a great vista of opportunities had suddenly burst upon his astonished gaze."

Before the catheterizing cystoscope had established itself various methods were used for obtaining urine separately from the two kidneys. Tuchman was the first to perform this feat by compressing one ureter at a time and allowing the urine from one kidney to collect in the bladder; he employed an instrument to slip over the elevation of the ureteric meatus, but this

\* *Lancet*, December 28th, 1929, "Campbell Oration."

method proved very uncertain. Silberman proposed the introduction into the bladder through a catheter of a thin rubber bag which could be filled with mercury and made to compress the ureter; the instrument, however, was never perfected.

Wier, with a similar idea, suggested that one ureter might be compressed temporarily by introducing a special instrument *per rectum*. Other similar suggestions were made and tried, but all proved worthless. Harris, working in Chicago, devised an apparatus which could produce a watershed between the two ureteric orifices, while Luys of Paris invented an instrument which was catheter-like, and across the concavity of which a band of thin rubber was placed which could be stretched by means of a chain; when *in situ* the rubber septum divided the bladder into two long compartments, the fluid from each compartment being collected into two separate bottles. Admixture very often took place across the midline and the instrument was thus of little use. As late as 1902 Guyon invented a similar instrument, which was perfected by Cathelin. This fact shows that even at this late date the catheterizing cystoscope was not in general use.

#### LISTER.

We now turn to the second great factor, Listerism.

So much has been written upon the benefit gained by surgery through the work of Joseph Lister that a full appreciation of the subject can be gained by merely walking into the modern operating theatre and "harking back to the olden days, and gratefully recalling the man whose labours in the past have made the present possible."

The history of nephrectomy is especially worthy of notice in the investigation of renal tuberculosis. Simon, of Heidelberg, was the first to determine whether a kidney could be removed with impunity. He performed nephrectomies on a series of thirty dogs with great success. He then carried out the operation on a young woman who was suffering from a ureteral fistula and it proved successful. This was in July, 1869.

Simon was not the first person to perform a nephrectomy, for Wallcott in this country eight years previously did a transperitoneal nephrectomy, the patient dying fifteen days later. Denham, in 1872, performed the first successful lumbar nephrectomy in this country, and since that date the operation has made steady progress. In 1879, however, Pilcher was able to find only fifteen cases recorded in the history of the time, which fact demonstrated that at the outset the operation was accompanied by a very high mortality, but the work of Lister waged its war against sepsis and the surgery

of the kidney became established. We read to-day that Wildbolz,\* after a series of 660 nephrectomies performed for renal tuberculosis, records a mortality of only 2.2-2.5%. What greater proof can be found of the advance of renal surgery than this fact?

#### KOCH: TUBERCLE BACILLUS.

The history of the third factor is common not only to this branch of tuberculosis, but to all tuberculous diseases. Morgagni was one of the first to remark upon the infectious nature of consumption, and this belief has never since failed of a following amongst physicians. Laennec tells us that at an autopsy on a tuberculous subject he cut his finger, and soon afterwards began to feel sick and showed the signs of tuberculosis. Klencke (1843) was one of the first to announce that he had injected tubercle cells into the jugular veins of a rabbit, and that twenty-six weeks later the animal showed a widespread tuberculosis of the liver and lungs.

The infective cause of tuberculosis still remained unknown, though Klebs (1877) and Toussaint (1881) closely approached the true explanation. It was reserved for Robert Koch to bring the problem to a final conclusion, and never was a man more rewarded for many unsuccessful attempts and much arduous labour in the pursuit of truth than he, when finally he was able to demonstrate fine, rod-like structures in the sections of fresh grey pulmonary tubercles of recently killed animals. This discovery was first given to the world in March, 1882, and was published in the *Berliner klinische Wochenschrift* on April 15th of that year. Speaking in 1900 Sir William Osler said: "Koch's brilliant demonstration of the tubercle bacillus had a hard uphill fight to recognition. The vested interests of many minds were naturally against it, and it was only the watchers amongst us men like Austin Flint, who were awake when the dawn appeared."

Pathologists and clinicians were slow in acquiring the technique for staining the tubercle bacillus, and as late as 1885 Dr. Osler,† at a meeting of the Pathological Society of Philadelphia, demonstrated a slide from the urine of a case of renal tuberculosis, and the staining properties of this bacillus.

#### PYELOGRAPHY AND RADIOGRAPHY.

The last factor influencing this decline in mortality began in 1897, when Tuffer suggested simultaneous combination of an opaque ureteral catheter with radiography; this took place two years after Roentgen's discovery of X-rays.

\* *Journal of Urology*, 1929.  
† *Trans. Path. Soc. Phila.*, 1885-1887.

Schmidt and Kolisher in 1901 independently suggested the same procedure, and published radiograms which showed the course of the ureter and the situation of the renal pelvis by means of a fused wire inserted with the ureteral catheterizing cystoscope.

In 1905 Hurry Fenwick suggested the passage of a ureteral bougie whose walls were impregnated with metal, and about the same time Klose put forward the idea of outlining the urinary tract by the injection of an emulsion of bismuth. Voelcker and Lichtenberg (1906) were, however, the first to outline the ureter and renal pelvis completely by the injection of a solution of collargol (col. silver). This discovery was made entirely by accident, as the investigators were trying, at the time, merely to outline the bladder, but by injecting too much solution they caused some of the fluid to ascend up the ureteric meatus into the renal pelvis.

In 1910 Braasch called attention to this form of pyelography as an aid in certain doubtful cases of renal tuberculosis, and in the following year Lichtenberg and Dietler suggested the use of oxygen as a medium for outlining the urinary tract in such cases. About the same time Uhle and Phahler used silver iodide in the solution for injection, and finally in 1913 Doederlein and Kroenig brought in xeroform as the opaque medium.

The importance of pyelography in renal tuberculosis to-day is perhaps not so great as it is in other genito-urinary diseases, but yet its development has played a very real part in the history of the disease. The introduction of uroselectan at the beginning of the present year is surely one further step forward to the attainment of perfection in diagnostic means.

The only hope, to-day, for effecting any definite cure in this disease is by performing an early nephrectomy; this can only be possible where early diagnosis is procured.

It is the discoveries of the last century which have made this early diagnosis possible.

J. MOLINEUX JACKSON.

#### ABERNETHIAN SOCIETY.

The Inaugural Sessional Address was delivered before the Society in the Medical and Surgical Theatre on the evening of October 16th by the Very Reverend Dean Inge, V.O., the subject being "Racial Decay and Regeneration."

The President (Mr. Koels) was in the chair. Dean Inge's address will be published in a future issue of the *Journal*. The address ended amid tumultuous applause, the vote of thanks being proposed by Mr. Geoffrey Keynes and seconded by Mr. Recordon. Dean Inge having replied, the meeting was adjourned.

#### STUDENTS' UNION.

##### RUGBY FOOTBALL CLUB.

##### ST. BARTHOLOMEW'S HOSPITAL v. OLD PAULINES.

September 27th, at Thames Ditton.

Played at the new ground at Thames Ditton, this game resulted in a victory for the Old Paulines by 0 points to *nil*. The new ground seems to be a lucky one for the Old Paulines, and their victory was decisively gained, though at one time towards the interval the Hospital seemed to be getting the upper hand.

The ball was very greasy at the start and Bart's adopted the proper tactics in keeping it on the ground, but the Paulines' pack was heavier, and though in the first half play was mostly in Old Pauline territory, in the second half weight began to tell and the Old Paulines started to attack.

The Old Paulines scored by Jankel; J. R. R. Jenkins equalized. In the second half Jankel and Salmons both scored for Paulines.

Bart's defeat was not the fault of their scrum half, J. T. C. Taylor; he did the work of three men both in attack and defence and was the best back on the field. T. J. Ryan showed plenty of pluck and judgment in kicking, but the three-quarters were, as a whole, unimpressive.

*Team*—Old Paulines: H. B. Phillips (*back*); A. Jankel, C. B. Cook, J. H. Salmons, E. A. Low (*three-quarters*); G. L. Oliff, S. M. Mischler (*halves*); J. J. A. Embleton, G. Embleton, J. S. H. King, G. M. DeLafield, C. H. Dixon, R. Klemm, W. R. Scott, R. H. B. Nicholls (*forwards*).

Bart's: T. J. Ryan (*back*); J. D. Powell, C. B. Prowse, J. A. Nunn, L. Buckland (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); V. C. Thompson, H. G. Edwards, W. Gabb, E. M. Darnady, G. D. S. Briggs, J. R. R. Jenkins, R. M. Williams, A. T. Blair (*forwards*).

##### ST. BARTHOLOMEW'S HOSPITAL v. ROSSLYN PARK.

October 4th, at Old Deer Park.

This was played in fine weather before a good crowd and resulted in a win for the Park by 19 points to *nil*.

Both sides played fine bustling football, and it was the kicking and tackling of E. W. Hunt, the Park full back, that prevented the Hospital scoring when they gained a footing close to the Park line late in the first half. Great credit must be given to the Hospital forwards, five of whom were newcomers. On the defence they tackled strongly, they were out-scrammaged and out-manoeuvred, but they put up a very good fight.

R. M. Williams, V. C. Thompson and J. R. Jenkins were always prominent, and H. G. Edwards got in some good work. Bart's backs struck an off day, and with Nunn injured soon after the interval, they were unable to put up any dangerous attacks.

*Team*: T. J. Ryan (*back*); J. D. Powell, C. B. Prowse, R. M. Kirkwood, C. F. Petty (*three-quarters*); J. A. Nunn, J. T. C. Taylor (*halves*); K. P. Smith, H. G. Edwards, J. M. Jackson, R. N. Williams, A. T. Blair, W. R. Gabb, V. C. Thompson, J. R. R. Jenkins (*forwards*).

##### ST. BARTHOLOMEW'S HOSPITAL v. OLD ALLEYNIAN.

October 11th, at Winchmore Hill.

Thanks chiefly to the superiority of their forwards in the set scrums, this game resulted in a victory for the Old Alleynians by 17 points to 6.

In the first half the Old Boys lost the services of Chapman, who broke a leg, but the game was bright and open, with fierce forward play and relentless tackling. Taylor played well, but was too closely marked to be as effective as usual. Actually Dart's should have done better than they did, but they missed several chances by faulty passing, whereas the Old Alleynians came through the game very well in this respect.

T. J. Ryan kicked the two Hospital penalty goals, while for the visitors Frankford (3), Miller and Stark scored.

*Team*: W. D. Bell (*back*); L. H. Buckland, T. J. Ryan, C. B. Prowse, J. D. Powell (*three-quarters*); A. H. Pirie, J. T. C. Taylor (*halves*); E. M. Darnady, A. Barber, K. P. Smith, R. N. Williams, J. M. Jackson, J. R. Jenkins, W. Gabb, V. C. Thompson (*forwards*).

## HOCKEY CLUB.

## ST. BARTHOLOMEW'S HOSPITAL v. BECKENHAM II.

October 11th, at Winchmore Hill.  
To lose this game by a narrow margin was not really discouraging; it was our first match of the season and our opponents had played several times before.

Pressing hard for the first twenty minutes we were a little unlucky not to score, and by half-time, with the score still 0-0, we had really had the better part of the game.

Early in the second half Berry scored for Beckenham from a corner—a fine shot which gave Smallhorn little chance. After this we had a serious lapse, allowing them to score twice more, but we soon retaliated with goals from Snell and Henton-White.

At right-half Heasman played well and Lloyd-Williamson had some good runs down the wing; Iliff worked hard in the centre and gave the forwards many good passes.

The last ten minutes of the match were exciting, but we were unable to score again, though Henton-White nearly equalized with a hard shot just a couple of inches outside the posts.

*Team*—T. Smallhorn (goal); D. Gale, P. M. Wright (backs); L. Heasman, A. D. Iliff, J. H. Hunt (halves); J. C. F. Lloyd-Williamson, L. P. Jameson-Evans, F. C. Henton-White, V. C. Snell, J. Symonds (forwards).

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

October 18th, at Woolwich.  
Playing at Woolwich on a fast ground we deserved to win this game, even though we started badly, allowing the Garrison to score twice in the first few minutes.

We were playing downhill and pressing hard, but the opposing backs cleared well and kept us out until just before half-time, when Heasman scored our first goal. Soon after we had changed over Williams and Jameson-Evans gave us the lead with two more goals—a lead we were able to keep to the end of the game.

Playing for the first time at outside-right, Henton-White gave the Garrison many anxious moments, and at left inside Heasman played a hard game; Hodgkinson in goal saved several good shots, his novel pair of boots proving a great success.

*Team*—H. L. Hodgkinson (goal); D. Gale, P. M. Wright (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); F. C. Henton-White, L. P. Jameson-Evans, A. G. Williams, L. Heasman, F. Symonds (forwards).

## ASSOCIATION FOOTBALL CLUB.

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

October 4th, at Chiswick.  
This fixture was more in the nature of a trial game, both 1st and 2nd XI's opposing the two Thomas's XI's.

The 2nd XI played first, and were successful in beating Thomas's 2-0. Bart's were superior in every department of the game, and were especially well served by their halves.

After a keenly contested game the 1st XI drew 2-2. In the first quarter of an hour the Thomas's forwards attacked keenly, and at half-time Thomas's were two up. In the second half, however, the Bart's forward line showed much better combination and Thomas's were on the defence for the whole of this half. R. G. Gilbert scored twice for Bart's, and we were unlucky in not adding to the score.

*Team*—D. J. Johnson (goal); R. MacGladdery, H. J. Roache (backs); F. E. Wheeler, C. A. Keene (capt.), G. H. Brookman (halves); B. F. Jackson, R. Shackman, R. G. Gilbert, C. M. Dransfield, W. Hunt (forwards).

## ST. BARTHOLOMEW'S HOSPITAL v. R.M.A. WOOLWICH.

October 11th, at Woolwich.

The whole team showed combination that was a great improvement on the previous game. The forwards pulled very well together. C. M. Dransfield being especially prominent. The halves easily held the R.M.A. forwards, A. Hollinrake doing very good work in this respect. Bart's scored five times to the R.M.A.'s once. Scorers were: C. M. Dransfield four, L. McAskie one.

*Team*—W. A. Owen (goal); R. MacGladdery, H. J. Roache (backs); F. E. Wheeler, C. A. Keene (capt.), A. Hollinrake (halves); W. Hunt, R. Shackman, R. G. Gilbert, C. M. Dransfield, L. McAskie (forwards).

## ST. BARTHOLOMEW'S HOSPITAL v. DOWNING COLLEGE, CAMBS.

October 18th, at Cambridge.

This match resulted in a win for Downing by 2-0. In the first half the play was extremely fast, the ball going from one end of the field to the other. Several times our forwards looked like scoring, but the shooting was erratic. The defence was very hard pressed and at times the Downing forwards being very quick on the ball, and their superior shooting put them two up before half-time. In the second half Bart's were mostly on the defensive, the forwards never getting together. The defence, however, held, R. A. Wenger clearing some very hard shots. The team, on the whole, were too slow in some very hard shots. The team, on the whole, were too slow in some very hard shots. The team, on the whole, were too slow in some very hard shots.

*Team*—R. A. Wenger (goal); R. MacGladdery, H. J. Roache (backs); F. E. Wheeler, C. A. Keene (capt.), G. H. Brookman (halves); W. Hunt, R. Shackman, R. G. Gilbert, C. M. Dransfield, L. McAskie (forwards).

## CORRESPONDENCE.

## THE LATE SIR FRANCIS CHAMPNEYS.

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

DEAR SIR,—All who knew the late Consulting Physician Accoucheur to the Hospital will feel grateful for the obituary account of his life and work, given to the October number of the JOURNAL in the way that Sir D'Arcy Power alone could give it. May I, however, offer a correction? Sir Francis Champneys did not perform laparotomy, but he carried out all the other surgery of his speciality himself. To assist him in a vaginal hysterectomy was a lesson in patience and dexterity.

Yours faithfully,

A. R. NELIGAN.

London, N. 6;  
October 23rd, 1930.

## MUSEUM MUSINGS.

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

DEAR SIR,—The belief expressed by John Landon in his "Museum Musings," contributed to the October issue of the JOURNAL, that "people have come great distances to see the original specimen of carcinoma of the nipple, described by Paget," though pious, is unfounded. A visitor to the Museum will search in vain for the original specimens of *Trichina spiralis* and of Paget's *Disease of the Nipple*. Our glowing affection for Paget's name and our legitimate pride in his illustrious achievements are inexhaustible, but our Museum takes little part in the exaltation of his memory. Some time ago (St. Bartholomew's Hospital Journal, 1929, xxxvi, p. 140) I suggested that a little cabinet might be reserved in the Museum to display those historical specimens which are milestones in the progress of that pathology. Though encouragement has been lacking where it should have been insistent, I am by nature an optimist. The day will come when my fond imagination will be like Adam's dream, who awoke and found it truth.

I am, Sir,

Yours faithfully,

W. R. BETT.

Shadwell, E.;  
October 13th, 1930.

## REVIEWS.

BOWLY AND ANDREWS' SURGICAL PATHOLOGY AND MORBID ANATOMY. Eighth edition. Revised by GEOFFREY KEYNES, M.A., M.D., F.R.C.S., Assistant Surgeon, St. Bartholomew's Hospital. (London: J. & A. Churchill, 1930.) Pp. 644. With 224 illustrations. Price 21s.

Bowly and Andrews! Generations of Bart's men have spoken of it with affection as their text-book of pathology and surgery in one. Indeed, some used to boast that, with the exception of the one, this was the only book on surgery which they ever read. To the surgical dresser it was the guide-book to that vast new country in which he was let loose. Those about to face the dictation, rejoiced in its classical brevity and in the clearness of its diction. Even the lions hot on the trail of the Fellowship were not too proud to be seen with this book. To them Bowly was the ideal teacher,

who in his crisp and forcible style taught the very kind of pathology which they served in surgery.

Having needed his apprenticeship in the museum and the post-mortem room, Bowly had broken the tradition that it was proper for a surgeon to pass through the portals of the dissecting-room to the serenity of the staff. *Surgical Pathology* was first published forty-three years ago at a time when pathology was just beginning to be recognized, if not as the mother, at least as the nurse of surgery. The success of later editions was enhanced by the facile pen of that master of scientific writing, Sir Frederick Andrews, whose chapter on "Diseases of the Arteries" has become classical. The seventh edition appeared in 1920, and, if it is true that it takes ten years for new facts to find their way into a text-book and twenty years for wrong statements to make their exit, a new edition was urgently needed.

Mr. Geoffrey Keynes, asked by Sir Anthony Bowlby in 1928 to prepare the eighth edition of the work, has brought to the task the reputation of a sound pathologist, of an up-to-date surgeon, and of a lucid, painstaking teacher, the meticulous care of a bibliographer, and the piety of a Bart's man. His aim to "maintain the general character of the book unaltered, whilst making the information as accurate as present knowledge allows," is ambitious enough, but the fruit of his labour can only be described as a literary event for a much wider circle than Bart's. The familiar red cover of 1920 has given place to green, and truly may it be said that the green years linger in the pages.

The introduction of countless minor alterations and the extensive revision of many sections have eliminated very little of the original matter of the book. Whole paragraphs, unsurpassed for their lucidity and directness, remain word for word, and the chapter on Diseases of the Arteries survives undisturbed.

The sections on tumours of testis, kidney, and parotid, on renal tuberculosis, and on scrofula have been modernized. The hand of revision has left its deepest impress on the accounts dealing with diseases of the thyroid (illustrated by excellent microphotographs) and with chronic mastitis—subjects which Mr. Keynes has made peculiarly his own. New accounts have been added of the Sigma Reaction, of fibro-cystic disease of bone, of pseudo-coxalgia, and of diseases of the pancreas. The last is singularly inadequate. There is an entirely new chapter by Mr. Paterson Ross on "Tumours of the Brain and Spinal Cord"—fully detailed, completely up-to-date and attractively presented.

The old description of lymphoma has been entirely omitted, though on pp. 150 and 260 the term is retained but not defined, and on p. 150 we are promised that lymphomata are fully described in the chapter on the Lymphatic System.

In connection with "quiet necrosis"—a term not used in the previous edition—it is curious that Morratt Baker's name should be mentioned. The condition to Bart's men at least is universally known as "Paget's quiet necrosis."

On p. 277 "Reidel" is a misprint for "Riedel." The lack of uniformity in references, such as the following, coming from so renowned a bibliographer as Mr. Keynes, is surprising:

p. 416: "Path. Soc. Trans., vol. xlvii, p. 291."

p. 421: "Transactions of Pathological Soc., vol. 55."

Striking X-rays, judiciously added, forcibly illustrate the descriptions. There is a remarkable microphotograph of Paget's disease of the nipple. The addition of one line to the content of each page has reduced the 651 pages of the last edition to 644, and the index is improved by the introduction of heavy type.

Like its predecessors, the new edition is dedicated to the Students of St. Bartholomew's Hospital. The excellence of the work to the surgical dresser has never been bettered, and its reputation remains secure. But knowledge has advanced by leaps and bounds, and a new generation exacts a new standard. The critical mind cannot dip into this book for points of guidance and time and again must turn to more modern works. *Mene, Mene, Tekel, Upharsin!* In reviewing an old-established text-book the voice of sentiment cannot be silenced. If a reviewer keeps his head a prisoner, he can allow his heart many liberties. And that way danger shows its teeth.

A TEXT-BOOK ON THE NURSING AND DISEASES OF SICK CHILDREN. Edited by ALAN MONCREIFF, M.D., B.S., M.R.C.P. (London: H. K. Lewis & Co., Ltd., 1930.) Pp. xvi + 580. Price 15s. net.

Nursing, and in particular the nursing of sick children, remains a closed book to many during their clinical training, and it is not

until bitter experience has opened their eyes that they gain some inkling into this great unknown.

This text-book has been compiled by various members of the staff at Great Ormond Street with the collaboration of the matron, all writing under the able editorship of Dr. Moncreiff. The work is in two parts—a description of nursing methods as applied to children, and an account of the commoner ailments of early life. Throughout the writing is clear and accurate, with excellent line drawings and photographs to illustrate the text.

It will be impossible to give an adequate idea of the scope of the book, but certain points may be touched on. In all probability the first part dealing with nursing will be of greatest use to the student or practitioner, for it is difficult to find a single book which will give details of such varied subjects as the preparation of enemata and the prevention of post-operative acidosis; all nursing procedures are described succinctly, and in the introduction to the section on surgical nursing there is an admirable little chapter on Bacteriology and Immunity by Mr. Twistington Higgins.

Dr. Schlesinger has written a most excellent chapter on that all-important subject, Infant Feeding; the various types of artificial milk are described and their relative merits discussed. Here are to be found both formulae for determining from first principles the proportions of foodstuffs, and tables for those who have no love for mathematics.

In assessing the merits of the main section on the Diseases of Children the reviewer is in some difficulty. It is admirably written in a simple style, but if the work is intended for nurses and welfare workers, it would appear to be more detailed than is necessary. What value can it be to a nurse to know the types of the myopathies or the varieties of hydrocele. It may be that these details are included to cover the syllabus of the Nursing Council, who, from the examination papers contained in an appendix, would appear to expect their candidates to be familiar with Hirschsprung's disease and the indications for tenotomy. On the other hand, it is intensely irritating to see every word which is in the least technical (such as impacted) placed in double inverted commas, which in actual fact should be reserved for reported speech, the single comma being sufficient for emphasis; certain of the authors place these unusual words in italics, which is preferable.

As an appendix there is a section on therapeutics and toxicology, a collection of sick-room recipes, and a most useful article on Breathing Exercises by Miss Butcher. The work concludes with a very full index.

Undoubtedly this book fills a real gap, and it can be thoroughly recommended as an addition both to nurses' and practitioners' libraries.

RECENT ADVANCES IN PHYSIOLOGY. By Prof. C. LOVATT EVANS, D.Sc., F.R.C.P., F.R.S. Fourth edition. (London: J. & A. Churchill, 1930.) Pp. xii + 446. 113 Illustrations. Price 12s. 6d.

The utility of the "Recent Advances" text-books to both teachers and students requires no emphasis here. The book under review formed one of the first of that series. In preparing the new edition the author has added two new and very interesting chapters, one, "The Coronary Circulation and its Regulation," the other, "The Part Played by the Carotid Sinus in the Regulation of the Circulation." Two chapters have been omitted from this edition, "The Origin of the Cells of the Blood" and "The Mechanism of Tissue Oxidations." Some of the remaining chapters of the book have undergone considerable revision, notably, "The Chemistry of Muscular Contraction" and "The Nervous Impulse."

ASTHMA AND ITS TREATMENT. By PERCY HALL, M.R.C.S., L.R.C.P. (London: Heinemann [Medical Books] Ltd., 1930.) Pp. vii + 130. Price 7s. 6d. net.

Dr. Hall writes with the experience of a practitioner and a sufferer, now happily cured. The book is intended to be read also by the layman, although one shudders at the thought of a patient who has read and digested its contents. Nothing new is claimed excepting in the application and combination of accepted remedies.

Over forty pages are devoted to a rather satiating recapitulation of all the possible causes of the disease, its signs and symptoms. On p. 30 the statement that immobility of the diaphragm may cause inhibition of the suprarenals is rather far-fetched. Vague terms are too frequent. On p. 35 is the statement that "adrenal dysfunction may be met with," and similarly on p. 36 that "a degree of

avitaminosis may be met with." Both suggest the literature of the vendors of proprietary preparations. The section on vitamins is perhaps the worst in the book. That vitamin B affects the growth of the body, and the nutrition of the muscular coats of the gastrointestinal tract, that deficiency leads to stunted or disordered growth, and that metabolism of calcium and phosphorus is intimately bound up with " . . . the thyroid in particular " all challenge criticism. The author has little use for skin tests, and has had disappointing results with vaccines. The latter may be useful in added secondary infections of pharynx and bronchi. The chapter on general hygiene, clothing, massage, etc., contains little else than a catalogue of common-sense measures, such as a daily bath on rising, light clothing, fresh air, ventilation, and exercise in the open. But it is necessary to impress the value of these on many patients, whose mode of life reveals their lack of intelligence on what seem matters of instinct to the practitioner.

It is unconvincing to read that " manipulation of the spine . . . will help to correct deformities due to adhesions or malplacements of the vertebrae from long-continued malposition," and again one is sceptical of the rationale of manual massage to the chest-wall over the heart. The section on drugs is traditional; the author soon dismisses them and repeats much about vitamin B and the endocrinoids. Again we have mention of " varying degrees of hypothyroidism, together perhaps with signs of pituitary inadequacy," a syndrome difficult to diagnose with certainty in its milder degrees. Much sound advice is given under "Diet," and our friends the vitamin turn up again, vitamin B a prominent figure in the front row of the chorus. The writer has nothing but praise for diathermy, both to chest and abdomen in all varieties of asthma.

Finally, after somewhat unenthusiastically handing out all recognized therapeutic measures from his bag, we find the author has left the best at the very bottom, and on p. 102 he brings out actinotherapy, which, in his opinion, easily takes first place in value. This is by far the best section of the book, well explained and written with a tone of conviction and authority. Twenty-one cases are quoted, all improved or cured, after actinotherapy combined with other measures where necessary. Were there no failures? "So very few cases returned . . . after satisfactory results . . . that it is a fair assumption that they did not suffer any relapse," is not a wholly reliable criterion for any treatment. One feels that Dr. Hall has spoiled his book in his attempts to make it palatable to the lay mind.

RECENT ADVANCES IN CHEMOTHERAPY. By G. M. FINDLAY, O.B.E., M.D., D.Sc. (London: J. & A. Churchill, 1930.) Pp. 532. 4 plates, 11 figures. Prices 15s. net.

Chemotherapy as a science began with Ehrlich's conception that chemical substances could be produced which would unite with and destroy the parasitic agents of disease without simultaneously injuring the cells of the body. This is an ideal which has never been attained; substances tolerated by tissues in large doses, but fatal to parasites in small doses, have had to be produced. Only a few remedies, such as emetine and some of the antelmintics, have been proved to have a direct action on the parasites themselves. For the rest the action of the chemicals used must be indirect through reaction with the body tissues. It is thus clear that chemotherapeutic agents as yet are not specific for the diseases which are treated by them.

This book is the first in English to describe the present position of chemotherapy from the viewpoint of medicine. About three-quarters of it is devoted to diseases due to helminthic, protozoal and spirochetal infections, these being diseases in which the presence or absence of the causal factor can be so readily detected in a blood-film or in feces. The detection of bacteria or viruses is necessarily more difficult and uncertain. The reader cannot fail to be impressed with the necessity of preliminary work on laboratory animals in this subject. Without it we should still be ignorant of the use of arsenic in spirochetal infections, and of Bayer 205 in trypanosomiasis.

Progress in the chemotherapy of bacterial infections has been very slow. All the chemicals at present in use are general protoplasmic poisons, which consequently inhibit the phagocytosis of the bacteria, and in addition decrease the bactericidal power of the leucocytes so that blood containing these substances allows the growth of more bacteria than normal blood. Intravenous injection of such antiseptic substances, therefore, would seriously damage the resisting power of the body were it not that they are usually removed by

combination with protein. This book again impresses us that there is as yet no perfect antiseptic, and that apart from parasitic infections there is really no certain chemical agent. The number of chemicals introduced for the treatment of urinary infections, each one lauded more than its predecessor, reveals the truth of this conclusion.

The author portrays the present position of his subject well. That so much of the book is devoted to parasitic diseases is justified, because chemotherapy in these diseases has a firm foundation, whereas in bacterial disease the foundation is yet to be laid. The excellent bibliography at the end of each chapter will be invaluable to those wishing to read up any portion in which they are interested. The production of the book is excellent, and we welcome the portrait of Ehrlich as frontispiece.

ULTRA-VIOLET RAYS IN THE TREATMENT AND CURE OF DISEASE. By PERCY HALL, M.R.C.S., L.R.C.P. Fourth edition. (London: William Heinemann, Ltd.) Pp. 248. Illustrations 57. Price 12s. 6d. net.

The author feels that actino-therapy is now so firmly established as a curative remedy of wide usefulness that no medical practitioner can afford to be without some knowledge of the subject, even though not practising this branch himself. This latest edition contains two new chapters which increase the value of the book, one dealing with the important question of lamps for self-administration, and the other summarizing the modern views on dosage. A large proportion of the illustrations is devoted to lamps and apparatus used in therapy. Case-histories are furnished to indicate the diseases which the author has found to be amenable to this form of treatment, the technique that he has used, and the results that he has obtained.

The account is clear and well presented, and the book should be of value to anyone who is considering the employment of this form of treatment, or who wishes to acquaint himself with its indications and limitations.

ROSE AND CARLESS' MANUAL OF SURGERY.—An error was made in the review of this book in our last issue. The book contains xiii + 7502 pages (not 500), 664 illustrations, 19 plates and 43 radiograms.

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

ABRAHAMS, ADOLPHE, O.B.E., M.D., M.R.C.P. *Exercise: Its Functions, Varieties and Applications.* London: Heinemann, 1930.

ALEXANDER, F. W., M.R.C.S. (Eng.), L.R.C.P. (Edin.), L.M., D.P.H. "Tobacco: Discovery; Origin of Name; Pipes; The Smoking Habit and Its Psychotherapy." *Medical Press and Circular*, July 30th, 1930.

"The Love of Perfumes, Aromatics, Cosmetics and Soaps: Origins, Uses and Physical Action of Odours." *Medical Press and Circular*, October 1st, 1930.

ANDREWES, C. H., M.D., "Antivaccinial Serum." *Journal of Pathology and Bacteriology*, April, 1930.

"11888 Culture in the Study of Immunity to Herpes." *Journal of Pathology and Bacteriology*, April, 1930.

ANDREWES, SIR FREDERICK W., M.D., F.R.C.P., F.R.S. "Note on the Fermentation of Starch by Certain Haemolytic Streptococci." *Journal of Pathology and Bacteriology*, January, 1930.

DALE, H. H., C.B.E., M.D., F.R.C.P., F.R.S. (and GADDUM, J. H.). "Reactions of Denervated Voluntary Muscle and their Bearing on the Mode of Action of Parasympathetic and Related Nerves." *Journal of Physiology*, September, 1930.

(A. B. CORKILL, H. H. D., and H. P. MARKS). "The Respiratory Quotient of the Eviscerated Spinal Cat." *Journal of Physiology*, August, 1930.

ECCLES, H. E. KARSLAKE, M.C., M.R.C.S., L.R.C.P. "Some Remarks on General Anaesthesia in Dental Surgery." *British Dental Journal*, October 1st, 1930.

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

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Out-Patients	Dr. G. Graham at 9 a.m.	Prof. Fraser and Dr. Hilton at 9 a.m.	Dr. Geoffrey Evans at 9 a.m.	Dr. F. G. Chandler at 9 a.m.	Prof. Fraser and Dr. Carmichael at 9 a.m.	Dr. G. Bourne at 9 a.m.
Surgical Out-Patients	Mr. Dunhill at 9 a.m.	Mr. W. Girling Ball at 9 a.m.	Mr. R. M. Vick at 9 a.m.	Prof. Gask at 9 a.m.	Mr. J. E. H. Roberts at 9 a.m.	Mr. Keynes at 9 a.m.
Diseases of Women	Dr. Shaw at 9 a.m.	—	Dr. Donaldson at 1.30 p.m.	—	—	Dr. Shaw at 9 a.m.
Ante-natal Clinic.	—	—	—	Dr. Donaldson at 12.15 p.m.	—	—
Orthopaedic Department	Mr. S. L. Higgs at 1 p.m.	—	—	Mr. R. C. Elmslie at 1 p.m.	—	—
Throat and Nose Department	Mr. Bedford Russell at 1 p.m.	Mr. F. W. Capps at 9 a.m.	—	Mr. Bedford Russell at 9 a.m.	Mr. F. W. Capps at 1 p.m.	—
Aural Department	Mr. S. R. Scott at 1 p.m.	Mr. T. H. Just at 9 a.m.	—	Mr. S. K. Scott at 9 a.m.	Mr. T. H. Just at 1 p.m.	—
Ophthalmic Department	Mr. Rupert Scott at 1 p.m.	Mr. Foster Moore at 1 p.m.	—	Mr. Rupert Scott at 1 p.m.	Mr. Foster Moore at 1 p.m.	—
Skin Department.	—	Dr. Roxburgh at 9 a.m.	Dr. Roxburgh at 9 a.m.	—	Dr. Roxburgh at 9 a.m.	—
Psychological Department	—	—	—	—	Dr. Porter Phillips at 1.30 p.m.	—
*Electrical Department	Dr. Cumberbatch, Males at 1 p.m.	Dr. Cumberbatch, Females at 1 p.m.	—	Dr. Cumberbatch, Males at 1 p.m.	Dr. Cumberbatch, Females at 1 p.m.	—
*X-Ray Department	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.
*Exercises and Massage Department	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. to 1 p.m.
Diseases of Children	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m.	Dr. Harris at 9 a.m. New cases (from District only), 1.30 p.m.	Dr. Harris at 9 a.m.
Dental Department	Mr. Fairbank at 9 a.m.	Mr. Coleman at 9 a.m.	Mr. Hankey at 9 a.m.	Mr. Fairbank at 9 a.m.	Mr. Coleman at 9 a.m.	Mr. Hankey at 9 a.m.
Tuberculosis Dispensary	—	12.30 p.m.	1½ to 7 p.m.	—	11.30 a.m. New cases only, 2 to 3 p.m.	—
Veneral Department	Men, 5 to 7 p.m.	Women and children, 4 to 6 p.m.	—	Men, 12 to 2 p.m.	Women and children, 12 to 2 p.m.	—
Plastic Surgery	Sir Harold Gillies 1.30 p.m.	—	—	—	—	—

\* Patients are not seen in these Departments unless recommended by the Medical Staff.  
† These hours are intended for patients who cannot attend at mid-day.

ELMSLIE, R. C., O.B.E., M.S., F.R.C.S. "Cyst of Synovial Membrane in the Region of the Internal Semilunar Cartilage." *Proceedings of the Royal Society of Medicine*, September, 1930.

EVANS, E. LAMING, C.B.E., F.R.C.S. "Three Cases of Congenital Edema (Milroy's Disease) in Two Generations of the Same Family." *Proceedings of the Royal Society of Medicine*, September, 1930.

GASK, GEO. E., C.M.G., D.S.O., F.R.C.S. See POWER.  
GREEN, F. H. K., M.B., B.S., M.R.C.P. "Miliary Aneurysms in the Brain." *Journal of Pathology and Bacteriology*, January, 1930.

GREY, H. MARTIN, M.R.C.S., L.R.C.P. "Fracture of the Frontal Bone involving the Frontal Sinus, with Formation of an Intracranial Pneumocoele." *British Medical Journal*, October 4th, 1930.

- GRIFFITH, H. K., F.R.C.S. "A Case of Lithopadion." *Proceedings of the Royal Society of Medicine*, September, 1930.
- "A Case of Pregnancy in one Horn of a Bicornute Ovary." *Proceedings of the Royal Society of Medicine*, September, 1930.
- HARRIDGE, H., M.A., M.D., Sc.D., M.R.C.P., F.R.S., and HAYNES, F., M.A. *Histology for Medical Students*. London: Oxford University Press, 1930.
- HATHAWAY, FRANK J., M.D. "A Note on the Technique of the Immediate Closure of Empyema (Pneumococcal)." *Practitioner*, August, 1930.
- HAYNES, F., M.A. See HARRIDGE and HAYNES.
- HERRSAMAN-JOHNSON, F., M.D.(Aberd.), D.M.R.E.(Camb.). "A Case of Pathological Fracture due to Malignant Metastasis: Cure by Deep X-ray Therapy." *Lancet*, October 18th, 1930.
- KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. "The Treatment of Primary Carcinoma of the Breast with Radium." *Practitioner*, October, 1930.
- KING, H. H., M.B., B.S., I.M.S. "Fly-Proofing Indian Latrines." *Journal Royal Army Medical Corps*, October, 1930.
- MAXWELL, JAMES, M.D., M.R.C.P. "Primary Malignant Intra-thoracic Tumours." *Journal Pathology and Bacteriology*, April, 1930.
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- MORLOCK, H. V., M.C., M.D., M.R.C.P. (A. J. SCOTT PINCHIN, F.R.C.P., and H. V. M.). "Abscesses of the Lung; Their Treatment and Diagnosis." *Lancet*, October 18th, 1930.

## CHANGES OF ADDRESS.

- BARNESLEY, A., Hawthorne House, Ellesmere, Salop. (Tel. Ellesmere 26.)
- DE LAMBLIERE, SURG.-LT. C. D. D., R.N., R.N. Hospital, Haslar. (Tel. 2.)
- MILLS, W. T., Botley House, Chiddingfold, Surrey. (Tel. 2.)
- MOIR, E. D., 1, Gordon Square, W.C. 1. (Tel. Museum 1266.)
- ORCHARD, S., 12a, Kensington Court Place, W. 8.
- PAYNE, R. T., 21, Norfolk Road, St. John's Wood, N.W. 8. (Tel. Primrose 5532.)

## APPOINTMENT.

- BELLAMY, W. A., M.R.C.S., L.R.C.P., appointed Honorary Anaesthetist to the South Eastern Hospital for Children.

## BIRTHS.

- CAMERON.—On May 7th, 1930, at Cranleigh, Surrey, to Lottie (née Higgs), wife of Dr. Donald Cameron—a son.
- CARNEGIE BROWN.—On September 25th, 1930, to Ella Mary (née Wright), wife of Dr. A. Carnegie Brown, of Ripon—a daughter.
- CHAMBERS.—On September 6th, 1930, in London, to "Senga" (Agnes, née Tombs), wife of Guy Chambers, F.R.C.S.(Eng.), of Gable End, Ryde, and 36, Bolton Gardens, S.W.—a son.
- CRIPPS.—On October 7th, 1930, at a nursing home, Horley, Surrey, to Vera, wife of W. Lawrence Cripps, F.R.C.S.—a daughter.
- DAY.—On October 22nd, 1930, at 17, Chapel Field East, Norwich, to Joan (née Miller), the wife of Dr. George Day—a daughter.
- HIGGS.—On September 23rd, 1930, at 11, Chester Place, Regent's Park, to Betty, wife of Sydney Limbrey Higgs, F.R.C.S.—a daughter.
- JONES.—On September 4th, 1930, in London, to Kathleen (née Macartney), wife of Dr. G. L. Colenso Jones, Kirkuk, Iraq—a son.
- MILLER.—On September 1st, 1930, at 18, Grosvenor Road, Tunbridge Wells, to Dr. and Mrs. T. Mackinlay Miller—a son.
- RYVES.—On September 30th and October 1st, 1930, at St. Peter's Lodge, Eltham Road, S.E. 12, to Dr. and Mrs. T. E. Ryves—a son and daughter.
- SMYTH.—On October 24th, 1930, at 22, Wimpole Street, W. 1, to Esther, wife of Michael J. Smyth, F.R.C.S.—a son.
- WILSON.—On October 23rd, 1930, to Kathleen, wife of W. Etherington Wilson, F.R.C.S., of Hillsborough, Torquay—a daughter.

## MARRIAGES.

- BRIGG—JACKSON.—On October 16th, 1930, at Radley Church, Denis Anderson Brigg, M.B., younger son of the late Mr. Thos. Brigg, of Addingham, and Mrs. Brigg, of 13, Langcliffe Avenue, Harrogate, and grandson of the late Sir John Brigg, M.P., of Kildwick Hall, Keighley, Yorks, to Eva Katharine Mary, elder daughter of Rev. A. A. and Mrs. Jackson, of Radley.
- JORY—FORSTER.—On September 27th, 1930, at Christ Church, Cockfosters, Norman Adams Jory, F.R.C.S., son of the Rev. J. D. Jory, of Auckland, New Zealand, to Daphne E. G. Forster, adopted daughter of Mrs. W. Bince Randall, of The Cottage, Cockfosters.
- PEEL—MONYPENY.—On September 2nd, 1930, at Fisherwick Presbyterian Church, Belfast, by the Very Rev. Dr. Thomas A. B. Smyth, assisted by the Rev. Dr. Woodburn and the Rev. T. A. B. Smyth, of Omagh, Albert A. Fitzgerald Peel, M.A., M.D.(Lon.), son of Dr. A. A. Peel and Mrs. Peel, "Allanbank," Queen Mary Avenue, Glasgow, and Ben Neagh House, Crumlin, Co. Antrim, to Mary Watson Monypeny, M.Sc., daughter of the late Dr. William Monypeny and Mrs. Monypeny, Shaftesbury Square, Belfast.

## SILVER WEDDING.

- GAY FRENCH—PIPE WOLFERSTAN.—On September 7th, 1905, at St. John the Baptist Church, Holland Road, London, John Gay French, younger son of the late Lieut.-Col. John Gay French, M.D., M.Ch., F.R.C.S.(Eng.), I.M.S., to Elinor May, youngest daughter of the late F. S. Pipe Wolferstan, of Statfold, Staffordshire. Present address: 135, Harley Street, London, W. 1.

## DEATHS.

- BRIDGEMAN.—On October 30th, 1930, the result of an accident, Francis Paul Orlando Bridgeman, Commander R.N., retired, of 17, Egerton Gardens, S.W. 3, much beloved husband of Alice Bridgeman, and second son of the late Brigadier-General the Hon. Francis Bridgeman, aged 42.
- HARVEY.—On October 13th, 1930, at 43, Holland Street, John Owen Harvey, M.D.
- LEGG.—On October 8th, 1930, suddenly, at 139, Harley Street, W. 1, Thomas Percy Legg, C.M.G., F.R.C.S., M.S.
- ROBERTS.—On October 2nd, 1930, Sidney Merton Pearson Roberts, J.P., M.R.C.S., of The Gables, Linslade, Leighton Buzzard, Bucks, aged 70.
- WARREN.—On September 2nd, 1930, at a nursing home, Reading, following an operation, Alfred Castle Warren, M.D., L.R.C.P., dearly beloved husband of Ina Warren, of The Lawn, Upper Redlands Road, Reading.
- WATTS.—On November 2nd, 1930, accidentally drowned, Cecil Francis Watts, M.A., B.Chir., M.R.C.S., L.R.C.P., dearly loved only son of Francis William and Julie Watts, of Red Hatch, Hutton, Essex, aged 28.
- WHITE.—On September 26th, 1930, at Streatham, very suddenly after two years' illness, Charles Powell White, M.D., F.R.C.S., fourth son of the late Prebendary Borrett White, D.D., formerly Director of Cancer Research at the University of Manchester.
- WHITEHEAD REID.—On October 20th, 1930, at West Kent Hospital, Maidstone, Edward Douglas Whitehead Reid, M.B., B.Ch., son of the late Dr. Thomas Whitehead Reid and Mrs. Reid, of Canterbury, aged 47.
- WILLEY.—On October 1st, 1930, at Farringford, Queen's Park, West Drive, Bournemouth, Thomas Willey, M.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. WILLIAMS, 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. XXXVIII.—No. 3.]

DECEMBER 1ST, 1930.

PRICE NINEPENCE.

## CALENDAR.

- Mon, Dec. 1.—Special Subject: Clinical Lecture by Mr. Elmslie.  
Rugby Match v. Keyham. Away.
- Tues., 2.—Dr. Gow and Mr. Harold Wilson on duty.
- Fri., 5.—Prof. Fraser and Prof. Gask on duty.  
Medicine: Clinical Lecture by Sir Thomas Horder.
- Sat., 6.—Rugby Match v. London Welsh. Away.  
Association Match v. University College. Home.  
Hockey Match v. Staff College. Away.
- Mon., 8.—Special Subject: Clinical Lecture by Mr. Just.
- Tues., 9.—Sir Percival Hartley and Sir Holburt Waring on duty.
- Wed., 10.—Rugby Match v. R.M.A. (Woolwich). Away.  
Hockey Match v. Epsom. Away.
- Fri., 12.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
- Sat., 13.—Rugby Match v. Northampton. Away.  
Association Match v. Lancing College. Away.  
Hockey Match v. R.N.C. (Greenwich). Away.
- Tues., 16.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.
- Fri., 19.—Dr. Gow and Mr. Harold Wilson on duty.  
**Last day for receiving matter for the  
January issue of the Journal.**
- Sat., 20.—Hockey Match v. Radlett. Away.
- Tues., 23.—Prof. Fraser and Prof. Gask on duty.
- Thurs., 25.—Christmas Day.
- Fri., 26.—Sir Percival Hartley and Sir Holburt Waring on duty.
- Tues., 30.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.

## EDITORIAL.

## THE NEW REGISTRATION.

WE publish in our correspondence columns a letter from the Dean explaining in some detail the plan of the new method of registration, which affects all students who commenced clinical work after September, 1930. The days of direct personal relationship between teacher and student have passed long since, for better or for worse, and, if we may say so, the powers that be are wise to take official notice of the

fact. Amongst the records the Dean proposes to keep a photograph of each student. We take this opportunity of re-introducing a subject that has already and without avail received editorial mention—the matter of photographs of the Visiting Staff. The Dispensary collection still requires bringing up to date.

\* \* \*

## THE CAMBRIDGE GRADUATES' CLUB.

The Fiftieth Annual Dinner of the Cambridge Graduates' Club of St. Bartholomew's Hospital was held at the Mayfair Hotel on Wednesday, November 19th, 1930. The chair was taken by Dr. C. F. Hadfield (Trinity), who carried out to perfection his duties as "Lord High Substitute." After the King's health had been duly honoured, the Chairman voiced the company's regret at the absence of Mr. Foster Moore. In proposing the health of the Club, he reviewed the year, making some shrewd comments upon the New Block, congratulating those members who had been picked out by fortune, calling to mind those who had departed, and welcoming cordially the newcomers.

Sir Percival Horton-Smith Hartley let flow his graceful learning and his polished wit upon the heads of the guests, revealing aspects of his subject hardly fit for a reporter's pen. Mr. Harold Wilson gave a brief reply to his sallies, and Mr. Girling Ball recounted some experiences, the early fruits of his new office of "human Dean" of Bart's.

Dr. George Graham, in proposing the health of the Chairman, touched tender chords of memory of the days when Dr. Hadfield had been a House Physician and Dr. Graham one of his clerks, and the toast was carried with musical honours.

The Hon. Secretaries then, in response to general acclamations, made their annual bow, and the party proceeded to Dr. Morley Fletcher's house in Harley

Street. The wonder of what followed must be seen and heard to be believed.

\* \* \*

FULTON'S 'READINGS IN THE HISTORY OF PHYSIOLOGY.'

The value of the historical method in the teaching of medicine was recently a subject of discussion at the Royal Society of Medicine. It was generally agreed that the history of medicine had a useful place in medical teaching, but that the place for teaching it was at the bedside. The history of physiology should likewise, by a logical extension, be taught in the laboratory. From the bench, where each student makes for himself the discoveries of observation and of experiment that were made by the master-builders of his science, the passage to "the front-line trenches of medical and physiological discovery" should be assisted.

With this object in view Prof. Fulton, of Yale, well known in Oxford as a brilliant physiologist, a relentless bibliophile, and a charming host, has recently published *Selected Readings in the History of Physiology* (Charles C. Thomas, Baltimore, 1930). Heading each chapter (the circulation of the blood—the capillaries—respiration, etc.) with a historical summary, and each reading with a brief note upon its author, he has gathered eighty-five extracts from works of outstanding importance in the history of physiology, including as history the work of many men still active. Two unexpected conclusions will strike the reader, as they struck Prof. Fulton himself—the early age at which many of the major researches were accomplished, and the frequency with which observation on human beings formed their basis. The book, lavishly illustrated with rare portraits and title-pages, forms the ideal companion for Michael Foster's classic Lane Lectures. It has the power, usually lacking in historical works, of stimulating curiosity towards the future as well as towards the past.

It is significant that Prof. Fulton and Mr. W. R. Bett, who so eloquently opened the discussion referred to above, both came early under the influence of the writings of Sir William Osler. Both have caught something of the spirit that made Osler the ideal medical historian.

\* \* \*

THE LORD MAYOR'S SHOW.

The Lord Mayor's Show, supported personally by the flower and vigour of the manhood of St. Bartholomew's, swept the streets of London with more than its perennial glory. We were not fortunate enough to see it; those who saw appear to have been rendered speechless thereby. We cannot, however, refrain from commenting

upon the stupidity of the elephant(s?) who reacted with such violence to the red lion. Had it been the white hart . . . .

\* \* \*

AN OLD STUDENT'S PARODIES.

Surgeon-General Percy Benson, in response to the request of several persons who heard with undisguised relish his recitations at the Old Students' Dinners of 1927 and of 1930, kindly allows us to reproduce them. Jackson's parody of "Lake Regillus," recited in 1927, is printed on p. 51; "The Bold Fifteen," by the same hand, recited in 1930, will appear in January.

\* \* \*

'THE LANCET' COMMISSION ON NURSING.

Prof. F. R. Fraser has been appointed to serve on *The Lancet* Commission on Nursing, the *personnel* and the terms of reference of which are announced in *The Lancet* of December 6th. Lord Crawford and Balcarres will preside. The objects are "to inquire into the reasons for the shortage of candidates," and "to offer suggestions for making the service more attractive." Medical men and women the world over will watch the proceedings attentively. That such a commission is necessary makes it imperative that it should reach valuable conclusions.

\* \* \*

Prof. George E. Gask has been elected Dean of the Faculty of Medicine in the University of London for 1930-1932. We congratulate him, and wish him good fortune during his years of office.

\* \* \*


We announce with regret the sudden death, on November 19th, of Mary Elizabeth Shore. It is especially cruel that such a misfortune should befall Dr. Shore at the very outset of his years of retirement; we can only assure him and his family of the deep sympathy of all the members of the Hospital and of the Medical School.

ACKNOWLEDGMENTS.

*The British Journal of Nursing—British Journal of Venereal Diseases—Bulletins et Mémoires de la Société de Médecine de Paris—The Clinical Journal—Les Echos de la Médecine—L'Echo Médicale du Nord—Guy's Hospital Gazette—The Kenya and East African Medical Journal—King's College Hospital Gazette—The London Hospital Gazette—The Medical Journal of Australia—The Nursing Times—South African Nursing Record—Sydney University Medical Journal.*

OBITUARY.

CECIL FRANCIS WATTS.

 ECIL FRANCIS WATTS was born in August, 1902, the only son of Francis W. Watts, and his wife, Julie. He entered Sherborne in 1916 as a Scholar. Here he rapidly reached the top of the school, and became head of his house (Ross's) and School Prefect. From Sherborne he went to Caius College, Cambridge, where he became an Exhibitioner, and subsequently a Scholar. In 1923 he won a research studentship in physiology, and gained first-class honours in Natural Science Tripos. He entered as a student at St. Bartholomew's Hospital in 1924. Here he continued to show the same keenness that he had displayed at his school and University, for he won the Burrows and the Skynner Prizes and the Willett Medal, and was *proxime accessit* in both the Medical Brackenbury and the Surgical Brackenbury Scholarships. In 1928 he became Casualty House Physician, and at the end of that time House Surgeon for the Professorial Surgical Unit. In this work he first showed his capacity for treating and handling patients, and he gave great promise for future work. He next became House Surgeon to the Orthopaedic Department, being attracted to this branch of surgery. About this time he went up for his Final Fellowship, but did not succeed, apparently owing to over-anxiety. He was, however, selected for one of the new Research Scholarships which had been instituted for the Royal College of Surgeons, and he was to have started work shortly. Just before he died he was also chosen as a Junior Demonstrator of Pathology.

Such a record of continuous progress from an early age at school is rare, and one cannot but believe that, if he had lived, Watts would have made a name for himself.

In addition to his work he had one great love, which was sailing. From early days he had been interested in this sport. He was Secretary of the Bart.'s branch of the United Hospitals' Sailing Club, and was an ardent and prominent figure in the regattas at Burnham and Farnbridge. His comrades represent him as a very keen and competent sailor.

On November 2nd he sailed with a crew of five from Portsmouth to Chichester. A big storm arose, and shortly before they made Chichester Harbour a heavy sea carried away the dinghy and damaged the mainsail. Watts was endeavouring to lower the mainsail when he was washed overboard and disappeared. His body has not been recovered.

On Thursday, November 6th, a memorial service was held in the Hospital church and was largely attended by his many friends.

One cannot but regret his early death, and yet, if one had to choose one's fate, it would be hard to find a better way of dying than a sudden painless death in the midst of the joy and zest of life. G. E. G.

J. B— writes: The early loss of a man of exceptional promise will always be lamented. But there is a far deeper sense of bereavement when that man combined with his talents a character and personality which endeared him to his fellows. We can only speculate on what medicine has lost in the death of Cecil Watts, but we are fully conscious of what we have lost personally.

His outstanding attribute was naturalness, and it is impossible to imagine him a "high-brow," a schemer, or the traditional "good fellow." His quiet charm was combined with a sense of humour, which found pleasure in the small happenings of life, and an equanimity which was unperturbed by success or disappointment. As is rare in a man of character, I believe he never made an enemy.

Dr. Thomas Nelson, Commodore of the United Hospitals Sailing Club, in a letter to the Warden, writes: "I was deeply shocked to learn of the death of Cecil Watts at sea last Sunday. As boatswain of the United Hospitals' Sailing Club he was the most valuable member of the Club, and the one who, from his position and his character, was better able to keep it together than anyone else. I need hardly say what a severe loss he is, both as a friend and a member of the Club. Would you express to the whole Foundation of St. Bartholomew's Hospital the deep regret which I personally feel at his death. And also I can speak on behalf of all the past and present students of St. George's Hospital who knew him and appreciated his personal character, and his services to the Club. I feel certain that it could only have been an unavoidable accident which would drown such an able sailor as Cecil Watts."

## A CASE OF RAYNAUD'S DISEASE TREATED BY SYMPATHECTOMY.

(Shown to the Abernethian Society on October 30th, 1930.)

THE rarity of a disease is often an excuse for its description; but the case of Raynaud's disease here described should be of value, not only for its rarity, but also for its historical interest in being the first to be treated at St. Bartholomew's Hospital by this particular "sympathectomy" operation.

The patient, a lady, *et. 33*, the wife of a farm labourer, was admitted to President Ward in January of this year complaining of her "fingers going numb and blue."

As a child she was quite healthy but at the age of fifteen, soon after she had gone into service, she noticed during a spell of frosty weather that some of her fingers "went quite numb," even though she wore thick gloves. She took to wearing two pairs of gloves but the attacks grew worse, other fingers also going numb and blue whenever she went out of doors in the winter or dipped her hands into cold water. For the past three years these "attacks" have come on even during the summer.

The first thing she notices on these occasions is a feeling of "pins and needles" in the finger-tips; this turns into a numbness, which spreads upwards to the metacarpo-phalangeal joints; the skin of the fingers becomes a bluish-grey, almost exactly the colour of lead, and her finger-tips become quite anaesthetic so that during the attack she can do no work. The attack passes off in two hours, or earlier if she warms her hands, and as it goes, patches of red appear on the skin, which run together until the whole hand is deep red and warm, and sensation returns. If she brings the circulation back too quickly the fingers are exceedingly painful.

Last winter she had two or three of these attacks a day, and began to have whitlows at the tips of the fingers; from one of these whitlows on her right index finger a piece of bone had to be removed.

She has had no trouble with her toes or with the lobes of her ears.

*Past history.*—As a child she did not suffer from chilblains, and she has never had haemoglobinuria. Her only illness was a persistent cough in 1921-1922, which has now cleared up.

All her family are healthy. She has no children.

*On examination* she was found to be cheerful and not at all nervous. Nothing of importance was discovered except the condition of her hands. When they were

warm they appeared normal except that in places the skin of her fingers was rather coarse, hard and shiny, and the scars of the old whitlows could be seen. When the hands were cold an attack came on, the fingers becoming blue, cold and anaesthetic up to the metacarpo-phalangeal joints. On being moved the fingers turned white, the blood being squeezed out of the skin, but when kept still they remained deep blue.

Repeating some observations already made by Sir Thomas Lewis (1) on other cases of Raynaud's disease, it was found that these attacks could be brought on only under special conditions. Cooling of the palm of the hand was necessary; cooling of the fingers alone by dipping them in cold water had no effect, yet when the palm was cooled the fingers would go blue even if they themselves were being kept warm. A temperature between 10° and 20° C. was needed; below 10° C. no attack came on, a marked hyperaemia taking its place: this Sir Thomas Lewis has called "the reaction to overcooling" (2).

It was thought until lately that the sympathetic vaso-constrictor fibres supplying the small vessels of the hand or foot passed down the limb in a plexus surrounding the artery, and it was on this theory that the operation of "peri-arterial sympathectomy" was based. Recently Prof. Woollard (3) and others have shown that this is not so, and that only the large vessels—in the arm, the axillary and brachial—receive their nerve-supply in this way; all the smaller vessels are supplied by sympathetic fibres which run down in the main nerve-trunks, those to the fingers passing down in the median and ulnar nerves.

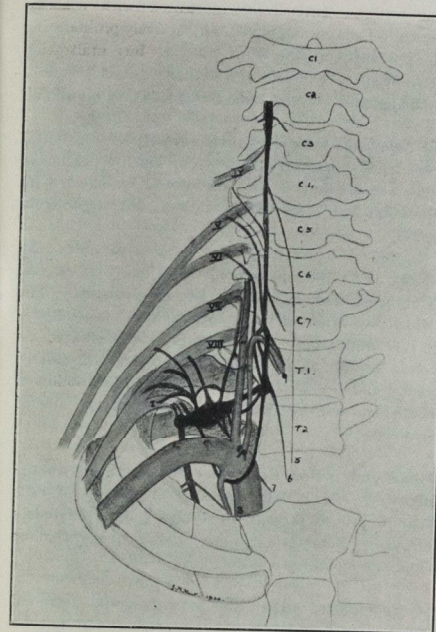
The results of the old operation of "peri-arterial sympathectomy" in Raynaud's disease were disappointing, but when these facts were realized and the fibres really supplying the peripheral vessels were divided very encouraging results were obtained. These fibres to the arm may be divided in three places:

(1) The sympathetic trunk itself may be cut below the first thoracic ganglion, destroying the white rami passing upward from the upper dorsal region of the spinal cord.

(2) The inferior cervical and first thoracic ganglia themselves may be removed—the operation of "gangliectomy."

(3) The grey rami passing from these ganglia to the brachial plexus may be cut—the operation of "ramisectomy." This latter method is not as satisfactory as the other two, as it is very hard to find all the rami at operation; from the figure, drawn from a dissection of the sympathetic in the neck, one can see how many of these rami there are, and how deeply they are placed—some of them alongside the vertebral artery.

Our patient was very anxious that we should do something to improve her condition. Her fingers were anaesthetic for a great part of the day so that she could do little housework. Even touching cold sheets while making a bed was enough to bring on an attack; her whitlows were occurring more frequently; she was beginning to lose the tips of her fingers and her doctor had told her that her condition was hopeless. She had tried many medicines without relief. Details of these



SYMPATHETIC CONNECTIONS OF THE BRACHIAL PLEXUS (FROM A DISSECTION).

cannot be obtained, but they were probably very similar to those taken by another patient with Raynaud's disease who has been attending hospital twice a week for two years; this patient has been treated with iodine and iodides, calcium lactate, arsenic, thyroid and parathyroid extracts, as well as radiant heat, ultra-violet light and electric arm baths—all without improvement.

Our patient was quite willing to undergo any operation which offered a hope of benefit, and she seemed to be a suitable case for sympathectomy.

Sir Thomas Lewis has suggested that in these cases,

before an operation is undertaken, observations should be made on the effect of temporary paralysis of the sympathetic fibres to the vessels in the hand by injection of local anaesthetic round the nerves. This was done by Dr. Hilton, and for over twenty-four hours after injection round the median nerve at the wrist no attack could be brought on in the fingers supplied by this nerve; when the hand was dipped in cold water the ulnar half of the ring finger and the little finger were the only parts that turned blue. Control injections without novocaine, the patient being unaware of the omission, were negative.

These results of temporary interference with the sympathetic supply to the fingers suggested that a more permanent improvement might be hoped for by operation. The operation was done by Prof. Gask and Mr. Paterson Ross on May 16th of this year. As the right hand was rather worse than the left the right side was chosen, and the incision was made just above the clavicle. When the brachial plexus had been exposed, as many as possible of the grey rami passing to this plexus were divided, and by deep dissection behind the dome of the pleura the right sympathetic trunk was found and cut below the first thoracic ganglion.

No change in the heart-beat or blood-pressure occurred during the operation; the right pupil contracted at once, and when the patient recovered from the anaesthetic her right eye was not so widely open as her left. Sweating was diminished down the right side of the face and down the right arm, and the skin of these parts was, and still is, considerably warmer than that on the other side.

In nearly all the published cases of this kind the operation has not brought about a complete cure. In this case, when the right hand is kept in cold water for a long time, or if we use the "differential bath" Sir Thomas Lewis kindly lent us, the tips of the fingers still become a little blue; but since the operation, now over six months ago, she has had no spontaneous attack in this hand, though her left still goes numb and blue two or three times a day. She seems delighted with the result, and wants the same operation done on her other side as soon as possible.

I have to thank Prof. Gask and Prof. Fraser for permission to publish this case.

### REFERENCES.

- (1) LEWIS, Sir THOMAS.—*Heart*, 1929, xv. 8.
- (2) *Idem.*—*Ibid.*, 1929, xv. 27.
- (3) WOOLLARD, Prof. H. H.—*Heart*, 1927, xiii. 319; with full references to other papers on p. 336.

J. H. HUNT.

## A CASE OF CARCINOMA OF THE CÆCUM IN A MAN, AGED 23.

**T**HE following case seems worthy of record in view of the age of the patient and the rapidity of the growth.

F. N., at. 23, was admitted to Addenbrooke's Hospital, Cambridge, on June 14th, 1929, complaining of a swelling in the right iliac fossa associated with pain.

*History.*—In January, 1929, the patient first noticed a sharp pain in the right iliac fossa, which made him vomit; he did not think he was feverish. From then up to the date of admission to Hospital he experienced a similar pain on and off; the pain was sharp and momentary, and used to be noticed about every two days. There was no vomiting after the first attack. About the beginning of May, 1929, the patient first became aware of a lump at the site of the pain about the size of a hen's egg. Appetite was poor, but he had no "indigestion" and the bowels were opened regularly every day. There were no other symptoms, and he had never had any previous illness of note.

*On examination.*—A fairly healthy-looking man, T. 99° F., P. 92. The teeth were carious and there was some pyorrhœa. The tongue was furred. Heart and lungs were normal. The abdomen was visibly enlarged in the right lower quadrant. Movement on respiration was equal all over. On palpation there was some tenderness and slight rigidity in the right iliac fossa, but not elsewhere. There was a swelling in the right iliac fossa, deep to the abdominal musculature, about 3 in. in diameter, the edges of which were indefinite except at the upper border, where it was rounded. The surface of the swelling was irregular, the consistency firm and no fluctuation could be elicited. It was immobile and tender to palpation. The liver was not enlarged; there was no free fluid in the abdomen and nothing else abnormal was discovered. Rectal examination revealed no tenderness or swelling.

A tentative diagnosis of chronic appendix abscess was made, and an operation performed by Mr. Vernon Pennell, F.R.C.S.

*Operation on June 14th, 1929,* under general anaesthesia. A right para-rectal subumbilical incision was made, and on opening the peritoneal cavity a large mass was found, involving the terminal portion of the ileum, the cæcum, the appendix, and the first foot of the ascending colon. There was also a spherical mass in the ileo-cæcal angle about 4 in. in diameter.

Since the mass appeared likely to cause obstruction and was not unlike ileo-cæcal tuberculosis it was decided to resect the portion of the gut involved together with the mass in the ileo-cæcal angle, the free ends of the gut being closed and an anastomosis between the ileum and the transverse colon was effected. The wound was closed without drainage.

*Description of part removed at operation.*—The specimen consisted of the terminal foot of the small intestine, the cæcum, the appendix, and the first 18 in. of the colon, together with the mesentery. The mucous membrane

throughout appeared normal. The walls of the terminal 4 in. of the ileum, the root of the appendix, the cæcum, and the first 9 or 10 in. of the ascending colon were considerably thickened, being about  $\frac{1}{2}$  in. at the thickest part; it was firm, and in section appeared yellowish-red in colour. In the mesentery between the small and large intestine was a large spherical mass about 4 in. in diameter.

*Pathological report* by Dr. C. H. WHITTLE.—"The cæcal wall is extensively infiltrated with a large spherical-celled type of growth, very actively proliferating and apparently arising from mucosa, but infiltrating muscle deeply. I incline to carcinoma; it is certainly very malignant. The glands show secondary invasion."

*Post-operative history.*—Convalescence was uneventful except for a superficial abscess from which a portion of catgut was discharged, and the wound was healed by July 16th, 1929, when the patient was discharged from hospital.

On August 21st, 1929, the patient attended the hospital, and it was discovered that there were several subcutaneous nodules present, soft in consistency, one of which was removed under local anaesthesia for histological examination. The nodules were situated as follows: two on the forehead, two on the right side of the chest and one over the left iliac fossa. The abdomen appeared normal, no swelling being felt at the site of operation.

*Pathological report on nodules* by Dr. N. E. GOLDSWORTHY.—"The nodule consisted of masses of cells similar to those present in lymph-gland previously reported. 'Metastatic nodule arising from tumour (colloid carcinoma) of cæcum.'"

In September, 1929, the patient again attended hospital. He looked very ill and feeble, but felt no pain. There was a large bony boss in the forehead, the size of a walnut—clearly a metastatic deposit in the frontal bone.

In the second week of October the patient died, but autopsy was not performed.

I wish to record my thanks to Mr. Vernon Pennell for permission to publish this interesting case, and to Dr. C. H. Whittle and Dr. N. E. Goldsworthy for permission to publish the pathological reports.

W. R. FORRESTER WOOD.

## RICHARD VON VOLKMANN.\*

**T**HIS year marks the centenary of the birth of Richard von Volkmann, who flourished during the period when the combined benefits of anaesthesia and antiseptics were beginning to change the whole outlook of surgery. His enthusiastic support of the antiseptic system, and his appreciation of the possibilities of progress which it had to offer, won for him the greatest reputation, and made his clinic the most popular in Europe in the 'eighties.

He was born on August 17th, 1830, at Leipzig, but all the rest of his life was associated with the University town of Halle in Saxony, where his father was Professor of Anatomy and Physiology. Although there is no record of his student days, the fact that he was chosen at the age of 26 to act as deputy for Prof. Blasius, director of the Surgical Clinic at Halle, implies that he must have distinguished himself as an undergraduate.

During his term as deputy his surgical ability came to be recognized, and he was appointed to the Chair of Surgery in the same year that Lister, who was three years his senior, published the first paper on "The Antiseptic Principle in the Practice of Surgery."

Volkmann had been Professor for only three years when the Franco-Prussian War of 1870, which was destined to be an important landmark not only in the history of Europe but also in the history of Surgery, interposed in his career a period of military service. Attempts were made during the war to introduce antiseptics in the treatment of wounds, but they were used merely as dressings, and it appears that the essentials of Lister's teaching and practice were unknown, or at all events were not followed. This haphazard use of antiseptics, though occasionally giving brilliant results in the field, was doomed to failure after the war was over. Volkmann's experience was similar to that of many of his contemporaries. He returned to his own hospital, conveniently situated over a main sewer, to try to cope with the overcrowding of the wards which resulted from the war and the industrial revival which followed it. The appalling ravages of pyæmia and infective gangrene made him consider closing the hospital, but he determined as a last resort to try Lister's method of antiseptics.

At this time many of the German surgeons were visiting Lister, or sending their assistants to Edinburgh to learn the system at first hand. Volkmann, however, made a collection of all Lister's papers, and from the information so obtained he was able in 1872 to establish in his hospital the Listerian method in every detail.

\* A paper read before The Osler Club on October 17th, 1930.

Despite all the disadvantages with which he had to contend, the results were so remarkable that for many years surgeons from all over the Continent flocked to his clinic. Thus although Volkmann was not the first in Germany to adopt Lister's practice, yet it was through him more than any other that it became widely known. In 1875 Lister paid a visit to Germany which assumed the character of a triumphal progress from one city to another. At Leipzig there was a banquet with 400 guests. Thiersch presided, and it fell to Volkmann to propose "The Ladies," including Mrs. Lister, who



*Richard von Volkmann*

watched the proceedings from the gallery. It is odd to think that this enthusiasm should have been shown in Germany, while in Edinburgh the managers of the Royal Infirmary still doubted the wisdom of substituting carbolic for the less costly water dressings, and William Savory, fighting in the last trench, was collecting his statistics to prove that surgery in London was in such a satisfactory state that the introduction of any new method would be unnecessary.

Volkmann's treatment of infected wounds showed slightly better results even than Lister's own figures, and it may be because he realized the importance of free drainage, and the beneficial effect of enlarging a



wound when necessary in order to drain it. In 1881 he visited London as a delegate to the International Medical Congress, of which Paget, then at his zenith, was President, and he delivered an impassioned address on "Listerism" and his conception of its influence on the progress of surgery.

Reference to the text-books popular at the close of last century shows how many were the contributions made by Volkmann not only to orthopædic surgery, in which he was specially interested, but to general surgery also. He improved the operation for excision of the rectum by the perineal route, and Kraske was among his pupils. He made a special study of cancer in paraffin workers, the treatment of lupus, chronic ulcers and chronic abscesses, and he suggested operating in stages for hydatid cyst in the liver so as to avoid general peritoneal infection. He saw excision of tuberculous joints replacing amputation, and he modified the treatment still further by introducing the operation of erosion and his sharp spoon, whereby the disease was removed as far as possible, leaving healthy parts undamaged. His classification of spontaneous dislocations served to clarify certain mechanisms previously little understood. He was a brilliant and beloved teacher, and many who afterwards became famous were his pupils.

Considering the wide range of his interests it may seem strange that his name is remembered in association with a mere muscular contracture. Volkmann's ischæmic contracture, however, is more than a tragedy which must be understood in order that its occurrence may be prevented; for it throws light on other problems involving the nutrition of muscle—for example muscle grating and tendon transplantation.

Apart from his contributions to Surgery, Volkmann is remembered for the delightful poems and fairy stories, many of which he wrote during the war and sent home to his own children, but which were afterwards published and became extremely popular throughout Germany. Unfortunately he had more worry than joy in his family life, and some who saw behind the scenes have thought that these home troubles shortened his life.

For some years he suffered from a severe and painful affection of the spinal cord. In 1889 he took a patient to Jena for a consultation, and while there he developed pneumonia and died on November 28th, at the early age of 59.

Volkmann is said to have been an elegant as well as a bold operator, a man of aristocratic appearance, and in his own town of Halle a king. A surgeon of originality and vision, a man of intellect and culture, his name deserves to be remembered and honoured in days to come.

J. PATERSON ROSS.

## SOME REMINISCENCES OF VOLKMANN.\*

**I** VISITED Halle in 1879, an important year—that in which Volkmann moved into his New Klinik. I think the new operation theatre must have been the first really adequately designed to meet the needs of the practice of antiseptic surgery. The most striking feature was the terrace paving so arranged as to allow efficient drainage—a very important matter, since flushing the wounds freely with 1 in 20 carbolic lotion was always employed during the operations in addition to the spray. The surgeons and assistants all wore long rubber boots, since when the surgeon called "Giesskanne," this lotion was poured out with great freedom from gardeners' watering pots with long spouts. The slogan of the Klinik was, "If dirt be unavoidable it must be antiseptic dirt." The dressings used were of the classical Listerian type: a piece of green protective over the actual wound, seven layers of carbolic gauze, an impermeable sheet of pink linen coated with rubber beneath the most superficial layer, and cotton-wool fixed with a calico bandage. No subsequent dressing was made except under the protection of the carbolic spray. It is perhaps needless to say that black urine and even serious instances of carbolic acid poisoning were not uncommon in the Klinik.

As had been the case with Lister, the successful treatment of compound fractures of the leg had been the most important determining factor in ensuring the general adoption of the antiseptic system. These injuries, which had before almost invariably been followed by death or amputation, were now proved to be capable of cure in the great majority of cases. It is of interest to recall that I saw the first compound fracture of the leg brought into the New Klinik operated on by Volkmann himself. Free incisions were made, abundant flushings of the wound with 5% carbolic lotion were employed, and rubber drainage-tubes were inserted. It is sad to relate that the wounds subsequently suppurated freely, but none the less both the patient's life and limb were saved.

Other departments of surgery in which Volkmann was taking most interest at the time were subcutaneous osteotomy, tuberculous joints, especially the hip-joint, and carcinoma of the rectum. During the summer session I spent at Halle three or four excisions of the hip-joint in children were performed every week; two years later at a subsequent visit I found that experience of the ill-effects of the operation on the growth of the limb had led to its abandonment in favour of more conservative

\* Read before the Osler Club on October 17th, 1930.

## THE OPIUM HABIT IN RURAL CHINA

**A** WESTERN doctor in China comes in contact with the opium habit in three ways. He is invited to smoke the opium pipe when he visits better-class Chinese families; he is called upon to assist patients to break off the opium habit; and he is frequently hurried to treat cases of acute opium poisoning.

A certain class of fiction is mainly responsible for the impression in many Western minds of the opium sot, hollow eyed and haggard, sneaking into some foul den, there to smoke until he falls asleep, dreams of devils, and lies drugged for hours, awaking cold, desolate and penniless. Doubtless there are tens of thousands of such poor creatures in the East, but in a small country town you see quite a different picture.

You receive an invitation to attend a feast, and the invitation is timed for noon. A messenger comes to "urge" you at 12.30, but etiquette demands that you wait for three "urges" before you leave home. At 2 p.m. you arrive at your host's house. There will be no food before 4 or 5 o'clock. Your host is busy hither and thither. How are you to spend the intervening hours? A table is arranged for cards, another for "ma jong," and a couch for opium smoking. It is a flat couch, raised a foot and a half from the ground, 7 ft. long and 4 ft. deep. At the back and sides hang white curtains suspended from a high wooden frame, something like the old four-poster bed. There are curtains for the front, too, but these are caught up by brass hooks from the upper front corners of the frame. At the centre of the back of the couch is a pile of cushions about 10 in. high, and in front of these a brass tray holding the implements for smoking. As a rule, two people recline together, one on either side of the pile of cushions. Observe the man on the left. He is lying very comfortably on his right side, his right arm resting on the cushions, his neat black velvet shoes and grey silk socks just visible beyond his carefully arranged gown, over the front edge of the couch. With the upper arm still resting on the cushions, the right hand can just reach the conveniently placed opium jar. By the side of this little jar lies a silver probe. This probe he proceeds to heat over a small spirit-lamp, also placed just in reach. When the probe is hot it is dipped into the sticky, black fluid opium. A little adheres. The probe is again held in the flame. The opium boils, and then sets into a firmish mass. The probe is again dipped and again heated, and the process continued until there is a plastic mass on the probe about the size of a filbert. This preparation of the mass takes about five

G. H. MARINS.

minutes. The smoker now takes the pipe in his left hand. The pipe is a hollow tube of some hard wood, about the size of a flageolet. Two inches from one end is a rosette-like structure, made of amber or some cheaper imitation. The centre of the rosette is cupped out with a central aperture communicating at right angles with the lumen of the pipe. The rosette is warmed over the spirit-lamp. The probe is then pushed down into the central hole, and wriggled out again, leaving its burden of opium adherent to the rosette, and with a central aperture through which air can be drawn when the pipe is put in the mouth.

During this preliminary canter the atmosphere of the shrouded couch gets well impregnated with opium vapour, and the smoker thus gets his *hors d'œuvres*. But now follows the real feast. The rosette is held over the lamp, and the pipe sucked at lustily and noisily. Soon the probe is required to re-establish the air-way, and the smoke again proceeds. Some smokers are satisfied in about three minutes; others make the smoke last more than a quarter of an hour.

When satisfied, our friend brushes a few imaginary specks from his immaculate silk gown, lights a cigarette, and returns to ma jong or a discussion of the bandit situation with another guest, the host inviting someone else to take the vacant place on the couch. Smokers of this class generally indulge in the habit three times a day, the last smoke merging into the night's sleep. They are not early risers! Such a smoker will consume 3 or 4 drms. of prepared opium a day, and will make no appreciable alteration in the amount used over a long period of years. But without that amount he is miserable, yawning, dull and morose.

Why do they smoke? Most of them start "for a joke" and because everyone else does—in fact for the same reason that you and I smoke cigarettes. The cynic will affirm that there is every excuse for opium-smoking in China. Life is very dull; political dreams never come true; there is continuous uncertainty. Actuality is horrid; take any means of escape from it. For a surprisingly large class of Chinese there is nothing to do. Retired civil officials, gentlemen living on their rents, officers of the old army—how are they to fill in the day? Eating only takes a small fraction of the time. There is very little decent light literature; they play no out-door games; the little daily paper can be read through in half an hour; private correspondence is but little indulged in. Travelling is so unpleasant that it is avoided at all costs. "A sleep and a forgetting" has the greatest appeal.

We are hardly ever without a few patients in hospital who are breaking off the opium habit. They are admitted for a minimum of 21 days, and are not allowed

under any pretext to leave the compound during that time. A man who is taking 4 drms. of opium a day receives an initial dose of 30 minims of tinct. opii with 10 gr. of pot. bromide to the ounce dose. This dose is given three or four times a day, at the hour when the patient is in the habit of smoking. During the first two days the nurse is allowed to anticipate the time of the dose if the craving becomes intolerable, but by the end of that time one can estimate accurately how much the patient requires to keep him reasonably content, and from that time on he must toe the line, and take his medicine only at the appointed times. The dose is steadily diminished until he is taking none on the seventeenth day. Three additional small meals are given besides the two main meals of the day, and some mixture—usually the Bart.'s haust. gent. c. rheo, with various little additions to overcome "that sinking feeling" from which they all complain.

With the full co-operation of the patient even a severe habit may be broken in three weeks, provided there are no complications. Great demands are made upon the physician. The patients must almost be "fussed." On the two daily rounds more than a few words and stereotyped questions are necessary. The whole realm of physiology must be reviewed each time, and excursions made into the sister science of psychology: "No, the little reddening of the conjunctiva is not serious and will certainly not lead to blindness." "A little cough? Certainly, we will prescribe another mixture." "Those nocturnal emissions are really a sign of returning normality." "Only managed one bowl of rice? We will make a slight addition to the gent. c. rheo." A little laying down of the law (called "Imperialism" in China) is very necessary, especially at the beginning of the treatment. A show of interest cannot be kept up morning and night for 20 days unless it is backed by a genuine interest, and that show of interest is demanded of the doctor. A bad night will make a patient give up the struggle unless you can convince him that the little sulphonal that you are about to order will ensure peaceful sleep on the coming night. Bad weather makes the treatment much more difficult, for the opium user finds dull and gloomy days intolerably depressing.

Some patients start smoking on account of the cough of early pulmonary tuberculosis. Such cases are so difficult as to be almost impossible. Dysentery, hemorrhoids, toothache, scabies—all these figure among the excuses given by addicts for commencing the habit.

Of the opium suicides who come for treatment, the large majority are among young women who have quarrelled with husbands, lovers, or mothers-in-law. Raw opium, prepared opium and opium ash is swallowed

in amounts up to 2 oz. Quite a number do not intend to die, but rather to frighten those who have annoyed them. An ill-treated wife will swallow opium in order to frighten her lord and master into treating her more kindly, and a son will swallow opium after a thrashing in order to prevent thrashings after subsequent lapses from virtue. These people report that they have taken much more than is actually the case, and see to it that they get immediate medical attention. On the other hand, the really keen ones take wine with the opium to hasten the absorption, and the most determined add the heads of three boxes of matches to their dose.

Cases brought to hospital are tackled at once by the nurses with draughts of warm potassium permanganate solution and the stomach-tube is prepared. As soon as the doctor arrives the stomach is washed out with several pints of the permanganate solution, until no more opium is seen in the washings and the colour of the permanganate solution is retained. Some solution is left in the stomach and the tube removed. Cases of moderate severity seen soon after the ingestion of the opium will not require any further treatment. They are allowed to sit, but not to sleep, and encouraged to drink hot tea. If the pulse is quite good they are taken for a gentle walk. If drowsiness comes on again the stomach is washed out a second time. More severe cases will require strychnine and camphor. The latter drug has been scoffed at, but there is ample evidence of its usefulness in acute opium poisoning. A grade more severe will require artificial respiration, perhaps for a few short intervals, perhaps for 24 hours at a stretch. Atropine in large and repeated doses has a good reputation. In apparently desperate cases good results have been obtained with very strong saline solution. One ounce of sodium chloride is dissolved in 4 oz. of water and administered intravenously. The administration is often difficult and slow, but the results in a majority of cases are immediate and striking. It is reported that a second injection has little or no effect.

When called to the home of an attempted suicide, we take 30 gr. of zinc sulphate and a tube of 1-gr. tablets of potassium permanganate and a stomach-tube. The latter often so alarms the innumerable friends and relations that we prefer to give a pint of hot permanganate and the 30 gr. of zinc sulphate in a little warm water. Vomiting is almost certain and immediate. Once it is started warm permanganate is pushed and the vomiting goes on steadily. If it ceases, a little tickling of the fauces with the ever-ready chopstick soon gets it going again. The patient is then taken to hospital, and the stomach lavage carried out in the cloistered calm of the ward. A purge is always administered at some stage of the treatment. In

mild cases calomel, 2 gr., is given as soon as the stomach washings are judged to have been sufficient. In bad cases a large dose of Epsom salts is given before the stomach-tube is removed.

A beefy and determined patient may make it exceedingly difficult to pass a stomach-tube. In such cases a less fussy procedure is to pass a large catheter through the nose and wash out the stomach through this catheter. Forcing a mouth-gag on a fighting patient always looks brutal, and nothing exciting is done in China without an audience.

Mr. Langford Moore used to teach us that there were five drugs in the Pharmacopœia which were essential to the physician, and the first on the list was opium. This was one of the many wise things he taught us—but opium in the hands of the general public is the very devil.

RALPH BOLTON.

## PARODY ON THE BATTLE OF LAKE REGILLUS.

This parody on the Battle of Lake Regillus was written by F. E. Jackson in 1871. It is not quite complete, as the original was lost, and I have had to rely on my memory for its production. At the time it was written Jackson was taking some course at the London Hospital, hence the allusion to his having to ride through Shoreditch, Cheapside and Little Britain to attend a dinner which was held in Rahere Hall each year in July, and to which all students who had taken prizes during the previous year were invited. Jackson had taken the "Wix Memorial Prize," the subject for which was "The Knowledge of Paley's Evidence of Christianity" (which he knew by heart), and I am told the prize is still in existence, but the subject has been changed. (I had taken the Foster Prize for Senior Anatomy.) "Holy Joe" alluded to in the parody was curate to the Rev. Polehampton, the Rector of St. Bartholomew's-the-Less, and being stout and having a very red face Jackson gave him that name. This parody was recited by me at the Old Students' Dinner in 1927.

Santoshia, Jersey Co. ;  
November 16th.

P. H. BENSON,  
Surgeon-Gen., I.M.S. (ret.).



O, trumpets sound a war note,  
Ho, students clear the way,  
For Jackson will ride in all his pride  
Along the streets to-day.

\* \* \*

Through Shoreditch dank  
He passed the Bank,  
And rattled up Cheapside;  
Through "Little Britain" tore,  
Until he reached those portals  
That Rahere reared of yore;  
To where in that long chamber  
Was heard the glasses' chink,

When on a night in July bright  
Was drunk that glorious drink.  
Whence flows the misspent charity  
From—unguarded till.

The students all in Rahere's Hall  
To-night shall drink their fill.

Now hearken, Percy Benson,  
We'll do the best we can

To fill that pious vessel,  
That red-faced holy man.

Then out spake Percy Benson,  
"I see a goodly sight:

Battalions of decanters  
Bear down upon our right.

I see the tawny '24'  
That shines with lambent flame,

The richest wine of that old vine  
That bears Oporto's name."

Then Jackson challenged Benson,  
And Benson Holy Joe,

And bravely these three champions tried  
To lay each other low;

Till round and round the chamber reeled,  
In one chaotic mass,

Like the roar of a mountain avalanche.  
Thundering down a pass.

Until the Holy Joseph's head  
Fell prone on his chest,

And his loud sonorous breathing told  
The vessel was at rest.

Then burst from the two victors  
A shout which shook the towers,

As having drained one goblet more  
They tried in vain to reach the door,

But sinking supine on the floor,  
Thundered, "The day is ours."

## PAGES FROM THE STUDENT'S HISTORY OF MEDICINE.

[There are many ways of writing history, all of which are stereotyped; or rather, all but one. The publication of 1066 and All That has demonstrated a new and utterly memorable historical method. It is to the authors of that (memorable) work this humble essay is (without permission) dedicated.]

### CHAPTER XXX.

#### THE SECOND HALF OF THE NINETEENTH CENTURY.

This was a time of great inventions, the first being the Medical Curriculum, which was to deal with all the others. Any new invention was immediately put on the

*Index Medicus* and had to be learnt by students. This was a Good Thing, as it caused the invention of students.

#### RISE OF SURGERY: PUFFING BILLY.

Surgery had been getting invented in pictures since the time of Galileo, the romantic Arabian anatomist, who made holes in skulls by dropping stones on them from the tops of towers. But it was a dirty business, and surgeons were very bad until the famous Scottish doctor Puffing Billy\* reformed them in a strong speech, in which he told them "to take off their blood-stained coats and wash," thus making surgery a comparatively clean business.

#### INVENTION OF ETHER.

Osler, the American horse-doctor, invented Ether, which was a jelly that filled in empty space and allowed vibrations. It was useful to surgeons and dentists, because they could use it to fill in the holes they made, thus making surgery a comparatively easy business.

#### CONTINENTAL JEALOUSY.

The Germans were so annoyed with the success of English (and American) speaking races (in England and America) that they invented Germs, thus causing the German Theory, which said that diseases were caused by T.B., K.L.B., V.D. (a sort of worm), R.D., C.O.D., etc., etc. This was followed by waves of meetings where everybody said that the other people's diseases weren't true and theirs was.

#### KOCK: THE SECOND ANIMAL EXPERIMENTS.

The first animal experiments were done by Jenny, the romantic English cow-girl, who stopped a scourge of smallpox vaccing too great by giving it to hens, thus inventing chicken-pox. Kock, the memorable German, made rules for animal experiments, called—

#### *Kock's Four (4) Preposterates.*

These were:

- (1) Any animal that had a germ must have a disease.
- (2) If any disease was not due to a germ, no animal was to have it.
- (3) No disease was allowed unless an animal had had it, and the player must miss his (or her) turn and go back to the START.
- (4) Was the same as (1).

This was a Good Thing, as it consumed rats, mice and stray cats, thus causing Animal Consumption.

\* Afterwards Lord Listerine.

#### FEARCOUGH AND WATCHMECOUGH.

Kock said T.B. was the cause of spitting and coughing. Naturally this was denied by Fearcough, the Kaiser's doctor, and the memorable mad Russian Watchmecough. Kock invited them to a meeting and showed it was true. As they left in disgust Kock cried, "They came to scough and went away!"

#### THE WASSERMANN RUCTIONS.

All these meetings annoyed the Church because they had suffered enough of that sort of thing with the Origin of Speeches,\* and when Ehrlich, a native of the town of Wassermann, said he could cure V.D. (a sort of worm), the Church said it was not a thing to talk about, but the Wages of Sin. Ehrlich, however, defeated it with his utterly memorable Six Hundred and Six Arguments.†

#### PASTEUR: ONE OF NATURE'S DOCTORS.

Pasteur was a brewer who kept silkworms and pretended he was a chemist. One day he saw a boy bitten in the ventricle (or stomach) by a great Claude Bernard dog, and saved him from the Ravies (*synonyms: Shouties, Singies, Talkies or St. Dilus' Dance*) with a single hair of a mad dog. This memorable success caused French science to spring up everywhere, and lots of animals were used by Gengou, Joujou, Hibou, Roux, Yersin, Bassin, Malsain and Reiu (and Yersin), who were called the Bawdy School, because they were French and probably went to the Folie Brightique (or Ruban Vert), a memorable place of relaxation for Parisians.

#### THE NEW SCIENCE AND HEALTH SOCIETY.

In England, prominent people said anyway British scientists weren't going to behave in a licentious French manner, so they founded the utterly eddifying Anti-Vivacious Society, which said there was no such thing as disease, and anyway they could cure it by not believing in it and letting the bowels do as they liked, and dumb animals were a good deal better than scientists (who were not dumb: see Origin of Speeches, *supra*).

This gave Pasteur a stroke, and his last invention was the memorable phrase, "Cochoons sceptiques" (pigs of unbelievers). The famous Anti-Sceptics were founded in his memory (Lord Listerine, Milton, Lysol Jeiz, the first Jew to receive the C.M.B., and Yabdil,

\* See "Darwin and the Theory of Elouction," 1066 and All That.  
† Argument 606: "The Ehrlich bird catches the worm."

afterwards excommunicated by the Pope because he smelt of garlic).

(Chapters Pass . . .)

#### CHAPTER XL: THE LAST.

The Medical Curriculum was now too full, and students said it was a Good Thing, because Medicine obviously was no longer memorable. So they played football instead.

FINIS.

M.

## SKIING IN THE ARLBERG.

### A TOUGHISH RACE.

**S**UPPOSING that a child in the Arlberg ever so far relaxed as to stay in its little cot till 8.30 a.m., its first peep through the blinds would be rewarded by a spectacle which to us would appear extraordinary. Picture to yourself a plain of snow surrounded by mountains; and upon it, regularly disposed at suitable intervals in a huge square, about fifty or sixty people on skis; and facing them, swaying them as the wind sways a reed-bed, a tyrant with a voice like a sergeant-major. Very unlike the English conception of a ski-ing holiday is the performance of the kick-turn by numbers, in an ice-cold valley, before the arrival of the morning sun. It must be seen to be believed; and the picture, seen at St. Christophe, is no exaggeration. Indeed, I gather from *A History of Ski-ing* that it is by no means the first time that such things have been chronicled in Austria. So that very early on in its career it is borne in upon the mind of the young Teuton that ski-ing is no mystery. It is part of one's life work, just as soldiering is, and that if you carry out certain orders, ski-ing will be yours. Has not Schneider himself said it?

#### IPSE DIXIT.

Now it is hardly possible for an Englishman to realize what Schneider means in the Tyrol. What Schneider says, goes, in the St. Anton district (and in the whole of ski-ing Austria, and of ski-ing Germany, for the matter of that). He seems to accept this ante-mortem defication quite calmly—just as calmly and as graciously as he receives any criticism of his methods. He knows that the criticisms are wrong, and that's that.

## TAKING THE COURSE AT ST. ANTON.

Warned, therefore, by this preamble, you will not be surprised at the goings-on at 10 a.m., six days out of every seven, upon the plain at the bottom of the nursery slopes at St. Anton. Schneider has fourteen assistants there, and at 10 o'clock they take up their several positions upon the plain. Gathered round them are the fifteen or less members of their class; and vaguely wandering about in front of them is a small crowd of, as yet, unattached pupils—everybody being armed with a course-ticket, price five schillings. Suddenly there is an awe-stricken murmur of "Here he comes!" and the whole plain stiffens to a worshipful attention as Schneider limps rapidly into view. He briskly questions each new arrival as to the number of seasons he has done and quickly details him to an appropriate instructor. He then exchanges greetings with the instructors and their pupils, allots each group to a suitable place for its evolutions, and disappears. During the course of the day he will appear at each class, and supervise progress.

## THEY "LARNED" ME.

In virtue of my grey hairs I was detailed to Luggi's class. And little knowing what was coming, I strolled over in rather a superior way to join my group (in which I perceived several people who did not look very athletic); then off we went for about half a mile up the long road gradient towards St. Christophe, carrying our skis. At the end of the first hundred yards I was puffing like a grampus (it was my first day out), and by the time that we had got to our practice-ground I would have wept upon the shoulder of anyone who could have offered me a Dunkels beer. We put on our skis, and side-stepped at an indecent pace to a lofty position upon a northern slope of 33 degrees (the oldest pupil carried a clinometer).

Without pausing to take breath, Luggi began, very, very slowly, to stem round upon the slope. He accompanied the manoeuvre with a lucid explanation of each step in German as he slid past the front of the pupils, who were now disposed in a vertical line at the side of the slope. The moment he got to the bottom he cried, "Also, Loos!" and his first victim started off down the slope, everyone else side-stepping up a couple of feet to fill his place; and so on for two solid hours.

At 12 noon, after I had completely given up hope, I could hardly believe my ears when I gathered that we would be allowed to begin lunch. I was man enough to tackle a couple of oranges; and during this all too short interval, Luggi (who, with his sterner pupils, took his lunch standing) collected the course-tickets. No sooner was this over than "Also, loos!" again, and away we marched to the southern aspect of the valley, where

by this time the crust had melted to a modified spring slush. And there in the baking sun the whole purgatory was re-enacted, interspersed at irregular intervals with some steep snow-plough practice. At 4 o'clock sharp Luggi turned his skis downhill, and off he rushed over the regulation Slalom Course towards the hotel, the pupils stringing out behind him. I calculated that as no stretchers were available, the quickest way to a double whisky and a hot bath was to try to do likewise. And only a seismographic record of the quivering of what was left of my poor knees could give you an idea of the effort it took to do so.

I cannot paint for you the ridicule which was cast upon my first attempt at the Arlberg turn on its native heath. My stance, my grip upon the sticks, the parts of me that were not bent, and the parts that were, with the degree thereof, all came under scathing review. And the dreadful sound that greeted a sudden involuntary prod with my stick which turned a would-be Arlberger into a lifted stem, made me heartily glad that my knowledge of German was rudimentary.

But it is a long lane that has no turning. And the time actually arrived when I heard a fervent, "Gott sei dank! He has actually achieved a stem-bogen." And I must say that with regard to teaching upon the parade-ground it could hardly be better. All the instructors have been trained to instruct, and the narrowness of the field of their teaching activities permits them an attention to detail only possible to specialists. The only useful addition that one could imagine is a cinema-record of one's morning efforts displayed during lunch.

## A DIAGNOSTIC TURN.

So much for the parade-ground. The moment I had an idea of the inwardness of the stem-bogen I proceeded to try it out on tour. Several members of the St. Anton Ski Club, with another Englishman and myself started down from the top of the Mirooikopfe in what we had regarded during the ascent as being perfect powder-snow. Although it had only lain for forty-eight hours, it turned out to be as heavy as lead—a thing I remember having seen once or twice before under conditions of intense cold with wind pressure. The Arlbergers duly began the slope (which was quite a mild one) with a couple of slow-motion examples of the prevailing turn. The Englishman, who was a very sporting and good runner somewhere in the neighbourhood of fifty years of age, started down at considerable speed and tried to bring off some ordinary Christis. When I had seen him hauled violently about once or twice, I began to realize that one of the virtues of the Arlberg turn is its diagnostic value, and humbled

myself to a bogen or two until I had felt the pace of the snow. I found that it was strangely possible of achievement, even in this very heavy telemark snow. And that further down, where there was about 6 in. of powdered snow on wind-crust, it was not productive of the unsettling skid at the end of the swing, so often found with telemarks on such a surface.

## THE DECLINE AND FALL OF THE LIFTED STEM.

Upon another occasion we began the descent from the Mattunjoch—on a very steep, wide snowfield, which undulated rather like a linen-fold carving. The surface was once more wind-crust covered with a few inches of recent powder, which had collected rather firmly in some of the hollows to a depth of nearly a foot. An experienced and sound Arlberger-type runner, who, by the way, is considered hardly up to their Kandahar standard, was the first to go down, and proceeded with what seemed to me an unnecessarily cautious degree of crouch. This idea evidently presented itself also to a young and spirited Mürren runner who was with us, and he made gaily off at a steeper angle, in what I am now beginning to recognize as the "upright Mürren style." (And to think that we all regard ourselves as being rather whole-hearted crouchers!)

Well, to make a long story short, the Arlberger sped very swiftly, surely and with increasing steepness of angle out of sight down this truly magnificent run; while the erect carriage and the lifted stem of Mürren were humbled in the dust. Now while it is more or less true that most Arlbergers may lift the inside ski a bit when they are turning on the steep slope, yet it is true only in the letter. They lift, when at all, less and later than we do, and they certainly never prod with the stick. And with all the glamour of the Arlberg still over me, I can find no greater condemnation of the lifted stem than that (as pointed out by Arnold Lunn) a man was able, as the tests were at one time, to get his "Q I" without ever being able really to stem at all.

## THE FORWARD SPIRIT.

As I see it, the point of technique in which Schneider's teaching is really ahead of ours is the means by which he achieves that the weight shall be forward. We all know that we should lean forward. But the average English runner so often tries to gain this end by courageously getting his head forward, while his chassis projects backwards, the weight finally being anywhere but on the ball of the foot (its proper place). Schneider emphasizes the attention that should be paid to the angle formed by the shin and the ski, which at no time should be as great as 90°. Bending of the knees, it will be seen,

follows automatically. And at no time are the heels allowed to leave the ski.

When sizing up a runner, the Arlbergers seem to lay great stress upon this angle. "Amstutz? Yes, a very good runner. But Luggi's knees are a bit further forward over his toes." (Bracken's knees, I may say, are approved of.) I have noticed that the same angle obtains in the case of good runners who employ the telemark position. Macintosh (whose position for straight running, by the way, is very much the same as that of Dahinden) has his knee well forward over the toe, with his chest further forward still. Perhaps the time will come when the qualifying tests will be determined, not by the angle of the slope, but by the angle that the shin makes with the ski. We will talk about a "45° man," or stigmatize a wretched beginner as a mere 90° chap.

And if your chin, knee and toe are in one straight line, as they teach, you are certainly in a very fine position. And this rule ensures that the steeper the slope, the further forward you lean. I think that a perfect exposition of this stance is what has enabled the master to evolve his well-known little pocket-Christis, which permit him to retain complete control while going down the steepest slopes. The weight is so much upon the toes that the heels can be flicked lightly from side to side with the minimum of effort.

I had my first real appreciation of the virtues of the Arlberg style one day when we were showing Benno Leubner, the well known Innsbruck runner, over the Almendhubel in February, 1929. Quorum Glade was at its worst—very much cut up, and at a stage of rattling semi-breakable crust, covered with a thin layer of light powder. He pointed his skis practically straight down the slope, in the position of a moderate stem and with the knees much bent; and then, in complete control, proceeded comfortably down to the bottom in a series of rapid little half-christis. Our usual method in such circumstances is either an unduly laborious no-fall zig-zag, or an unduly rash attempt to belittle the difficulties by trying to take it too steeply and with too few turns. The best Arlbergers have shown Europe that they do not lack speed, but you never see them run out of control.

"THERE IS NOT GOOD SNOW AND BAD SNOW—ONLY DIFFERENT SNOW."—Schneiderian saying.

And so at present it can be well understood why it is our custom at Mürren to avoid racing except on snow which is safe. Our runners can, of course, go anywhere. But I regard our system as having one great gap in it, until we are able to race anywhere. In other words, till control at speed is not only the prerogative of a

few unusually athletic people, but is the habit of the generality of our alumni.

And I rather feel that a further leavening of Arlbergism, already so ably introduced into our midst by Bracken—last year's champion—is going to be the way to fill the gap.

With regard to St. Anton as a centre—there are a great number of good runs, with every type of terrain. The first thousand feet is done by Citroen caterpillar up to St. Christophe; and if there were a continuous chain of these vehicles, the transport question would work out somewhat as it does with us. But there were only two last season; and while I was there in January the old hands were booking seats for the day of the Arlberg Kandahar Race in March! The provision of a funicular or even of a rope-way up to the Ulmer Hutte or to the pass above it would make it one of the most popular ski-ing centres in Europe. English people are beginning to find their way there. I met one party who had been going there since 1922, a friend having spotted the possibilities of the place from the train while going through during the summer. (The main line from Calais and Paris to Vienna passes close by the Hotel.) There were a large and very cheery party of Dutch folk, and a few American and French runners.

I met there Signor Gilleoni, instructor to the Italian Army, who has just published a book on ski-ing. He was loud in his condemnation of the ugliness of the style; and it is conceivable that it is more adapted to the Teutonic than to the Latin mentality. Certainly the intensive culture of it is; but perhaps the time will soon come when runners the world over will take a day or two with the pro. at the beginning of the season, just as we have an hour or two at the nets, or a knock-up or so with a pro. on a covered court before our first game of tennis in the spring. And then what a time the Yanks will have!

BEDFORD RUSSELL.

### ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB.

"Lord of the sovereign heights—I ask no length  
Of honoured life, no span of gracious days—  
Yet while I live I pray Thee grant me strength  
To follow year by year the old snow ways."



ONCE again St. Bartholomew's Hospital has led the way, this time in the realms of sport. Most sports are already represented, but two of the most fascinating which claim the indulgence of both old and young alike, have now been added, namely mountaineering and ski-ing, and are together represented by the Hospital Alpine Club.

Only a few weeks ago, after much discussion, it was decided to find out if there was a sufficient number of enthusiasts to inaugurate such a Club. It was proposed that a Dinner should be held which any who were interested might attend, and the movement met with such whole-hearted reponse that on Monday, November 24th, 56 people gathered at *Ye Olde Cock Tavern*. Prof. G. E. Gask very kindly took the chair, and many others of the Senior Staff afforded their support by being present at the dinner and joining in the subsequent proceedings.

The whole evening was a great success, and during dinner many happy memories of climbs and ski runs and days spent in the snow and sunshine were recalled.

After dinner the inaugural meeting was held. Prof. Gask proposed that a Club should be formed called the St. Bartholomew's Hospital Alpine Club, membership of which should be open to all past or present members of the Hospital who are interested in climbing or ski-ing. This was carried unanimously with a great deal of enthusiasm, and the new Club came into being. The following officers were then elected with acclamation.

*President*.—Prof. GASK was proposed by Dr. HADFIELD, who referred to his distinguished record as a mountaineer and congratulated the Club on gaining such a prominent member of the English Alpine Club as its first Chairman.

*Vice-President* (to represent the Mountaineering Section).—Dr. FINZI was proposed by Dr. CORSI. The "Gipfel" being now occupied by the President, a suitable sharp pinnacle as near as possible to it, he suggested, should be found for another distinguished member of the Alpine Club.

*Vice-President* (Ski-ing Section).—Mr. BEDFORD RUSSELL was proposed by Mr. CAPPS, who referred to his very active interest in ski-ing, his record as a racer of merit, and his gift of a cup for a race held annually at Mürren.

*Hon. Treasurer*: Mr. HIGGS, whose enthusiasm as a ski-er is well known, was proposed by G. H. BRADSHAW.

*Hon. Secretaries*: R. G. ORR, G. H. BRADSHAW (Editor).

*Committee*.—Dr. CORSI, C. WARREN, G. D. BRIGGS.

The meeting having been adjourned, the President called upon Mr. BEDFORD RUSSELL to say a few words about ski-ing. Then, after Mr. Bradshaw had shown a few lantern-slides of Switzerland and the Dolomites, Dr. FINZI described his recent ascent by a new route up the north-west face of the Wetterhorn, illustrating his description with some excellent slides.

Mr. BEDFORD RUSSELL: The things that I wish to discuss fall naturally under two headings: (1) The relationship between mountaineering and ski-ing, and (2) the purpose of this Club.

(1) Very few of you, either mountaineers or ski-ers,

seem to realize that ski-ing and mountaineering are *not* separate branches of winter sport. All the good continental mountaineers have taken up winter mountaineering on skis with enthusiasm; and I think that if you were to ask a good continental ski-er the difference between ski-ing and mountaineering, he would be unable to comprehend you.

The relationship becomes more obvious the moment you begin to look into the origins of ski-ing. Ski-ing did not begin immediately after the war, as seems to be generally believed, but was probably practised in Finland in prehistoric times. Mr. Gask has just told me of a picture he remembers in childhood which portrayed two Vikings on skis. Procopius, writing about 500 A.D., mentions that the Lapps covered large tracks of level ground on skis of unequal length—a short one to push with, and a long one to glide upon.

But just as the question of transport upon the whole surface of the globe probably remained in abeyance many thousands of years before the invention of the wheel, so there was really no progress in ski-ing until the arrival of two Telemark peasants in Christiania in 1870. These individuals, or their tribe, had been lucky enough to stumble upon a method of stopping while running downhill; and the publicity which their accomplishment engendered was the real impetus which made Scandinavia the cradle of the sport of ski-ing.

How it arose in other countries is not so clear. In England it has been in use in the Lake District for hundreds of years; and I believe that it was mentioned in *Lorna Doone* as having existed in Devon three hundred years ago. We know that ski-ing was done in Austria in the eighteenth century in several of the Tyrolean valleys, but that it died out there, and did not reappear until after 1880. Strangely enough, ski-ing was done in Austria in 1884 before it was known in Switzerland; in Kiandra there is still a school of ski-ing whose unconventional skis and methods derive directly from the arrival of Swedish workers in the gold mines about that time. And it was introduced into Switzerland, apparently at the hands of some Englishmen, about 1887. Nowadays there is practically no country in the world where ski-ing cannot be had; and there is no month in the year in which a man of leisure cannot get ski-ing somewhere. So much for the origins of the sport.

So that we see that ski-ing arose first of all not as a sport, but as a means, if we may define it so, of getting across snow-covered country—"tute, celeriter et jucunde." And to those that lay more stress upon the *tute* and *jucunde* than *celeriter*, I would say that for cross-country ski-ing there is no such good exercise as *ski-racing*.

While to those young fire-eaters among you to-night whose flag bears only the legend "*Celeriter*," I would say, out of my thirteen seasons' experience, that the man who goes in solely for racing misses the highest pleasures that the mountains can give. I have never done any climbing in the summer; but I find it very hard to equal the pleasure that you can get by lunching in gorgeous sunshine after a four hours' climb on skis (with seal-skins) to some of the lesser peaks of ten thousand feet or so (which is probably the level from which the *Alpine* side of our Club really begins to count)!

My chief aim in speaking to you is to point out that just as you cannot become a doctor either by book-work or by practical work alone, so you must not make the mistake of Alpine specializing; there must be *no* branch of the sport that you leave untried. And with regard to ski-ing in particular, do not confine yourself to ski-ing on such and such a type of snow, remembering the saying of Hannes Schneider (the *doyen* of Austrian ski-ers): "There is not 'good snow' and 'bad snow,' only 'different snow.'" Nor should you concentrate on one type of turn to the exclusion of others, remembering the saying of Dr. Hoek (one of the earliest writers on ski-ing technique): "There are only two turns in ski-ing—the one to the left, and the other to the right!"

(2) With regard to the purpose and use of our Club, our enthusiasm must be tempered by the knowledge that we are all likely to go to different centres upon different dates, and that we may think that we have done well if we can organize *one* event per season, upon the Continent. But I may mention here that our President is brooding a plan for a meeting in the English mountains. Apart from this, it will possibly be found that our meetings will be chiefly a means of affording us pleasant opportunities, in good company and with good cheer, of boasting to one another about our annual achievements amid snow and ice.

Dr. FINZI.

While staying in Grindelwald in 1923, Dr. Finzi made his first attempt on the north-west face of the Wetterhorn the steepness of whose precipices is outlined so clearly against the sky when seen from the village. At first sight it seemed almost impossible that man could find a way up such pitiless slopes, but after much study from all angles, and from the lower slopes of the mountain itself, a possible route seemed to present considerable chances of success, only to be undertaken by a very fit and experienced climber. Starting with a steep chimney, which presented little real difficulty to the party, the way led upwards by a series of long

zigzags over the lower slabs of the mountain. Given good weather, and wearing "Klettesschuhe" instead of nailed boots, this was safe, but sensational and not easy, owing to the outward and downward slope of the rocks: it was essential that they should not be caught on these slopes by bad weather.

Towards the end of the season of 1923 a start was made on the ascent, but when these lower slopes had been conquered, and the more problematical part of the climb began, a change took place in the weather, and reluctantly further efforts had to be abandoned and a return to the valley made, not without difficulty, involving the use of the doubled rope down the first chimney. The next season, owing to continued bad weather, no further attempt was possible. However, the presence of snow on the mountain gave additional help in picking out a final route, by displaying clearly the less steep pitches which definitely "would go." In the years which followed, though frequent returns to the district were made, and the mountain was scrutinized afresh from all angles, the weather still prevented a serious attack being made.

In 1929, at last, circumstances changed, and there was the prospect of a really settled season. Once more plans were arranged, and the battle, with the difficulties of the route still as yet to a large extent unknown, was begun. The party consisted of Dr. Finzi, Franz Binert and Joseph Knubel. The first slopes, already described, were conquered without much difficulty to such an experienced party, and a halt was called for breakfast at the foot of "The Great Tower," which was to prove the first big problem of the ascent. "Would it go or not?" was the question running through their minds, and should they go to the right or left? While breakfast was being prepared, the two guides went on a little way to reconnoitre the probable route to be taken, and in a short time returned with gloomy news of the prospects.

However, their fears were not quite justified, as, by continuing on further and descending a little, the portion of the climb which had been observed to be the key to the situation was found. This consisted of a 60 ft. long chimney, followed by an oblique upward traverse. One piton was used on this where the direction changed, but only as security and not as an artificial aid to climbing. The full 120 ft. of rope was needed between each climber.

But such was the confidence of all that no hesitation was made in tackling forbidding stretches such as this. For the true mountaineer—

" . . . revels in the sheer ascent,  
And finds new worlds for wonderment  
In every grim recess."

With the defeat of the Great Tower the worst troubles were over, and a way was made to the left, which brought the party up on the north-east *arête*. From here on to the summit of the Scheidegg Wetterhorn the route lay along the ridge, and no real difficulties were encountered to compare with those of the previous section. Thus finally the party emerged triumphant on the peak to taste the joys of victory of a new ascent, for—

"He opens an enchanted gate  
For each untrodden ridge.

"How small the earth to those wide eyes,  
And the near welcome of the skies  
How infinitely great."

The descent was made in *klettesschuhe* to the Glectstein Hut on the west face, a way which had previously been proved possible, and so by the usual route to the valley.

"Look from a height: the city and the plain  
And the near clouds are but as one in seeming;  
All earth is but a link in the dim chain  
That binds our little seeing to our dreaming;  
Life, with its limits merged in larger truth,  
Looks as it looked once from our heights of youth.

"Only a hill: yes, looked at from below;  
Facing the usual sea, the frequent west.  
Tighten the muscle, feel the strong blood flow,  
And set your foot upon the utmost crest.  
There, where the realms of thought and effort cease,  
Wakes on your heart a world of dreams, and peace."

Will any Past or Present members of St. Bartholomew's Hospital who are interested in either mountaineering or ski-ing, whether actively indulging in these pastimes or not, and who would like to have further information, or better still join the Club, kindly send me their names? The subscription has been fixed at the very modest and reasonable sum of 5s. a year. It is hoped to hold at least two meetings a year, and possibly more, at which either a film will be shown or a paper will be read on a subject of general interest to members. We should be very glad to welcome any Old Bart.'s men who are living within reach. A notice will be sent out to all members as soon as the date of the next meeting is fixed. This will probably be about the second Wednesday in February.

G. H. BRADSHAW.

R.S.Q.,  
St. Bartholomew's Hospital.

## STUDENTS' UNION.

### RUGBY FOOTBALL CLUB.

#### ST. BARTHOLOMEW'S HOSPITAL v. OLD HAILEYBURIANS.

October 18th, at Winchmore Hill.  
After a very close struggle, in which the steady and determined tackling of both sides played a big part, the Old Haileyburians won by a point for the first time since the fixture was made. Bart.'s were without the services of J. T. C. Taylor and this undoubtedly made a big difference, but it was a day on which nothing could go right for the Hospital and nothing wrong for the Old Boys. Play was fast and open throughout and the Bart.'s pack more than held their own, but the strong running and quick following up of the Old Boys' pack prevented the ball from getting moving as often as it should. In the first half all the points were scored.  
Tries by J. D. Powell and E. M. Darmady. T. J. Ryan kicked a penalty goal and placed Powell's try.

#### ST. BARTHOLOMEW'S HOSPITAL v. CAMBRIDGE UNIVERSITY.

October 22nd, at Cambridge.  
Cambridge fielded a very strong XV and after a much better game than the score would indicate, won by 37 points to 5. The game had hardly started before Smeddle, using his strength and great speed to full advantage, had dashed over for a try fairly far out; Brook failed with the kick. Play was even for a time, then a clever cut-through by Collison gave Cambridge a further lead. The Bart.'s pack, though outweighed, got a reasonable share of the ball, especially in the line-out, but the centres were so closely marked that the wings hardly got a chance.

Shortly after this Jenkins sent in Gabb for a try near the posts which Darmady converted. The game was then even for a time until Cambridge found a weak point in our defence and by their superior speed proceeded to add steadily to their score.

Team: C. W. John (back); J. R. Martin, A. H. Pirie, C. B. Prowse, J. D. Powell (halves); G. F. Petty, J. T. C. Taylor (three-quarters); R. M. Williams, V. C. Thompson, M. L. Maley, B. S. Lewis, J. R. Jenkins, E. M. Darmady, W. H. Gabb, K. J. Harvey (forwards).

#### ST. BARTHOLOMEW'S HOSPITAL v. OLD LEYSIANS.

October 25th, at Winchmore Hill.  
This game resulted in a well-earned win for the Hospital by 8 points to 3. The game was fast and open, and our success was largely the result of the excellent marking of the Bart.'s backs and the steady brilliance of J. T. C. Taylor at the base of the scrum. The pack was much weakened by injury and county games and did very well to hold its own. Play was mostly in the Old Boys' half and the Hospital were within an ace of scoring on more than one occasion.  
Scorers: B. S. Lewis, A. H. Pirie (the latter converted by E. M. Darmady).

#### ST. BARTHOLOMEW'S HOSPITAL v. PONTYPOOL.

November 1st, at Pontypool.  
Played before a large crowd on a rough and rain-soaked pitch this game resulted in a win for the home side by 25 points to 3. Bart.'s were obviously unused to the tactics employed by their opponents and for some time did not settle down to their work, and it was in this period that most of the score was amassed. Petty ran through strongly for Bart.'s but Darmady failed with the kick.

The Hospital team had to be altered suddenly at the last minute owing to the absence of a wing three-quarter, and this still further disorganized the pack, who were as a consequence rather ineffective. The game was one of many injuries, at the final whistle there being only twenty-five players on the field, but except for the last ten minutes the game was clean and open. H. D. Robertson was a welcome addition to the side after his long absence through illness.

B. S. L.

### HOCKEY CLUB.

#### ST. BARTHOLOMEW'S HOSPITAL v. R.N. and R.M., CHATHAM.

November 1st, at Winchmore Hill.  
To win this game 3-0 was encouraging. Our forwards, although held up several times for being offside, were playing well together

—better than they had done so far this year—and early in the game Heasman and Jameson-Evans took full advantage of two mistakes made by our opponents' defence. These were our first two goals, the third coming also from Jameson-Evans early in the second half. Our defence was good, Fowler at right back playing well for the first game after his illness.

Team: H. L. Hodgkinson (goal); E. Fowler, P. M. Wright (backs); V. C. Snell, A. D. Iff, J. H. Hunt (halves); T. C. Houston, White, L. P. Jameson-Evans, L. Heasman, A. J. Owston, J. Symonds (forwards).

#### ST. BARTHOLOMEW'S HOSPITAL v. OLD CRANLEIGHANS.

November 15th, at Thames Ditton.  
On a wet and bumpy ground we started badly, allowing them to get three goals before we ourselves had scored. The third goal, by their outside left after a long run down the wing, was a very fine shot which gave Bamford no chance at all. P. M. Wright at left back played a good game. Our forwards, though pressing hard, were slow to score, and it was not until late in the second half that Owston gave us our two goals.

Team: B. Bamford (goal); E. Fowler, P. M. Wright (backs); V. C. Snell, A. D. Iff, D. Gale (halves); F. C. Henton-White, L. P. Jameson-Evans, L. Heasman, A. J. Owston, J. Symonds (forwards).

#### ST. BARTHOLOMEW'S HOSPITAL v. GLOUCESTERSHIRE REGIMENT.

November 16th, at Winchmore Hill.  
Again on a muddy ground, on an afternoon when the light was bad, with five of our regular players away, we did well to win this game 2-1. Burstal, by following up well, gave us our first goal. After this we had one or two very narrow escapes, but were able to keep them out till just before half-time, when they drew level with a hard shot into the corner of the net.

At one time in the second half both Burstal and Phipps were off the field for injuries, but the backs were playing a good game and Bamford in goal saved several shots by cunning foot-work. Though he had been up all the night before Symonds played hard and sent in some excellent centres from the left wing; from one of these Heasman scored our third and last goal with a good first-time shot. We hope to see more of these in future.

Team: B. Bamford (goal); D. Gale, P. M. Wright (backs); C. A. Brockbank, A. D. Iff, J. H. Hunt (halves); P. G. Roberts, E. W. Burstal, G. G. Phipps, L. Heasman, J. Symonds (forwards).

J. H. H.

### DRAMATIC SOCIETY MEETING.

At the annual General Meeting of the Society Dr. Geoffrey Evans took the chair. After the secretary, Mr. C. K. Vartan, had read the minutes, the officers for the present year had been elected and the Treasurer had spoken, we came to the hardest item on the agenda—the choice of a play.

A list of plays was read, and while we were thinking over them, the Treasurer suggested a revue. There was at first a little but enthusiastic support, but also a larger body of silent opposition, which after a few moments found voice. The Christmas ward shows provided excellent revue. Why should we—a Dramatic Society—try to improve upon the ever-increasing excellence of these strolling players, especially if they were again to be collected into such an entertaining and lucrative programme as that which Mr. J. R. B. McBride and his many helpers provided last February in the Great Hall. We should—we must—remain the exponents of Dramatic Art.

We thought again. *This Woman Business* was suggested—an old stager. Although produced at the Haymarket only four years ago this play has been eagerly championed at three successive annual general meetings. *The Crooked Billet* was the next candidate, and it lost more through lack of support than active opposition. *Bull-Dog Drummond* was enthusiastically received, but when the difficulty of stage managing was remembered and its excessive popularity realized it was quickly passed over. And then, was it Dramatic Art? For the "noises off" of *The Ghost Train* special machines were needed and special mechanics to work them: we should be our own artists. A voice said Galsworthy—a new opening, but they all looked at him; tactless fellow, but no one liked to say so—such serious stuff. "His plays are problems. We have too many of them ourselves—here—everyday—in real life you see. Quite!" Galsworthy was laid aside, but honourably and in silence. Sheridan

was murmured, but not loud enough to be taken as a proposal. Too difficult—needs graceful . . . well, the style, you know. *This Woman Business* remained. But someone had said *The Fourth Wall*, a thrilling detective play by Milne. It was chiefly because *This Woman Business* was an old stager that it was, like we old chronics at the Conjoint, doomed to be referred politely till next time. Also it was hard to act: it had so little action, and it was too like last year's *The Mask and the Face* in its cynical attitude towards the problems of sex, and we—well . . .

The most item was, Should we or should we not invite women to take women's parts? Some "ex-women" of the Society spoke, and so much weight did their opinions carry that we agreed that we should have real women. Although we realized that the audience enjoy seeing some clumsy dresser from the Surgery transformed into the caricature of a pure lady, we considered that our ideal of Dramatic Art would be more readily achieved if we had real women.

The dates fixed for the performance are January 6th to 9th, on which days the Governors have very graciously given us the use of the Great Hall to present A. A. Milne's thrilling three-act detective play, *The Fourth Wall*. H. W. R.

## ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. CORPUS CHRISTI, CAMBRIDGE.

October 25th, at Winchmore Hill.  
The standard of play was very poor on both sides during the first half. Dransfield, however, scored twice for Bart's, who led by 2-1 at half-time. In the second half Bart's showed a great improvement, especially the inside forwards. Corpus Christi were continually on the defensive and four more goals were scored against them. Dransfield (3), Shackman (2) and Gilbert (1) scored for Bart's.

ST. BARTHOLOMEW'S HOSPITAL v. KEBLE COLLEGE, OXFORD.

November 1st, at Oxford.  
This match resulted in a win for Keble by 1-0. For the first half-hour the Hospital were continually attacking, but the shooting was very poor. In the second half Keble had the game well in hand, and kept the play in our half of the field. The Bart's defence played well, Wheeler being particularly outstanding.

ST. BARTHOLOMEW'S HOSPITAL v. LANSING COLLEGE.

November 8th, at Shoreham.  
The result of this game was a win for Lansing by 5-2. In the first half, Lansing, having the advantage of a considerable slope on the ground, scored twice, and kept the Hospital on the defensive. For the first twenty minutes of the second half Bart's completely outplayed them and drew level. The shooting of the Hospital forwards was very poor, and many chances were missed. Lansing then gained the upper hand, and aided by mistakes in the Bart's defence added three more goals. The Hospital XI showed rather a lack of combination and understanding, and were badly overrun by a much faster team.

Team.—R. A. Wenger (goal); A. Hollinrake, H. J. Roache (backs); F. E. Wheeler, C. A. Keane (capt.), G. H. Brookman (halves); B. F. Jackson, R. Shackman, R. G. Gilbert, C. M. Dransfield, W. Hunt (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. OLD MERCERS.

November 15th, at Winchmore Hill.  
Played in continual rain, on a very slippery ground, this match resulted in a win for the Old Mercers by 6-1. In the first half play was very evenly divided, the Old Mercers scoring once.  
After half-time the visitors were too fast for the Bart's rather erratic defence, and scored five times. Mis kicking was prevalent on both sides, although more common on the Hospital side. The forwards showed lack of combination and their shooting was weak. C. A. Keane played very well in the second half.

H. J. R.

## UNITED HOSPITALS HARE AND HOUNDS.

UNITED HOSPITALS HARE AND HOUNDS v. THAMES HARE AND HOUNDS.

November 8th, at Roehampton.  
Neither team was at full strength, nevertheless a keen race was expected. The course of 6½ miles over Richmond Park and Putney Common was in "fast" condition. There were 15 starters.  
From the very beginning J. F. Roberts (Thames), closely followed

by H. C. Harley and J. R. Strong, both of the Hospitals, went right ahead, and by 2 miles had opened up 100 yards' lead on the rest. At 3 miles Roberts and Strong were running easily together, with Harley 20 yards behind. 150 yards behind were three Thames men, with H. B. Lee of the Hospitals close up. At 4 miles Harley was now up with Strong and Roberts and the three were covering the ground fast, increasing their lead on the back men with every stride, and so they kept together till 1½ miles from home. Here Harley and Strong left Roberts, and increasing their speed finished together in 40 minutes 43 seconds, Roberts being some 40 yards behind. The next four men were of the Thames, and so, mainly through their splendid "packing," we lost by 5 points, although we filled the first two places. H. B. Lee, of the Hospitals, was very unfortunate in losing his way about 1½ miles from home when lying 7th.

Results.—J. R. Strong (U.H.H.H.), H. C. Harley (U.H.H.H.), 1st; J. F. Roberts (Thames), 3rd; R. E. Brown (Thames), 4th; R. G. Smith-Sparkes (Thames), 5th; H. G. Heale (Thames), 6th.  
Thames (3, 4, 5, 6, 7), 25 points; U.H.H.H. (1, 2, 8, 9, 10), 30 points.

## CORRESPONDENCE.

*The New Registration.*

DEAR MR. EDITOR,

In my capacity as Dean of the Medical College I am frequently consulted with regard to the career of a student while he is still at the Hospital, and, after his qualification, asked for a testimonial to assist him to obtain a resident, or other appointment.

Although I am blessed with a fairly good memory, it is impossible for me to be aware of the doings of every student, and I am therefore compelled frequently to confer with the various teachers of the College. Again, in order that the student may be signed up, both he and the members of the Staff are confronted with the nuisance of getting the yellow card signed. It is still more difficult to remember him after he has left the Hospital for any considerable time.

In order to overcome these difficulties, I have initiated, with the consent of the College Committee, a new system of registration which will comprise a record of every student's work. In order that this shall be kept up-to-date, the teachers in the various departments of the College will receive from me at the end of each three months a list of the students in their charge, with a request that they will fill in, opposite each name, a record of work done. This will be returned to me and kept in my office.

This method of registration will do away with the necessity of the yellow card for all students who have entered the Hospital, or who have commenced clinical work, after September, 1930, and will help me to answer such queries as may be put to me.

The Students' Union has also agreed to obtain for me a passport photograph of each student, which will be attached to his record. This will enable me and other members of the Staff to recognize men who ask for testimonials, and will manifestly be beneficial to both sides.

I think it only right that the students should be aware of this new system, and I shall be grateful if you will place this letter in the next issue of the JOURNAL.

I should like to take this opportunity to thank the many present and past students of the Hospital who have shown me the courtesy of congratulating me on my taking up the office of Dean. I can assure them that I appreciate very much what they have said and done.

Yours sincerely,

(Signed) W. GIRLING BALL,  
Dean of the Medical College.THE DEAN'S OFFICE,  
THE MEDICAL COLLEGE,  
ST. BARTHOLOMEW'S HOSPITAL,

November, 1930. E.C. .

## SIR THOMAS BARLOW'S CHRISTMAS APPEAL.

DEAR SIR,—Next month we shall be preparing to give, as is our usual custom, a Christmas Gift of 30s. to each of our annuitants and to some of the most necessitous of the grantees. These gifts are looked forward to by many.

Some of the regular recipients are blind, others are deaf, and many of them are old and infirm, all are facing the hardships of poverty. Each year the number on our books increases and we need no less a sum than £550 this year if no one is to be left out.

I appeal in plenty of time before Christmas, because we urgently need the money.

Will any reader who has not yet contributed please make his first Christmas Gift to this cause and thereby help a fallen colleague, or his widow or orphan?

If he cannot give a large donation, may I ask him not to disregard my appeal, but to send any sum, however small, to the Treasurer, Royal Medical Benevolent Fund, 11, Chandos Street, Cavendish Square, W. 1?

Yours faithfully,

LONDON, W. ;  
November, 1930. THOMAS BARLOW,  
(President).

## MEDICINE IN FICTION.

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

DEAR SIR,—May I ask readers of the JOURNAL if any one of them has seen in a case of malignant endocarditis in which cerebral thrombosis has occurred? The only one I have met is the hero of Norah James's excellent novel, *Shatter the Dream*, recently published by Messrs. Constable. On p. 273 the young man has a right hemiplegia with aphasia, preceded by giddiness: "Suddenly he felt giddy and the wall began to race by him." I believe I am right in saying that the hemiplegia of embolism is unattended by giddiness, and that in the hemiplegia of hemorrhage there is no aphasia. I suppose that thrombosis could easily occur in the mycotic aneurysms of malignant endocarditis, and should be very interested to know if anyone has seen such a thing happen.

Doctors sometimes become novelists, but the clinical acumen of the modern novelist makes one fear and/or think that the converse might happen. If Aldous Huxley, Norah James and Arnold Bennett were called in to a consultation on an obscure case I think and/or fear that they might make a correct diagnosis. They certainly drink deep of the Perian spring.

I am, Sir, yours faithfully,  
LONDON, W. 1 ;  
November 11th, 1930. H. A. CLEGG.

## REVIEWS.

SICK CHILDREN: DIAGNOSIS AND TREATMENT. By DONALD PATERSON, M.D., F.R.C.P. (Cassell &amp; Co., Ltd., 1930.) Pp. 538 (488 + 50 index). Price 16s.

Here is a new book on diseases of children. It is admirably suited for those who, wishing to know something of paediatrics, have not the time or the inclination to go to the length of studying the larger standard works, such as Still's or Batten and Thursfield's.

The book extends over approximately 500 small pages, with large clear type and numerous photographs and diagrams. These photographs, mainly of children showing the typical characteristics of the disease in question, have been collected from various sources and deserve notes of special mention. Having dealt with the examination, development and feeding of the normal child, the author proceeds to take each system of the body separately and deals with the related pathological conditions.

The chapters especially noteworthy include those on infant feeding, diseases of nutrition and of the genito-urinary system, whilst that on diseases of the nervous system is perhaps the best of all, with its excellent articles on acute anterior poliomyelitis and pink disease.

In line with most other modern paediatricians, the author of this volume stresses the frequent occurrence of acidosis as a complication in children's diseases, and special mention is made of the necessity of giving added glucose in one form or another as an essential part of the treatment in a large number of varying illnesses.

Although, as the title implies, the chief aim of this book is in regard to diagnosis and treatment, each disease is, in fact, considered in its entirety, incidence, etiology, pathology and the clinical picture—all being dealt with under separate headings.

On the whole this is an excellent and handy little volume, and perhaps the only objection one can raise is that on some points the author has not gone into sufficient detail, thereby implying a regret rather than a criticism.

THE CLINICAL INTERPRETATION OF AIDS TO DIAGNOSIS. Volume I. (Published by the *Lancet*, 1930.) Pp. viii + 380. Price 70s. 6d.

This extremely useful book outlines the scope and usefulness of pathological methods in the diagnosis of disease, and also deals with the interpretation of electrocardiograms, ocular and hearing tests, mental tests for children, pycnography and cholecystography. Technique is not described in detail, but the book guides the practitioner in the choice of cases which will repay investigation by these methods. The material required and the best ways of collecting and preserving it are described. The interpretation of the results is fully dealt with.

Close co-operation between clinician and pathologist is insisted upon: lack of full information as to the nature and source of the material is responsible for many incomprehensible laboratory reports.

Each subject is treated by an expert, and in many cases methods are described by those who have themselves helped to establish the significance of them. As a means of quick reference, each chapter is preceded by a paragraph indicating its contents.

A SYSTEM OF CLINICAL MEDICINE. By THOMAS D. SAVILL, M.D. Eighth edition. (London: Edward Arnold &amp; Co., 1930.) Pp. xxviii + 1019. 167 illustrations. Price 28s.

This well-known text-book has been completely revised and re-written in part. Several authors have undertaken this work. Dr. Reginald Hilton has revised the chapter on Diseases of the Lungs, Dr. Goodall that on Diseases of the Heart, and Dr. Harry Campbell the chapter on Nervous Diseases. A dozen other experts have also contributed to the book, which is probably one of the best for students beginning medical work. Each chapter consists of three sections, the first dealing with symptomatology and the second with physical examination, while the third contains a classification of the diseases of the region, a summary of the routine procedure to be adopted for purposes of diagnosis and finally an account of each disease. This disease is approached from the standpoint of symptoms, physical signs, diagnosis and treatment following. This is the order in which the physician must attack his problem, and there is no doubt that Dr. Savill's arrangement possesses many advantages both for the student and for the practitioner when in difficulty. The value of

the book is enhanced by the addition of chapters on Diseases of Women, Diseases of the Eye, Ear, Nose and Throat, and Mental Diseases, all dealt with in the same manner. The book is liberally illustrated with temperature charts. The characters of pathological fluids are tabulated in a useful way and there is an appendix of valuable prescriptions. Much new matter has been added in this edition, including sections on Plummer-Vinson Syndrome, Quinidine Therapy, Uroselectan, Liver Treatment, Malarial Treatment of G.P.I., the Parkinsonian Syndrome, Hypoglycaemia, Cisternal Puncture.

Dr. Agnes Savill is to be congratulated on this new edition, which we have no hesitation in recommending to students and practitioners.

**HUMAN PHYSIOLOGY.** By F. R. WINTON, M.D., and L. E. BAYLISS, Ph.D. Foreword by C. LOVATT EVANS, F.R.S. (London: J. & A. Churchill, 1930.) Pp. x + 583. 227 illustrations. Price 15s.

There can be no doubt that a sound knowledge of the normal working of the human body is indispensable to every student of medicine. This admirable book has been written to supply such a need. Investigations on man are quoted in illustration of general physiological principles. Thus the first chapter contains an excellent account of muscular activity before going on to the study of the intimate nature of the processes involved.

The arrangement of the book is original and the text lucid. Its value is increased by a certain number of references to disease in man. There is a great scope both for the teacher of physiology and of anatomy to help the future doctor to focus his attention on the most significant parts of his studies. We should like to suggest that the student would be grateful for even more of these sign-posts, as, for instance, in the short section on the cerebro-spinal fluid.

This is not a book for the lazy; rather is it the antithesis of the cram-book. It should be in the hands of the intelligent student who really wants to understand his work.

**AN INTRODUCTION TO HUMAN EXPERIMENTAL PHYSIOLOGY.** By F. W. LAMB, M.D. Foreword by A. V. HILL, F.R.S. (London: Longmans, Green & Co., 1930.) Pp. xii + 335. Price 12s. 6d.

The book is designed for the use of those who are engaged in studying the experimental side of human physiology. It consists of a detailed account of experiments on the blood, circulation and respiration, and inasmuch as the experiments are clearly described and explained and the range of the practical work is extensive the book is to be commended. The neglect of the nervous system, sense organs, digestive and excretory systems, however, is to be deplored, and without an account of these systems any practical book such as this must be regarded as incomplete.

After each experiment a detailed bibliography on the subject of the experiment is included, so that the book is also useful for reference purposes.

**AN INTRODUCTION TO MIDWIFERY.** By MARY MAYES. (London: Faber & Faber, 1930.) Pp. xii + 178. Price 4s. 6d. net.

It was not an easy task which Miss Mayes attempted in introducing the art of midwifery to her readers. It is difficult enough to teach the subject to those who have already been grounded in the elements of medicine and its attendant subjects and are already qualified nurses, but the authoress writes particularly for those who have had no previous training. We find, therefore, a summary of elementary biology, chemistry, anatomy and physiology, ethics, tables of weights and measures, hints on the answering of examination papers, the legal side, a history of midwifery, illustrations, glossary and index, and the whole occupying only 171 pages of a small book. On the whole the book is well balanced, and important practical points receive the space they deserve.

The anatomical and physiological parts are not separated from their appropriate pathological sections. Thus we find a discussion on rickets under the section which describes the skeleton, the account of the kidneys followed by clampsia and its complications. This is a commendable arrangement.

The section on antiseptics is extremely well written, being clear, adequate and concise.

A few questions are given at the end of each chapter to assist in revision. The glossary and index might be amplified with advantage. The book should have a long life, for it contains little that can soon be out of date. It commends itself at once for its simplicity and completeness, and the authoress can be congratulated on providing student midwives with an attractive and useful introduction to their subject—a book, moreover, to which they can frequently refer in the later course of their work.

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

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## RECENT ADDITIONS TO LIBRARY.

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- BORRADAILE: *Manual of Elementary Zoology*. Sixth edition.
- BOWLBY and ANDREWS: *Surgical Pathology*. Eighth edition.
- BREND: *Handbook of Medical Jurisprudence and Toxicology*. Sixth edition.
- CABOT: *Physical Diagnosis*. Tenth edition.
- CECIL: *Textbook of Medicine by American Authors*. Second edition.
- ELLIOT: *A Treatise on Glaucoma*. Second edition.
- *Glaucoma: A Handbook for the General Practitioner.*
- *Glaucoma: A Text-Book for the Student of Ophthalmology.*
- *Lectures on Tropical Ophthalmology.*
- *Sclero-Corneal Trephining in the Operative Treatment of Glaucoma*. Second edition.
- *The Care of Eye Cases.*
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- *Tropical Ophthalmology.*
- MAGLEAN, HUGH: *Modern Views on Digestion and Gastric Disease*. Second edition.
- *Modern Methods in the Diagnosis and Treatment of Renal Disease.*
- MAXIMOW: *Text-Book of Histology.*
- *Modern Technique in Treatment*. Vols. iii and iv.
- OSLER: *Principles and Practice of Medicine*. Eleventh edition.
- PESLEY and WYKARD: *Clinical Atlas of Blood Diseases.*
- PLARR: *Lives of the Fellows of the Royal College of Surgeons of England*.
- POULTON: *Taylor's Practice of Medicine*. Fourteenth edition.
- ROMANIS and MITCHNER: *Science and Practice of Surgery*. Third edition.
- ROSE and CARLES: *Manual of Surgery*. Thirtieth edition.
- SAVILL: *A System of Clinical Medicine*. Eighth edition.
- TEN TEACHERS: *Diseases of Women*. Fourth edition.
- TIDY: *Synopsis of Medicine*.
- TREVES: *Student's Handbook of Surgical Operations*. Fifth edition.
- WHITMAN: *Orthopaedic Surgery*. Ninth edition.

## EXAMINATIONS, ETC. University of Oxford.

The following degree has been conferred:  
B.M.—Brunyate, W. D. T.

*Final Examination for the B.M., B.Ch., June, 1930.*

*Materia Medica*.—Mandelstam, M.  
*Pathology*.—Beal, J. H. B., Marshall, R. M., Scott, R. B.  
*Medicine, Surgery and Midwifery*.—Brunyate, W. D. T., Hawking, F., McMenemy, W. H.

## University of Cambridge.

The following degrees have been conferred:

M.D.—Dicks, H. V., Holmes, E. G.  
M.B., B.Chir.—Barnes, R. E., Eason, G. A., Forrester Wood, W. R., Johnson, A. J.  
M.B.—Beattie, W. J. H. M., Heathcote, H. J., Janes, L. R., Richards, F. A., Roberts, A. M.  
B.Chir.—Alsop, A. F., Guiney, A. H., Levick, P. G., Nicholson, B. C.

*Third Examination for Medical Degrees, June, 1930.*

*Part I.* Barnes, C. O., Blair, A. T., Church, W. F., Cross, R. M. S., Goodhart, C. E. D. H., Gurney, A. H., Hancock, F. R. T., Harrison, J. O., Robertson, H. E. W., Wood Smith, F. G.  
*Part II.* Alsop, A. F., Forrester Wood, W. R., Hancock, P. E. T., Levick, P. G., Nicholson, B. C., Prowse, C. B., Radcliffe, W., Sugden, E. C.

## Royal College of Physicians.

The following have been admitted Members:  
Cutting, P. E. J., Dockray, J., Leitch, J. N.



**Royal Colleges of Physicians and Surgeons.**

The following Diplomas have been conferred:  
*D.P.H.*—Eyton-Jones, F. M. M., Leitch, J. N., Nash, W. R., Spencer, J.  
*D.I.O.*—Handousa, A. El. S.  
*D.P.M.*—Ogden, W.

**Royal College of Surgeons of Edinburgh.**

The following have been admitted *Fellows*:  
 Ashmaur, M. I., Jennings, C. M., Langhorne, D. A., Olsen, C. W.

**Conjoint Examination Board.**

*Pre-Medical Examination, October, 1930.*

*Chemistry.*—Hutchence, C. H., Macdonald, J. M.  
*Physics.*—Macdonald, J. M., Nicoll, J. A. V.

*First Examination, October, 1930.*

*Anatomy and Physiology.*—Howell, T. H., Kirkwood, R. M., Reavell, D. C.  
*Anatomy.*—Cooper, H., Edwards, D. H.  
*Physiology.*—Davies, D. L. L., Fear, R. G., French, J., MacColl, A. H., Seidman, I. I., Squire, J. A.  
*Pharmacology.*—Chester Williams, T. L., Papert, A., Roberts, P. G., Savage, O. A., Symonds, J. W. C.

**Final Examination.**

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

Barnes, C. O., Blair, A. T., Clarke, R. T. V., Coltart, W. D., Davy, A. F., Durbach, D., Foot, E. C. I., Grace, A. H., Hancock, F. R. T., Harrison, J. O., Hogg, W., Jenkinson, E. N., Knight, G. C., Malkin, G. R., Solomon, N., Vartan, C. K., Williamson, H. W.

**L.M.S.S.A.**

The Diploma of the Society has been granted to the following:  
 Ellison, C. W., Finn, R. F. T., Games, J. D. B., Johnston, J. H., Liberis, A., Newton, R. D.

**CHANGES OF ADDRESS.**

Griffiths, G. B., Smitham Cottage, Warwick Road, Coulsdon, Surrey. (Tel. Purley 4448.)  
 Pickering, W. Cowper, The Downs, Broad Oak, Heathfield, Sussex.  
 Robinson, V. P., Millfield House, Diss, Norfolk.  
 Saunders, W. E. K., 1, Stanley Avenue, Holly Bush Estate, Quinton, near Birmingham.  
 Stocker, C. J., 2, Queen's Square, Lancaster.  
 Strugnell, F. W., 1, Cliff Terrace, Chale, Ventnor, Isle of Wight.  
 Turner, P. E., Travancore, 189, King's Hall Road, Beckenham, Kent. (Tel. Sydenham 7312.)  
 Wise, C. S., 76, New Street, Sandwich, Kent. (Tel. Sandwich 101.)

**APPOINTMENTS.**

SKEGGS, B. LYNDON, M.R.C.S., L.R.C.P., appointed Honorary Medical Officer to the North Hertfordshire and South Bedfordshire Hospital.  
 SOLTAU, H. K. V., M.D. (Lond.), appointed Medical Superintendent to Rendlesham Hall, Suffolk.

**BIRTHS.**

DALTON.—On November 11th, 1930, at 41, Fomereau Road, Ipswich, to Pamela (*née* Raynes), wife of Dr. C. H. C. Dalton—a son.  
 DAVENPORT.—On November 24th, 1930, at 82, Adelaide Road, N.W. 3, to Helen (*née* Mayfield), the wife of Robert Davenport, F.R.C.S.—a daughter.  
 GOW.—On November 5th, 1930, at 3, Upper Harley Street, N.W. 1, to Dr. and Mrs. A. E. Gow—a son.  
 LEDGER.—On November 2nd, 1930, at Nowgong, C.I., to Cicely B., wife of Major Lloyd K. Ledger, I.M.S.—the gift of a son.  
 LONGFORD.—On November 20th, 1930, at 57, Botanic Avenue, Belfast, to Elizabeth (*née* Dunn), wife of Dr. W. U. D. Longford, of Holywood, co. Down—a son.  
 NELSON.—On November 24th, 1930, at 4, Harley Road, N.W. 3, to Kathleen, wife of H. P. Nelson, F.R.C.S.—a daughter.  
 STOCKER.—On November 21st, 1930, at Lancaster, to Madeleine, wife of Major C. J. Stocker, I.M.S.—a son.  
 WAYLEN.—On November 12th, 1930, at 41, Long Street, Devizes, to Betty, wife of George Waylen—a son.  
 WILLOUGHBY.—On November 1st, 1930, at a nursing home in London, to Kathleen, wife of Dr. Hugh Willoughby, Assistant M.O., Port of London Sanitary Authority—a son (Christopher John d'Eresby).

**MARRIAGES.**

HARRISON—DAVIS.—On November 1st, 1930, at Beckenham, Kent, Dr. W. R. E. Harrison, son of Mr. and Mrs. G. Harrison, to Dr. Mirabel Grace, daughter of Mr. and Mrs. J. Irwin Davis, of Beckenham.  
 NEILL—DEMPSTER.—On November 4th, 1930, at St. Bartholomew's the Great, by Rev. G. M. Neill, Eric James, youngest son of Rev. C. and Mrs. Neill of Mirzapur, India, to Isabella Mary, only daughter of Mr. and Mrs. Alexander Dempster, of Avondale, Bucksburn, Aberdeenshire.

**DEATHS.**

BARROW.—On October 30th, 1930, at Lynorne, Shalford, Surrey, after a short illness, Willie Netterville Barron, C.M.G., M.V.O., M.R.C.S., L.R.C.P., youngest son of the late Gerald E. Barron, of Cranborne Corner, Ascot.  
 KEIGHTLEY.—On November 18th, 1930, suddenly, in New York, Archibald Keightley, M.D., late of 46, Brook Street, W., and Glanmawdach, Barmouth, N. Wales.  
 KENNEDY.—On September 4th, 1930, at Potgietersrust, South Africa, Robert Pettigrew Kennedy, M.R.C.S., L.R.C.P.  
 MAINGAY.—On November 17th, 1930, at a nursing home, Henry Bertram Maingay, F.R.C.S., of 34, Queen Street, Scarborough, beloved husband of Kathleen Edith Maingay, and only surviving son of the late William Benjamin Maingay, of Guernsey, aged 63.  
 SHORE.—On November 19th, 1930, at Upper Norwood, Mary Elizabeth, beloved wife of Thomas William Shore, M.D.  
 TURNBULL.—On November 3rd, 1930, at Hampstead, after an operation, George Lindsay Turnbull, M.D., M.A. (Oxon.), of Herman's Orchard, Crookham Hill, son of George Turnbull, C.E., aged 70.  
 WARD.—On November 10th, 1930, at 14, Dynevor Road, Richmond, Walter Alfred Ward, M.R.C.S., aged 82.

**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, F.C.T. Telephone: National 4444.

# St. Bartholomew's Hospital



## JOURNAL.

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

Vol. XXXVIII. No. 4.]

JANUARY 1ST, 1931.

PRICE NINEPENCE.

**CALENDAR.**

Fri., Jan. 2.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  
 Sat., " 3.—Rugby Match v. Harlequins. Home.  
 Hockey Match v. Shoburyness Garrison. Away.  
 Tues., " 6.—Dr. Gow and Mr. Harold Wilson on duty.  
 Tues., Wed., Thurs. and Fri., Jan. 6, 7, 8 and 9.—At 8 p.m. in the Great Hall: **The Amateur Dramatic Society presents "The Fourth Wall."**  
 Fri., " 9.—Prof. Fraser and Prof. Gask on duty.  
 Sat., " 10.—Rugby Match v. Moseley. Home.  
 Association Match v. Old Wykehamists. Home.  
 Hockey Match v. Sittingbourne. Away.  
 Tues., " 13.—Sir Percival Hartley and Sir Holburt Waring on duty.  
 Wed., " 14.—Hockey Match v. Gloucestershire Regiment. Away.  
 Fri., " 16.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.  
 Medicine: Clinical Lecture by Sir Percival Hartley.  
 Sat., " 17.—Rugby Match v. Coventry. Away.  
 Association Match v. Old Westminsters. Home.  
 Hockey Match v. Reading University. Home.  
 Mon., " 19.—**Last day for receiving matter for the February issue of the Journal.**  
 Special Subject: Clinical Lecture by Mr. Elmslie.  
 Tues., " 20.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  
 Wed., " 21.—Surgery: Clinical Lecture by Sir Holburt Waring.  
 Fri., " 23.—Dr. Gow and Mr. Harold Wilson on duty.  
 Medicine: Clinical Lecture by Dr. Gow.  
 Sat., " 24.—Rugby Match v. Old Paulines. Home.  
 Association Match v. St. John's College, Cambridge.  
 Hockey Match v. St. Albans. Away.  
 Mon., " 26.—Special Subject: Clinical Lecture by Mr. Just.  
 Tues., " 27.—Prof. Fraser and Prof. Gask on duty.  
 Wed., " 28.—Surgery: Clinical Lecture by Mr. Harold Wilson.  
 Fri., " 30.—Sir Percival Hartley and Sir Holburt Waring on duty.  
 Medicine: Clinical Lecture by Sir Percival Hartley.  
 Sat., " 31.—Rugby Match v. Bridgewater. Away.  
 Association Match v. Emmanuel College, Cambridge. Home.  
 Hockey Match v. R.N. and R.M., Chatham. Away.

**EDITORIAL.**

SIR D'ARCY POWER.

The following lectures were delivered by Sir D'Arcy Power at the Institute of the History of Medicine of the Johns Hopkins University:

Nov 19th: The Essentials of Medical Biography.  
 " 25th: Medical Bibliography.  
 Dec. 2nd: The Meals of our Ancestors.  
 " 3rd: Aristotle's Masterpiece.  
 " 10th: Medical Iconography.  
 " 17th: The Growth of a Hospital.

We understand that at a ceremony shortly to be held in the Great Hall of the Hospital, Sir D'Arcy Power will be presented with a specially printed and bound copy of his 'Selected Writings.'

\* \* \*

PEARSON: BOX-CARRIER.

The retirement of Pearson from the Surgery means that the Hospital loses not only one of its oldest and best servants, but also the last of its "box-carriers." The original duties of the box-carriers have long since passed into the hands of others; but they were of considerably greater importance than the mere carrying of a box of catheters in the wake of the visiting surgeon.

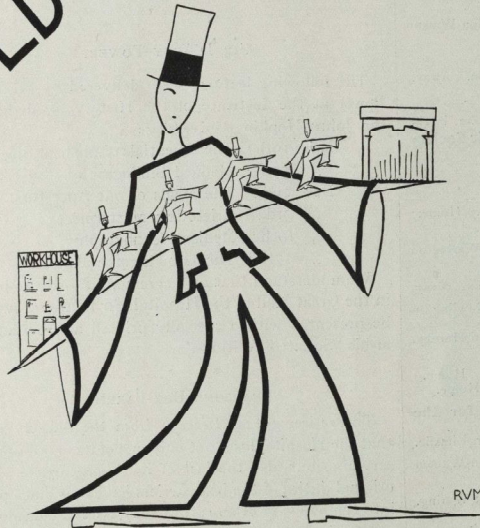
The first mention of a box-carrier occurs in the Journals of March 28th, 1728, when "complaint being made against 3 of the patients of this hospital, who are employed as box-carriers under the surgeons, for fighting, it is ordered that they be discharged."

In 1744 (Feb. 9th): "On enquiry into the nature of the office of box-carriers and their fees, Mr. Bigg, Surgeon, said that as long as his memory went [and he had been appointed Assistant Surgeon in 1728], the box-carrier was a patient of sufficient strength who attended each surgeon, 'to carry their box when they go through the

house to dress the patients, and receiving no fee, only diet and money as the other patients."

The remaining entries in the Journals relate to the question of fees. In 1754, doubtless stimulated by the expenditure on the building of the Hospital then in progress, they "demand a fee of 3d. or more for every patient ordered to be bled. This is an abuse, and is not to be allowed, nor any other fee." None the less the box-carriers, as also the sisters and the house surgeons, developed and profited by a system of fees levied upon the patients, until in 1813 it was decided that "in lieu

## OLD STAGERS



of fees each house surgeon to be allowed £25 per ann., and each box-carrier one guinea per week. All house surgeons and box-carriers in future are to be recommended by the principal surgeons, and approved by the house committee."

The duties of the box-carriers, as Pearson remembers, were not only to carry, but to care for the surgeons' instruments. In the 'seventies and 'eighties operations were often performed in the wards behind screens, and at these the box-carrier assisted, the nurses' share in the operations being simply to chaperone the female cases.

Arrangements for a testimonial to Pearson are being

made. We give him all good wishes for health and happiness in his retirement.

### THE CHRISTMAS SHOWS.

We hope that all our subscribers enjoyed a Merry Christmas. They certainly would have done had they spent it within the Hospital precincts.

We wish all our subscribers a Happy New Year. [The Editor means 1931. AEST. ED.]

It is impossible to remember *exactly* about Christmas. There remains a general impression that it was a "good show." Indeed the shows were all good—or at least all those that we saw, for we were foiled in our determination to see *everything*. The *Ghouls*, for example, became completely invisible; and as they were likewise inaudible, some foolishly concluded that there were no *Ghouls*. We, however, drew the correct inference from their spectral name. The *Green-fies* emulated their cousins the *Mayflies*—a brief, inglorious career. This was unanimously voted a Good Thing.

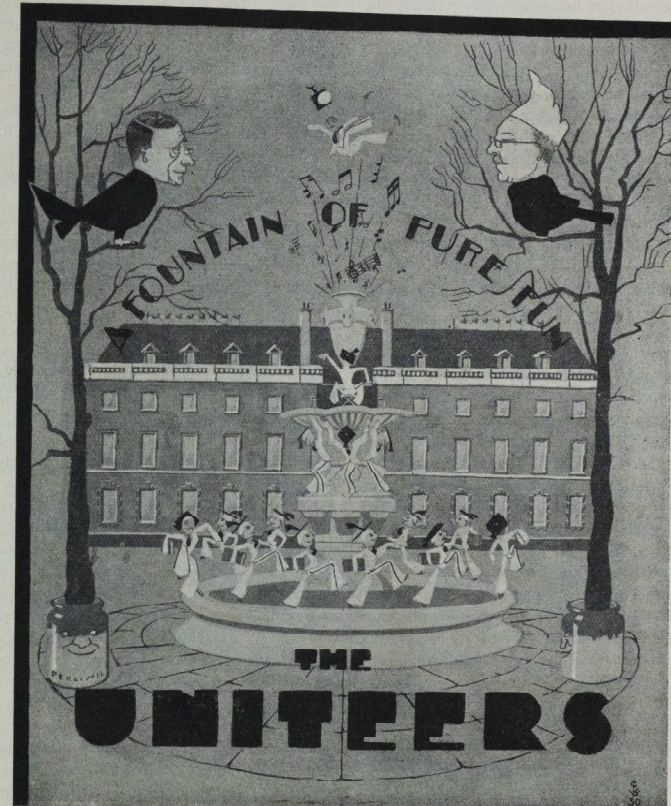
The Residents were transformed into *Hayes' Angels* (for two afternoons only). From the intimacies of their opening chorus to the community singing at the end the show went with a swing, if not, as some averred, with complete abandon. *Ingredients*: a lugubrious lament by an anaesthetist from the farther North, an equatorial ballad of Borneo, music from piano and ukeleles, a masterpiece of gangrenous black-chat, and a sketch, the superb acting of which left us wondering at the time whether to be diverted or dismayed by the amnesia and the miscuing.

The *Old Stagers* overflowed with talent and *real* actors. Their sketches, "For England" and "Ah-Hah!" were extremely good; but the best performance in this, or in any of the shows, was given by Furber, who had the audacity to be Maurice Chevalier, and the talent to carry it off. The *Minstrel Circle* "struck a new note in Hospital dramatics," a note that was mechanical but very pleasing. From instruments that Tubal-Cain might have conceived in a nightmare they produced the beautiful strains of Liszt's Hungarian Rhapsody, No. 2; and they engineered exquisitely a twilight and a dawn. They had, too, a pianist.

The *Uniteers*, drilled to perfection, gave one of the best shows. "Now I'm a Houseman" was executed with the natural touch of a born comedian; and Vartan, whom we suspect as the slave-driver, was his inimitable self. In *Al Waring's Follies* a quick-change rendering

appointment to the Chair of Bacteriology at McGill University.

Congratulations to H. P. Nelson, to whom the Surgical Scholarship of the Association of Surgeons of Great



of "Three Blind Mice," including the impersonation of a well-known country surgeon, took everyone by storm. The *Harricans*, pink and piratical, produced the handsomest "girl," several sonnets to whose rosebud lips have already been refused publication in this *JOURNAL*.

We reproduce the two best posters.

Congratulations to Prof. E. G. D. Murray on his

Britain has been awarded, to enable him to spend a year in America studying thoracic surgery.

We regret to announce the death of Mrs. McAdam Eccles on November 28th.

We extend our sympathy to Mr. McAdam Eccles on his sad bereavement.

## RACIAL DECAY AND REGENERATION.

*Inaugural Address delivered before the Abernethian Society, on Thursday, October 16th, 1930.*

By The Very Rev. W. R. INGE, D.D.

**I**N spite of all that historians have written, the problem of the fate of nations remains very obscure. It is the privilege of historians to be wise after the event, and to lecture our ancestors for doing many things which they probably could not avoid, and for not doing many things which they probably could not have done. But even historians have not succeeded in discovering the law of national growth and decadence. Several young sciences are involved, and we may have to wait a long time before the knowledge which we desire is fully available.

Some have taken a fatalistic position. They have argued that the life of a nation must be analogous to the life of an individual. A nation, like an individual, has its periods of childhood, adolescence, maturity, senility and death. The early stages are characterized by turbulent vigour and healthy barbarism; the middle life of a nation exhibits disciplined prudence and mature energy; after which we may trace an increasing feebleness in every department of national life.

This analogy seems to me fallacious. There is no necessary resemblance between the life of an individual and the history of a nation. In all the higher organisms, the body, which biologically is only a shell for the protection of the germ-cells, grows old and dies when it has done its duty to the next generation. The germ-cells are potentially immortal; the body perishes and is renewed from parent to child. There is nothing resembling this in national life. I see no reason whatever why a nation should ever grow old. If it perishes, it perishes either from disease or from violence. Empires die of indigestion.

Let us consider briefly the course run by the civilizations of the past which have decayed.

Until the sixth century B.C., the Greek race was very prolific, sending out colonies to all the coasts of the Mediterranean and even to the Black Sea. The Greeks were a hardy and long-lived race, quick to assimilate and improve upon whatever inventions or institutions they found in other countries. They were divided into small city states—a type of polity which again existed in Italy in the Middle Ages, and which on both occasions proved itself to be a forcing-house of genius, but very wasteful of its best material. Unable to maintain their independence against larger political aggregates the Greeks became a subject race, treated, however, with unusual consideration by their conquerors. Soon after

this loss of independence depopulation set in, and continued till the real Greeks were almost extinct. What was the cause of this phenomenon?

The ancients themselves were convinced that the soil of the Mediterranean lands was exhausted, so that agriculture was no longer nearly so productive as it had been. This may be true, when we remember that much of the land round the Mediterranean responds only to intensive culture, and that the smelting of iron and the keeping of goats had led to the destruction of the not very extensive woods which fringed the inland sea. The soil, denuded of trees, was swept into the sea by rain and river till in many places only bare rock was left.

It has been lately suggested that another cause may have contributed to the decay of both Greek and Roman civilization. Many districts, such as the Roman Campagna, and the heel and toe of Italy, are now highly malarious, but were once the seat of populous towns. Is it possible that malaria first became endemic in the period of decline, and accelerated the decay of the classical races?

Microbic disease is certainly a possible cause of the ruin of races. Until lately, scorn was heaped upon the degenerate Spaniards of Cuba, and on the "mean whites" of the Southern States of North America. These people are the descendants of Castilian hidalgos and English gentlemen—two of the finest types in the world. Yet their laziness and incompetence have made them contemptible. The cause is now known. The hotter parts of North and Central America and the adjacent islands are infested by the parasite called the hookworm, which attacks more than half the population, and saps their energies without killing them. The United States government is now conducting a vigorous campaign against this pest. Malaria itself has protected several tropical regions against occupation by the white man, and has decimated the European population in other places. The Guanches of the Canaries became extinct soon after the Spanish conquest. They are said to have died of broken hearts at losing their independence; a more prosaic but more probable explanation is that they were attacked by an epidemic against which their constitutions were unfortified. The recorded symptoms suggest that it was the African sleeping-sickness. In the case of the Greeks and Romans the evidence is insufficient to prove the theory. But it is likely enough that after a once populous district had been devastated by an enemy, as part of Italy was devastated by Sulla, the malaria mosquito took up his abode in the undrained marshes and prevented the ravages of war from being repaired. It is also true that marshes appear on the site of destroyed forests. The damage in Italy may have begun when Hannibal invaded the

peninsula. We may remember that the malaria of the English fens, which our ancestors called ague, disappeared only when the marshes were drained and turned into cornland or pasturage. Nevertheless, I think malaria was at most only one of several causes why these races decayed, female infanticide being one, some of the other causes being very obscure.

Depopulation began in the Roman Empire not later than the second century B.C. I am disposed to attribute it mainly to the slave-system, which is always wasteful of human life, except in those rare cases when, the hunting grounds of the slave traders being no longer available, the owners find it profitable to keep human stud-farms, as was done in the United States. The Romans used up their slaves callously, and gave them few opportunities of procreation. The system also drove out a great deal of free labour, especially in Italy, where Sicilian and African corn killed wheat-growing and encouraged the formation of large sheep-runs, tended by slaves. The presence of slaves also encourages the owners to postpone or avoid marriage, living in vicious celibacy. Lastly, the slave system is unfavourable to mechanical inventions, which, as we know, increase the wealth and population of a country more than anything else. It is significant that Rome, in its best days, never had any manufactures on a large scale.

But the history of the Roman Empire can be understood only if we realize that throughout antiquity civilization was in a state of siege. Alexander's conquests, which are remembered to this day in the East, were the only example of real aggression of the West upon the Orient. The barbarians from the North, and various invaders from Asia, were a standing menace. The Roman Republic was doomed on the day when Marius was commissioned to form a standing army to drive back the Germans. This was as early as 105 B.C. The Roman Empire was a necessity for the peoples of southern Europe; the alternative was extermination at the hands of Gauls, Germans, Persians, Arabs or Tartars. The line of the Rhine, the Danube and the Euphrates was held for a long time, but at last it was broken, and civilization was eclipsed in the West for many centuries. Long before this catastrophe, there were no more nationalities in the modern sense in the Empire, except the Jews. The mixture of peoples was complete. A Roman meant a citizen (and all free men after Caracalla were now citizens) of the Empire, even if his "Rome" was Constantinople; a "Hellene" came to mean a pagan. I have seen a gold coin of Mohammed II (1453) inscribed in Greek, "Emperor of the Romans."

Another very interesting but obscure example is the fate which overtook Spain at the end of the sixteenth

§

century. That country had been the first in Europe as a military power, and had lately been enriched beyond the dreams of avarice by plundering the gold and silver of Mexico and Peru. Then quite suddenly a sort of paralysis seized upon it. The population fell off rapidly; the "despoblados" round Madrid began to make their appearance. What was the cause? Was it that the stolen wealth disorganized the economic system? Was it that the Inquisition burnt, tortured, imprisoned or expelled the most valuable and independent men in the country? Or was it that Spain, which was admirably adapted for a state of society in which the most important elements were the soldier and the priest, fell behind in the race when the conditions of the modern period demanded new types and different ideals? It is very easy to see that a strong monarchy and a somewhat tyrannical Church, which actually increased the power and prestige of Spain as the champion of the Counter-Reformation, had a cramping and repressive effect on the nation when new ideas had to be assimilated, and above all when civilization everywhere was passing into the industrial stage. At the present time the revolt against the monarchy and the Church in Spain seems to be of a violent and subversive character, which does not offer much prospect of orderly progress.

One of the causes of national decay is undoubtedly an internal disruption of the body politic. Culture can hardly be developed unless there is a privileged class, with leisure to cultivate the art of fine living. But if the fruits of civilization are confined to a few, the pyramid will rest on too narrow a basis, and the excluded masses will not feel that they have any strong interest in preserving it. In the East the subjects have so little pride in their government that they usually offer a feeble defence when it is attacked. Countries like India, China and Egypt have been easy to conquer; but the conqueror is obliged to respect what the masses value much more than political independence—their religion and their customs. It may happen sometimes that the masses entertain a positive hatred against their rulers, and will overthrow them in a blind fit of rage, even at the cost of extreme national humiliation. This we have seen lately in Russia. Short of this, it has often happened that a government has not dared to pursue the policy which was most advantageous, for fear of causing a rebellion at a critical time. And, as we shall see presently, an exaggerated class-feeling, expressing itself in injurious or predatory legislation, is one of the chief dangers for a highly organized industrial community.

One potent cause of weakness in a modern nation is the sectional treason of one geographical area in the political aggregate which desires to separate from the main body. This separatist movement is sometimes

based on the plea of race, sometimes on the memories of past ages. Many states have broken up since the Peace of Vienna, some justifiably, others with no valid excuse. Belgium and Holland were the first to separate, Belgium adopting the singular motto, "L'Union fait la Force." Then the Southern States of the American Union attempted to form an independent state, but were crushed after a struggle of four years by a ruthless exercise of naked force. Sweden and Norway then parted, bloodlessly. The component parts of the Austrian Empire broke up as the consequence of the Great War, regardless of the fact that they were thereby forfeiting the status of their country as a great power. Ireland would have been glad to destroy Great Britain in the same way. This fissiparous tendency, manifested in many parts of the world, may be regarded either as a reaction against nationalism, or, more plausibly, as an aberration and parody of it. It exists also in Spain, where the Catalans hate the other Spaniards, and in Germany, where Bismarck's skilful policy of unification is in danger of being undone. France is the country which has surmounted this danger most successfully.

I said that nations die either of disease or violence, never from old age. Foreign conquest has stopped the natural growth of some nations, and consigned them to decay. Among the most striking examples of this are the conquests of the Spaniards in America, where the flourishing civilizations of Mexico and Peru were destroyed, and the spirit of the people apparently finally broken. But by far the worst enemies whom civilization has encountered are the nomad tribes of Central Asia, known to history as Scythians, Huns, Tartars, Mongols, or Turks. Those historians who think that the biggest battalions are on the side of Providence, who always side with the gods against Cato, who assume that nations are always punished for their own faults, and that the hero is the man with the mailed fist, should study this most tragic and terrible chapter in human history.

The essential fact in the history of the Tartars is that their part was determined for them by the geography of Central Asia. These tribes of shepherds had to travel many hundreds of miles twice every year between their summer and their winter pastures. Their summer pastures were uninhabitable in the winter, being covered with deep snow; their winter pastures were uninhabitable in the summer, being baked as hard as concrete. The climate in which they had to live varied from 30° below zero to 120° in the shade. They could have no homes, no possessions except their animals, and no sort of civilization. They lived on horseback, and their horses could carry a heavy man 120 miles a day. They lived very healthily, in a microbe-free country, mainly on milk products. They could ride round and destroy

any army sent against them. They continually raided all the civilized countries within their reach, robbing everything and violating all the women. Resistance was punished by the entire obliteration of the offending city or nation. They swept over Europe as far as Chalons; they wiped out the very interesting Arab civilization of Bagdad—the scene of the Arabian Nights; they conquered China, paralyzing another of the great civilizations of the world, under Jenghiz Khan and his successors; they dominated and barbarized Russia for 200 years; they conquered India and set up the Mogul dynasty there; and finally they did all that we know that the Turks have done. Even in the nineteenth century, before their overthrow by Skobelev in 1881, the Tekka Turkomans carried off a million Persians, who were sold back at £10 or more a head. Their part in history has been purely destructive, they have been an unmitigated curse to humanity.

Dr. Peisker, of Graz, sums them up with truth and excusable bitterness: "Such is the rôle of nomadism in the history of the world. Countries too distant from its base it could only ravage transitorily, with robbery, murder, fire and slavery, but the stamp which it left on the peoples which it directly dominated or adjoined remains uneffaceable. The East, the cradle and chief nursery of civilization, it delivered over to barbarism; it completely paralyzed the greater part of Europe, and it transformed and radically corrupted the race, spirit and character of countless millions for incalculable generations to come. That which is called the inferiority of the East European is *its* work, and had Germany or France possessed steppes like Hungary, where the nomads could have maintained themselves and thence completed their work of destruction, in all probability the light of West European civilization would have been extinguished, the entire Old World would have been barbarized, and at the head of civilization to-day would be stagnant China."

As for the race-corruption which followed their raids, you may see the unmistakable tartar features not only everywhere in Russia, but very often in Germany.

I pass to some other causes of national decay which no efforts on the part of its victims could avert. Changes of climate have probably not had much effect within the historical period, since such changes, except when brought about by the carelessness of man, as in cutting down trees, operate very slowly. There is, however, reason to think that the African desert has encroached upon the once fertile lands of Tripoli, once, as Cyrenaica, a granary of Italy and other countries, and there are remains of large cities in Central Asia, standing in a waterless desert. The sea inundated part of Holland in the Middle Ages, and has reduced the size of our little

island by hundreds of square miles. On the other hand, the earliest sea-port of Mesopotamia, Eridu, is now 150 miles from the Persian Gulf.

Far more important are the discoveries of new trade routes and of new means of production. The Atlantic phase of international intercourse followed the Mediterranean, giving Antwerp and the British ports a decisive advantage over Marseilles, Genoa and Venice. In the future the Pacific trade will be as important as the Atlantic, and for this reason nothing can prevent North America, with its unique position on both oceans, from being the centre of the world's wealth and commerce. Our position, geographically, is still a good one, but it is no longer the best.

The historian of the distant future will probably call ours the age of coal. The populous and powerful countries to day are mainly those which have large coal- and iron-fields. The industrial revolution has given an entirely new importance to these natural resources, and in the nineteenth century it favoured the ascendancy of the Teutonic as against the Latin nations. In Europe, out of every 1000 inhabitants there were in the years named the following proportion of Teutonic, Latin and Slav elements:

	1801.	1850.	1905.
Teutonic . . .	375	369	373
Latin . . .	355	321	251
Slav . . .	268	310	375

The prodigious increase of the Slavs is due to the vast area, only half peopled a hundred years ago, which they occupy. Their enormous birth-rate was only possible because there was so much elbow-room in the East of Europe. They have, however, pushed their way westward because of their low standard of living, just as the Irish have unfortunately done in England and Scotland. I shall have to return to this factor in the fate of nations.

The rise and decay of races is more interesting and important than the rise and decay of nations. The Jews have long ceased to be a nation, but the Jewish race has been, and is, an important factor in human history. A great deal of nonsense has been talked about race. It has become the stalking-horse of political schemes, just as what men called religion was four hundred years ago. There are hardly any pure races anywhere, though the Jews have kept their blood relatively pure. The population of Europe is made up of three strains—the Nordic, indigenous in the lands round the Baltic, the round-headed Alpine, which came from Central Asia, and the long-headed, dark-haired Mediterranean. The so-called Celts, in Ireland and Wales, are not Celts at all, but Mediterraneans, with an admixture of a still earlier Neolithic stock. The "British"—I protest against the word, for we are the countrymen of King Alfred,

not of King Arthur, but we need a name to include the English and Lowland Scots—are predominantly Nordic, but partly Mediterranean; the Alpine strain is very slightly represented. There are many Alpine round-heads in France and Germany, and this type prevails in East Central Europe and in Russia. The racial types of Europe are so mixed that all wars between Europeans are fratricidal quarrels.

Imperialists sometimes forget that the expansion of a nation is limited, not by its military power, but by climate. Europeans, and especially Nordics, cannot flourish in the tropics; it is doubtful, for example, whether our race can maintain itself in the northern parts of Australia. The Nordics tend to die out even in the south of Europe, which they invaded as conquerors. Homer's Achæans had light hair, but you will seldom see light hair in modern Greece. The African race cannot live in temperate climates. The thousands of negro servants who were kept in England in the eighteenth century have not left a single descendant. The fears of the Americans that the negroes may settle in large numbers in their Northern States seem to be groundless, though the American negro has become much more resistant to European diseases than the native African.

There are some interesting facts about the results of racial mixtures. It seems to be an ascertained fact that the first results of miscegenation are very favourable. Anthropologists speak of "hybrid energy." But this advantage disappears after two or three generations. If this law is established, as it seems to be, it explains many things in the history of nations. For example, the Greeks may have profited by the admixture of Nordic and Mediterranean blood in the period following the northern invasions, and have lost their advantage when the mixed race assumed a fixed type. It will be found that a disproportionate number of distinguished English and Scots have had one foreign ancestor, French, German, Italian, or Scandinavian, within the last three generations; and the same holds good of the distinguished men on the Continent. But the disparity between the two intermingling stocks ought not to be very great. On eugenic grounds marriages between Europeans and Japanese or negroes or American Indians are probably undesirable. Nevertheless, the bad qualities of half-breeds have certainly been exaggerated. They come into the world with every disadvantage, sharing the traditions and sympathies of neither race; and perhaps the white man who forms a connection, legitimate or otherwise, with a coloured woman is not likely to be a very good specimen of a white man.

The last part of my lecture must be given to a discussion of the effects of civilization upon racial and national health.

We shall be following the best authorities if we assume that man, recognizable as human, has been in existence for at least half a million years, probably nearer a million, and that the beginnings of civilization, taking the cultivation of cereals as the test, may be placed at from 12,000 to 15,000 years ago. An authority (Peisker) says the cultivation of cereals was discovered in Asia long before 8000 B.C. The domestication of cattle, pigs, and sheep, and probably of the horse, was accomplished between 8000 B.C. and 6800 B.C. It follows that the precivilized period was immensely longer than civilization up to date. The evolution of man from a simian condition was not the work of civilization, but of a very long period when natural selection favoured the development of the human type. The Cro-Magnon race, who flourished about 30,000 years ago, and may be among the ancestors of some existing European races, were already, both physically and intellectually (judging from their brain capacity), on a level with the highest races of our own time. Even Neanderthal man, a type now extinct, had large brains combined with some ape-like characteristics.

It seems, then, that civilization brought with it an arrest in human evolution. Man provided himself with tools, and thereby forfeited the further improvement of his natural weapons, which have indeed declined rather rapidly. Even in brains he has made no further progress: what we call progress is the result of accumulated experience. Tradition has assimilated the life of the race to the life of a single individual who profits by the memories of a long career.

We may wonder that in these conditions physical and mental deterioration have not been more marked. But in the early stages of civilization—under what we may call barbarism or the highersavagery—a considerable selection in favour of higher types has usually taken place. Especially important is the almost unlimited polygamy of the barbarian chieftain, who wins and retains his position by superior physical strength and courage, by force of character, and by cunning. The long marches of nomads cause all weaklings to be left behind. The stronger tribes exterminate the weaker in war. In countries where there has been complete isolation, as in Australia, the indigenous population has remained on, or has reverted to, a condition not very much above that of the apes.

Until quite recent times, the most vigorous and successful classes probably supplied more than their share of the next generation. Old genealogies show that the gentry married young and had enormous families, while the peasantry and journeymen hardly increased at all, not because they practised birth-control, but because they married much later. The number of cottages and small holdings was limited by the acreage of the parish,

and further subdivision was discouraged. I am not suggesting that the gentleman is necessarily a finer human animal than the labourer; but on an average he is so, and the effect of civilization before the industrial revolution was at least not markedly dysgenic. There was always in England a large class of submen, beggars and wastrels, who were outside the social system; but the enormous death-rate of the towns kept them down, and they were not subsidized and encouraged to multiply as they are to-day.

The industrial revolution brought to an end the era of "subsistence agriculture," when each parish was a self-contained unit, supplying its own needs. Local industries were transferred to the towns, and the output of commodities of all kinds was enormously increased. The old checks to population were removed. The manufacturers clamoured for more hands to produce their wares, and more backs to wear them. Improved methods of agriculture, promoted by the enclosure of common lands, greatly increased the production of food, and food began also to be imported in exchange for the products of the factories. The result was the prodigious increase of wealth and population which is the most important fact of the nineteenth century, due mainly to decline in death-rate. Natural selection was almost entirely suspended, and the old apprentice system, which was the real educational provision for the young before the industrial revolution, disappeared. A population grew up with no traditions, social or religious. It was a totally new phenomenon in history.

It is futile to use opprobrious words about a change which was inevitable. We have only to consider its effects upon national health. It will be convenient to take first the biological and then the social and political problems which the new conditions have produced.

Only one kind of natural selection is favoured by modern town-life—that against disease. This has gone on so rapidly that most of the epidemics which formerly ravaged our cities have assumed a much milder type, and are far less destructive of life. To introduce a savage into any European town is to sentence him to certain death. The modern man may be physically a poor creature, but he has developed quite a new power of resisting microbes. Certain non-microbial diseases (if they are non-microbial—I speak as a layman) have increased, since people must die of something. Cancer has trebled, diabetes has doubled the number of its victims. The expectation of life after 55 or 60 is stationary, though the death-rate is little more than half what it was 60 years ago. We should, perhaps, add that the modern man has become magnificently resistant to alcoholism.

It is the unexampled decline in the death-rate, due

partly to sanitation and medical skill, but partly also to increased adaptation to town-life, which has created the very menacing problem of over-population, to which the most bigoted can no longer shut their eyes, with two million unemployed to feed out of the taxes. The decline in the birth-rate from 36 in 1878 to 16 in 1929, and the losses in the Great War, have prevented a social revolution and the death of many millions by famine, but it has not gone far enough to remove the danger.

We have further to regret that this decline in the birth-rate is itself dangerous, because it is steadily impairing the quality of the population. We are breeding from the bottom, and dying off at the top. In each generation the cream of all classes is skimmed off, raised to a better social position, and there sterilized. You will probably not dispute that among the finest strata of our population, physically, intellectually and morally, are the members of the learned professions. It is therefore a bad symptom that the lowest birth-rates at present are those of the doctors, the ministers of religion, and the teaching profession. I know that the socialists, who, for reasons which will be stated presently, try to prevent any rational discussion of these grave problems, cry out that we are assuming, contrary to the fact, that the wealthy are more desirable parents than the working man. But we are not doing so. If it were the skilled workman who was filling the cradles there would be much less ground for alarm. It is the slum-dweller, the subman, the untaxed dole-receiver, the *hirudo aerarii* as Cicero calls him, who is the father of the next generation, or of by far more than his share of it. The highest birth-rate of all is that of the feeble-minded. And the State does all in its power to increase the evil, by throwing on the industrious the whole burden of maintaining, in constantly increasing numbers, these waste products of the social machine, whose disappearance would simply augment the prosperity of the country. The only healthy class which has a high birth-rate is the miners.

Those who have not studied the subject may be asked to remember two things. First, that the peril is a new one: the dysgenic effects of our present social and political order have not yet had time to manifest themselves fully. But there can be no doubt either that they are at work, or that the consequences will be, if they are not checked, the rapid decay of our nation in physique, intellect and character.

The other point to remember is that it is not necessary to prove that there is any very great inferiority as parents in the half submerged class which is populating the country as compared with the class which is barely keeping up its numbers. An average inferiority of 10% (and the real figure is probably much higher) would be quite enough, in its cumulative effect pro-

ceeding for generations, to be a fatal handicap to the British race in the future. The effect of counter-selection is a steady and progressive deterioration in the national stock. The burden of civilization grows heavier, and if the backs which support it are weaker in each generation, the burden will be dropped, piece by piece, on the roadside.

Mr. Austin Freeman, in his valuable book, *Social Decay and Regeneration*—a book which is strong in diagnosis, but unfortunately weak in the remedies proposed—brings two other indictments against civilization: He says that civilized man is living on his capital—using up and rapidly destroying the natural resources of the world, its coal, iron, wood, etc. This is true, but I do not see any remedy for it. We have to remember that new sources of energy are likely to be discovered. The use of water-power to generate electricity has already introduced factories on a fairly large scale into Scandinavia and Switzerland; there are great possibilities of the same kind in Italy and elsewhere, even in Iceland, where the unutilized water-power is prodigious. The twentieth century may see the tides harnessed, the nitrogen from the air extracted in large quantities, and perhaps the manufacture of food directly out of the elements. But this country, which is not strong in water-power, could hardly maintain its position after the coal supply began to run short.

His other indictment is against machinery. He says quite truly that the African savage is a much handier man than the civilized machine-minder, and that the latter tends to be a parasite on his machine, without which he would starve. The old-world craftsman, who could take a pride and enjoyment in his work, has vanished. I need not enlarge on this theme, which is an old story by this time. Once more, I see no remedy; for we cannot go back 150 years, breaking our machines and going back to village industries.

It is notorious that the present conditions of labour do not satisfy those who are engaged in it. So acute is their discontent that many of the workmen wish to subvert the social order altogether, a catastrophe which would be far more ruinous in this country, with its complex industrial life, than in a rural and undeveloped country like Russia; though there the consequences have been terrible enough. The aims of this party are anti-social and anti-national. Nothing can be more sinister than their angry opposition to schemes of emigration and the regulation of population. These schemes are devised primarily for the benefit of their own class. This country is over-populated, and there is room for millions of the right sort of workpeople in the dominions, where they can lead happy and self-respecting lives.

I have no doubt that my critics will say, with their usual urbanity, that I have characteristically said a great deal about decay and very little about regeneration. Well, diagnosis must come before treatment, and if we do not agree what the disease is, we shall not be able to do much to help the patient. And I am not ashamed to confess that I have no panacea. There probably is none; but much may be done by emigration, by encouraging the best types of the nation to multiply, and by discouraging the worst, to restore the patient to health.

### A CASE OF PEA-NUT IN THE BRONCHUS.

**F**OREIGN bodies in the bronchi may produce their effects in two ways: In the case of inert bodies by local trauma and by the obstruction due to the presence of the body. In the case of organic materials such as portions of nuts, vegetables, etc., there is also irritation of the bronchus by products of the foreign body. In the United States pea-nuts are the most commonly aspirated vegetable bodies. The irritation they cause is intense and gives rise to severe toxæmia. Two globulins present in the pea-nut, arachin and conarachin are supposed to contain the special irritant. Only the immediate effects of aspiration of a foreign body into the bronchus are discussed.

**SYMPTOMS.**—Cough may or may not be present. Cough is favoured by movement of the foreign body. It is also increased by the formation of secretion, and so is more likely to occur with organic foreign bodies.

**Dyspnoea** is usually absent with inert foreign bodies; with organic bodies it is present and may be very severe.

**SIGNS** are due to the obstruction of the bronchus by the foreign body and by the surrounding exudate. The obstruction may be partial or complete: it is very frequently of a ball-valve nature, air being allowed into the lung but not out, thus causing obstructive emphysema. Any of the signs of obstruction to a bronchus may therefore be present, the most important being diminished movement and alteration in size of the affected side of the chest, and corresponding displacement of the heart.

The rapid accumulation of secretion may cause impairment of percussion note over the affected area. This impairment of note is most frequently found low down in the axilla. With organic foreign bodies signs of toxæmia are also present.

The presence of a vegetable foreign body in the bronchus is to be regarded as an emergency, for death

may rapidly ensue from toxæmia. The only effective treatment is its removal through the bronchoscope.

The following case illustrates many of these points:

J. H., æt. 6, schoolgirl, was admitted to Luke Ward, under Sir Percival Hartley on July 7th, 1930, on account of shortness of breath and pain in throat.

**History.**—July 4th, 1930 (3 days ago): She had had a little cough.  
July 5th (2 days ago): Her breathing became rather wheezy.  
July 6th (1 day ago): She was a little feverish and fretful in the evening.  
July 7th: At 2 a.m. she started to climb the stairs to her parents' bedroom. She cried out and was found by her parents on the stairs. She said that her throat hurt, and it was noticed that she was breathing heavily and rapidly. The shortness of breath continued, and she was brought to the hospital and admitted at 11 a.m. with a provisional diagnosis of pneumonia.

The patient was seen by Dr. George Graham during the afternoon.

She appeared flushed and dyspnoic, but not cyanosed. Temperature 103° F., pulse 115, respirations 45. The *alae nasi* were working. She pointed to the lower part of her neck and complained of pain there. No cough was heard and there was no sputum. The mouth and fauces appeared normal.

**Chest.**—The apex-beat was in the fifth space just outside the nipple line. The right side of the chest was fuller than the left and the respiratory movements on the right side much diminished. The percussion note was everywhere resonant. The liver dullness commenced at the seventh rib in the right nipple line. The breath-sounds were markedly diminished all over the right side but more so at the base than at the apex. They were vesicular in character.

It was concluded that these signs might be caused by obstructive emphysema due to a foreign body in the right bronchus.

The patient afterwards admitted that she had swallowed a pea-nut: that it had gone the wrong way and that it caused her throat to hurt. Both parents were then questioned, and stated that two days before admission, on July 5th at 1 p.m., she came in from play and said that she had swallowed a pea-nut and that her throat hurt. They remembered that the wheeziness of respiration had started from this time. They had thought this to be irrelevant when they brought the child in the morning.

During the afternoon a radiogram of the chest was taken (Fig. 1).

The right diaphragm was displaced downwards. The heart was displaced to the left. The right apex was dull. The lower two-thirds of the right lung show increased translucency with widening of the intercostal spaces. No opaque foreign body was seen. The appearances suggested obstruction to the right apertorial bronchus, causing atelectasis of the right upper lobe with corresponding emphysema of the right lower and middle lobes.

During the afternoon the pulse and respiration-rate rose: temperature 104°, pulse 160, respirations 85.

At 11.30 p.m. bronchoscopy was performed by Mr. Bedford Russell under gas and oxygen anaesthesia. There was very little exudate in the trachea and bronchi. A foreign body was discovered in the right lower lobe bronchus. This was whitish, surrounded by a little

exudate and was hard when touched with a probe. It was found impossible to remove it with the forceps available and the patient was returned to the ward.

During the night the patient was restless and the pulse and respiration remained very rapid.

July 8th, 1930: The physical signs remained the same except that there was a slight impairment of note at the right base as high as the angle of the scapula, and that the breath-sounds at the right apex were harsher in character. The leucocyte count was 22,000 per c.mm.

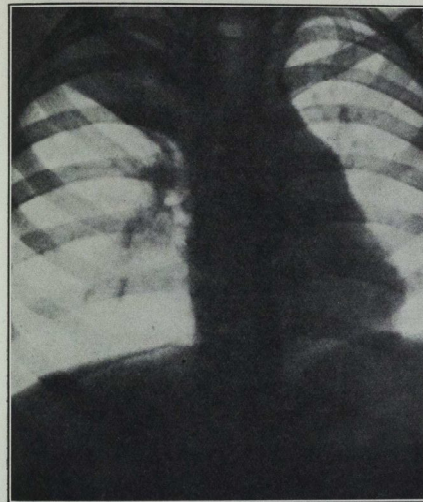


FIG. 1.—JULY 7TH, 1930.

At 5.30 p.m. a second bronchoscopy was performed by Mr. Bedford Russell under gas and oxygen anaesthesia. The foreign body was found to be in the same position. There was still very little exudate round it, the air passages being dry. The foreign body was engaged in the forceps, but was not successfully withdrawn. A bronchoscope with continuous suction was then passed into the same situation, and after further attempts to dislodge the foreign body it was found to be in the bronchoscope and on withdrawal was found to be sticking to the continuous sucker of the bronchoscope. The bronchoscope was again passed and the right lower lobe bronchus appeared clear.

The foreign body removed appeared to be a portion of a pea-nut about  $\frac{1}{4}$  in. diameter.

The patient was then returned to the ward, where immediate examination showed that the air entry into the right chest had much increased and that there were good breath sounds all over.

July 9th, 1930: The general condition appeared rather better. The respiration and pulse-rate were less. The right chest was still fuller than the left but the movements had much increased and were almost as full as on the left. The air-entry on the right side was almost as good as on the left. A further radiogram was taken during the morning (Fig. 2).

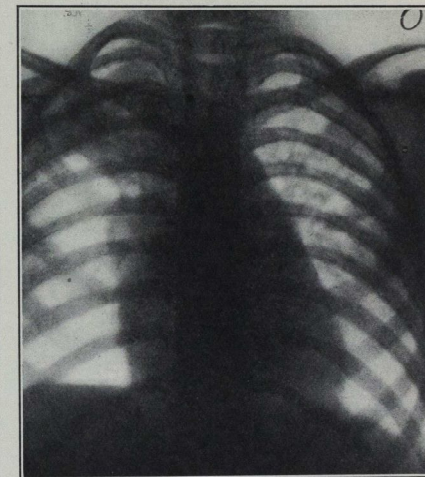


FIG. 2.—JULY 9TH, 1930.

The displacement of the heart is no longer seen. The uniform opacity seen in the right upper zone is no longer homogeneous. The increased translucency of the middle and lower lobes is no longer seen.

July 11th: There was a sudden attack of dyspnoea lasting about one minute at 1 p.m., and two further, more severe, attacks lasting four and five minutes during the afternoon. The patient became very distressed and cyanosed. The attacks appeared to be due to obstruction in the region of the larynx. There was increasing dyspnoea with laryngeal stridor between the attacks. Tracheotomy was considered advisable owing to the probability of further attacks of dyspnoea.

At 7 p.m. a low tracheotomy was performed by Mr. Bedford Russell. The patient was anaesthetized with

gas and oxygen; an endotracheal catheter was passed through the nose, and the anaesthetic was given through this. Tracheotomy was then performed.

The larynx was examined through the laryngoscope and found to be normal: but œdema of the tracheal mucosa could be seen below it (subglottic œdema).

The patient appeared better and less dyspnoic after the tracheotomy and there was no further cyanosis.

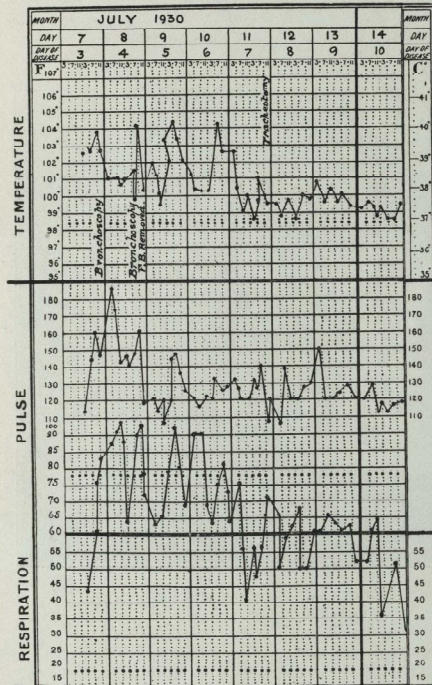


FIG. 3.

From this time the general condition of the patient continued to improve. There was still, however, an intermittent pyrexia up to 100° or 101°F. each day with exacerbations lasting two to five days where the temperature rose from 102° to 105° each day. This pyrexia continued till September 18th.

The right chest remained slightly fuller than the left and there was diminished movement on this side. The apex-beat remained  $\frac{1}{4}$  in. outside the nipple line in the fifth space. The percussion note at the right base below

the angle of the scapula became more impaired. The air entry at the right base remained weak.

July 17th: A radiogram of the chest showed clouding in the right lower zone above the diaphragm, suggesting consolidation rather than fluid.

July 19th: The right chest was explored but no fluid obtained.

August 7th: Tracheotomy; outer tube removed.

August 10th-15th: Exacerbations of pyrexia: Temperature 104°-105° F. daily. Owing to the continued pyrexia and signs at the right base it was thought that a piece of pea-nut might still be present. It was decided that bronchoscopy should be performed and the bronchus washed out and that this should be repeated if necessary.

August 14th: Bronchoscopy by Mr. Bedford Russell under gas and oxygen anaesthesia with chloroform. The posterior aspect of the right main bronchus close to its division was seen to have a bright red inflamed area continuous with a linear red area on the posterior aspect of the right lower lobe bronchus. There was some exudate in the right lower lobe bronchus. The right middle-lobe bronchus appeared normal. The right eparterial bronchus appeared normal. No foreign body was seen.

The right lower lobe bronchus was washed out three times with 2 or 3 c.c. of 1% sodium bicarbonate, which were injected and then sucked out through the bronchoscope in the hope of removing any debris of pea-nut.

The general condition and physical signs continued the same. The temperature remained intermittent.

August 25th: Very early clubbing of fingers was noticed.

September 2nd: Bronchoscopy by Mr. Bedford Russell under gas, oxygen and chloroform anaesthesia. A red area like a caruncle was again seen on posterior aspect of right main bronchus;  $9\frac{1}{2}$  in. from the teeth in the right lower lobe bronchus exudate was seen, and also what appeared to be a foreign body but which may have been slough.

On axial pressure on this body with any instrument pus was seen to exude from the bronchus. A considerable amount of pus was removed in this way. It proved impossible to grip the foreign body owing to the narrowness of the lumen of the bronchus. Silver nitrate was applied to the œdematous mucosa proximal to the position of the foreign body in the hope of causing the mucosa to shrink and so allow the foreign body to be released.

Two c.c. lipiodol were then injected through the bronchoscope into the position of the foreign body.

A radiogram of the chest taken immediately showed that the lipiodol was in the bronchus to the right lower lobe. Clouding was still present in the right lower zone.

## A CASE OF "APLASTIC ANÆMIA."

THE following case is placed on record partly on account of its intrinsic interest, and partly because it presents certain problems which it seems possible to solve only by critical investigation of future cases of a similar nature.

Mrs. A. J. T—, æt. 64, had suffered since the age of eighteen from alternating attacks of constipation and diarrhœa of the lienteric type. In the summer of 1928, during a thorough medical investigation, achylia gastrica was found and gall-stones were demonstrated by X-ray; but after repeated culture no abnormal organisms could be detected in the stools. She was also shown to be somewhat anæmic, though conclusive evidence of Addisonian anæmia was lacking. Cholecystectomy was performed in April, 1929, and convalescence from that operation was uneventful. But during the summer and autumn of the same year, in spite of the fact that she was taking hydrochloric acid by the mouth, the patient's alimentary symptoms continued and she began to suffer from lassitude and shortness of breath. Pallor was not marked. In February, 1930, a crisis in her condition occurred. The diarrhœa, which for some time had been growing more and more troublesome, now became quite persistent, and a few days later intractable vomiting set in, so that she had to take to her bed. The type of vomiting was peculiar. In her own words: "After a meal I was suddenly seized with a strange sensation in my stomach, so that for a moment I did not know whether I was feeling very hungry or very sick—and then without warning I was violently ill." Slight inconstant jaundice developed, and so rapidly did she go downhill that a diagnosis of advanced malignant disease was made. On March 10th there was a severe epistaxis and three days later, prior to a long journey to London, a blood transfusion was performed.

When seen on March 15th she was in a condition of profound collapse, extremely emaciated and slightly jaundiced. She was vomiting persistently, and even such small meals as half an ounce of water were immediately rejected by the stomach. Treatment with rectal salines and small doses of iodine by the mouth was instituted. On March 19th her general condition was definitely better, for the vomiting had been successfully controlled and a regular supply of glucose had been maintained *per rectum*. Great weakness and emaciation were marked features. She was pale, slightly jaundiced, the tongue was smooth, and there was a small retinal hæmorrhage in the left eye. There was no evidence of an abdominal tumour. The stools were natural in colour and the occult blood-test was negative. The urine contained urobilin.

September 6th: Cough was more troublesome and caused vomiting. No foreign body was seen in the vomit. The physical signs were unaltered except that well-marked bronchial breathing was heard below the angle of the right scapula.

September 9th: Bronchoscopy by Mr. Bedford Russell under gas, oxygen and chloroform anaesthesia. The affected branch of the right main bronchus (lower lobe bronchus) appeared to have benefited from the use of silver nitrate. The lumen was larger. Little or no pus was found. No foreign body could be seen. It was thought possible that slough or foreign body had been coughed up when vomiting occurred on the 6th.

September 18th: The patient had a fit of violent coughing in the evening lasting ten minutes. She became very distressed. This terminated by the patient coughing up a portion of a pea-nut about the size of a pea, together with a little blood-stained watery fluid.

This portion of pea-nut was larger than that previously removed by bronchoscopy.

Since this time the temperature has remained normal. The patient has put on weight and has appeared in robust health. The signs in the chest have gradually cleared.

On November 14th the right chest still appeared slightly fuller than the left. The movements on the two sides were equal. The percussion note was still slightly impaired at the extreme right base. The air entry was still slightly diminished at the right base behind. The finger-clubbing which had previously been detected had disappeared.

The patient was discharged to a convalescent home.

In conclusion it may be pointed out that in any case of respiratory distress in a child the possibility of the aspiration of a foreign body into the bronchus should be borne in mind. The frequency of the occurrence of subglottic œdema following bronchoscopy in young children makes it necessary that tracheotomy should be immediately available during the after-treatment.

I am indebted to Sir Percival Hartley for permission to publish these notes.

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J. F. VARLEY.

The icteric tinge of the patient, taken with the facts that urobilin was present in the urine and that the stools were not pale, made it clear that her symptoms were partly those of a hæmolytic jaundice. But hæmolytic jaundice and absence of occult blood in the fæces seemed scarcely compatible with a diagnosis of malignant disease of the alimentary tract. And since she was obviously anæmic, with a smooth tongue, and had had more than one recent hæmorrhage, and in addition was known to be an achlorhydric—pernicious anæmia was diagnosed. A complete blood-count the following day, March 20th, showed:

Red blood-cells, 1,450,000; white blood-cells, 3400; hæmoglobin, 35%; colour index, 1.25; polymorphs, 44% = 1500; lymphocytes, 45% = 1530; Türk cells, 8% = 270; large hyalines, 3% = 100.

Poikilocytosis and anisocytosis were very marked and polychromasia was present. No normoblasts or megaloblasts were seen.

Treatment in the form of "oxyntin," gradually increasing amounts of hydrochloric acid and Armour's liver extract in full doses was at once started; but the anæmia steadily progressed. On March 28th the hæmoglobin had fallen to 30% and a reticulocyte count gave a value of 0.8%—a total of 11,600 per c. mm. Marked punctate basophilia was present and the red count was stationary. The treatment was continued as before but the patient grew slowly weaker, and on April 4th a blood-count showed:

Red blood-cells, 983,000; white blood-cells, 1200; hæmoglobin, 22%; colour index, 1.3.

In the blood film the complete absence of normoblasts and megaloblasts gave evidence of the inert condition of the bone-marrow.

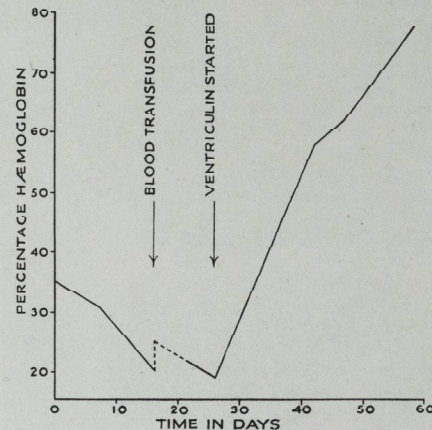
On April 5th a blood transfusion of 450 c.c. was performed. The patient was now taking 40 minims of dilute hydrochloric acid with each meal. Parke Davis's liver extract was substituted for the Armour preparation, and in addition she was persuaded to eat half a pound of fresh liver daily. But in spite of this intensive medication, a blood-count on April 10th showed that the good effect of the transfusion had been only temporary. There was gross evidence of active hæmolytic. The hæmoglobin had again reached 22%, and the urine contained an excessive amount of urobilin. On April 15th, when the patient's heart was clearly on the point of failure and the systolic pressure had fallen to 96 mm. mercury, it was not altogether surprising that she was no longer able to digest raw liver. After she had twice vomited it, it was discontinued.

It was now decided to try the effect of "ventriculin," and two tubes of that preparation were added to the patient's daily list of medicines. Almost immediately

her general condition seemed to improve, and on April 20th, the fifth day after beginning the new treatment, a fresh blood-count was performed. It showed:

Red blood-cells, 1,980,000; white blood-cells, 1600; hæmoglobin, 30%; colour index, 0.8.

A reticulocyte count gave a value of 1.2%, 22,800 per c. mm., and many cells containing a minute blue granule were also seen. These cells, which were not included in the count, may, in the light of subsequent events, be regarded as the beginning of a well-marked reticulocytosis.



Note.—Full doses of liver were given throughout the period of the graph.

During the next week the patient rapidly gained strength; colour returned to her finger-nails, and on April 26th the blood-count was:

Red blood-cells, 2,700,000; white blood-cells, 4800; hæmoglobin, 43%; colour-index, 0.8; polymorphs 50% = 2400; lymphocytes, 44½% = 2136; eosinophils, 3% = 144; basophils, 1½% = 72; large hyalines, ½% = 24.

As on all other occasions, no immature red cells were seen.

The improvement continued. On May 1st the hæmoglobin had risen to 57%, and on May 7th to 62% with a red count of 3,475,000. On May 19th a van den Bergh test was performed; it was within normal limits. The systolic pressure was now 145 mm. mercury and the blood-count—

Red blood-cells, 4,290,000; white blood-cells, 7200; hæmoglobin, 78%; colour index, 0.92; polymorphs, 62½% = 4500; lymphocytes, 32% = 2304; large

hyalines, 3½% = 252; eosinophils 1½% = 108; basophils ½% = 36.

There was slight anisocytosis.

During the last six months this improvement has been maintained and the hæmoglobin value is now 96%.

On reviewing the case the most striking feature is that this severe primary aplastic anæmia responded easily and promptly to treatment with liver in conjunction with ventriculin. The improvement in the blood picture was demonstrable five days after the ventriculin was started, and from that date the hæmoglobin increased rapidly, rising in thirty days from 19% to 78%. Closely coinciding with the recovery of the hæmopoietic system was a steady decline of the hæmolytic process which had been so prominent a feature in the acute phase of the disease. That on the date of the final blood-count this process had fallen entirely into abeyance is shown by the result of the van den Bergh test. Though the case was more than satisfactory clinically, from the scientific point of view one important link is missing: we do not know whether ventriculin alone would have brought about the cure. The association of liver with ventriculin was empirical, having its origin in a natural reluctance to discard the former, whose value in pernicious anæmia is so clearly established. But it is interesting to note that a paper appeared shortly afterwards (W. B. Castle, *Lancet*, May 17th) adducing evidence to show that there is indeed a chemical interaction between the gastric mucosa and the liver, the former stimulating the latter to stimulate the bone-marrow. This work leads one to suppose that by itself ventriculin would not have been sufficient treatment. At the same time it is only fair to add that ventriculin alone is sufficient to keep such patients well, once the cure is far advanced. It is to be hoped that careful investigation of future cases will make this point clear.

My cordial thanks are due to Dr. Langdon Brown and to Dr. Robb, who were in charge of the case and who have been kind enough to read through and to criticize these notes.

H. BUCKLAND.

### PAGET'S QUIET NECROSIS.

THE history of the pathological condition known to us as "Paget's quiet necrosis" is a matter of some dispute, and it is the purpose of this article to throw light upon certain facts concerned with the names of those who were connected with its description.

In the new edition of Bowly and Andrewes' *Surgical Pathology* the following paragraph appears (p. 302): "Morrant Baker many years ago first drew attention

to the occasional occurrence of necrosis without external suppuration, and the subject is one of so much importance that it is well worthy of consideration." The reviewer of this book, in the November number of the *JOURNAL*, points out that "it is curious that Morrant Baker's name should be mentioned. The condition to Bart's men at least is universally known as 'Paget's quiet necrosis.'"

That Baker's name should be connected with this condition is justifiable although he has no claim to its original description. In the *Medico-Chirurgical Transactions*\* he gives a very full description of the special features which characterize this form of necrosis, and describes their clinical significance with reference to a case. The patient in question was admitted to this Hospital in August, 1872, with a ten months' history of deep-seated pain in his thigh accompanied by swelling. He sustained a spontaneous fracture of his left femur, and with the impression that the disease was probably of a neoplastic origin it was decided to amputate the left lower extremity through the hip-joint. This was performed, and the specimen removed was prepared in two halves; one half of the preparation is in the Museum of St. Bartholomew's Hospital (see Fig.), and the other in that of the Royal College of Surgeons.

Edward Stanley, a surgeon to this Hospital, was one of the first to observe that necrosis of bone might take place without causing suppuration. In his work on *Diseases of the Bones*† he remarks: "When the bone attacked by necrosis is of small size, or only a small portion of it has perished, and in a patient who is not of an irritable habit, the inflammation which ensues in the surrounding soft parts is usually so mild that it gives rise to the effusion of fibrin or of serum, without suppuration; the disease then passing through its several stages unaccompanied by any other change than the simple enlargement, and thickening of the parts adjacent to the dead bone. Under such conditions difficulty is often experienced in determining the nature of the disease." Stanley, beyond remarking upon the existence of the condition, gave it no name, although it might quite justifiably be termed "Stanley's necrosis without suppuration."

It remained for Sir James Paget to apply the name of "quiet necrosis."

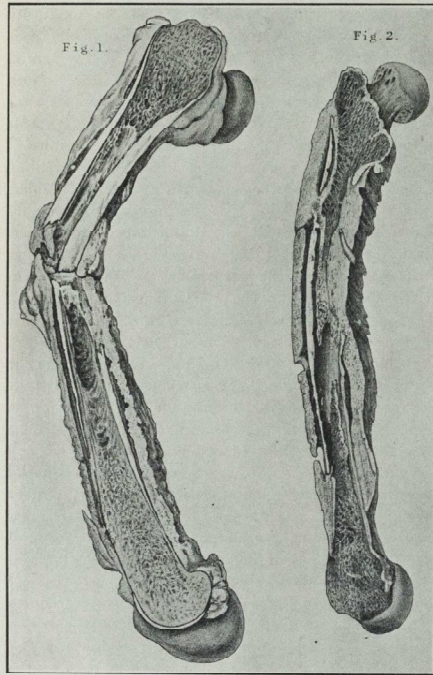
Paget writes: "But all the essential parts of the process of necrosis, the death of the bone and its exfoliation, and the formation of new bone, may take place without any of the attendant phenomena of either inflammation, or fever; and the cases in which this happens, the cases of 'quiet necrosis' as I would call them, are of great

\* 1877, lx. 187-200.

† *A Treatise on Diseases of the Bones*, London, 1849, 83.



interest in both pathology and diagnosis"\* His first description of a case of this disease was in 1869, when a young servant girl was admitted into St. Bartholomew's Hospital with severe pain and a swelling of the left knee-joint; a hard swelling was found surrounding the middle of the shaft of the femur, the nature of which was unknown. Finally after some preliminary treatment with potassium iodide it was decided that the



SPECIMEN OF "QUIET NECROSIS" DESCRIBED BY MORRANT BAKER. (IN ST. BARTHOLOMEW'S HOSPITAL MUSEUM.)

From *Medico-Chirurgical Transactions*, 1877, lx, pl. X. ]

swelling should be explored by open operation; this was performed, and a thin rough sequestrum was found and removed from a cavity in the substance of the femur.

Pridgin Teale† described a process of necrosis of cartilage which was very similar to the quiet necrosis of bone. Paget, ignorant of Teale's description, published an independent account of this necrosis of cartilage.‡

\* *Clinical Lectures and Essays*, 1875, 339.

† *Med.-Chir. Trans.*, 1856, xxxix, 31.

‡ *St. Bartholomew's Hosp. Rep.*, 1870, vi, 1.

He writes: "By a similar process we may explain the formation of loose bodies in joints. Of these bodies there are two chief kinds. Some are abnormal out-growths of cartilages, formed in chronic rheumatic arthritis, or in the dendritic growths of synovial fringes, and, as it were, accidentally detached. Others are portions of the proper articular cartilage, with or without some subjacent bone, which have suffered a 'quiet necrosis,' and been exfoliated into the cavity of the joint." Of its causation Paget says: "I am unable to explain the conditions under which a process of necrosis thus widely dissimilar from that which is usual takes place. I suspect that the death of the piece of bone or cartilage is always due to violence, that the piece is killed, as a tooth may be, by a blow, and that as a tooth thus killed may be ejected or exfoliated quietly."\*

Morrant Baker advises that the term "intra-osseous necrosis" be adopted instead of "quiet necrosis," for he points out—"the term, however, cannot be applied to a process which leads, with such symptoms as those which have been described, to necrosis of nearly the whole shaft of a femur; and it is, I venture to think, to the cause of the necrosis, viz. chronic osteitis, rather than to the quietude of the diseased process, that we must look for an explanation of the absence of suppuration."† The causation, he suggests, lies in a chronic or subacute inflammation of bone which produces a long delay in the separation of the sequestrum without producing suppuration. To-day, "quiet necrosis" is thought to be a low-grade staphylococcal infection of bone, and is but one of the many manifestations of chronic osteitis. It is of sufficient rarity as to be seldom seen in the practice of a large teaching hospital, but its historical value should be of interest to those who glimpse at the original specimens of this condition during their "Museum musings." "The pathological museum contains many such fascinating little corners if one chooses to go a little off the beaten track."

J. MOLINEUX JACKSON.

### SOME WEST AFRICAN PATIENTS.

**S**ANTIGI, a lorry driver, was shocked to find on a certain occasion that his horn was not, as he had supposed, a powerful juju which would enable him to go round sharp and slippery corners at 35 m.p.h. on the wrong side of the road, and was brought to hospital with a broken leg. He only wanted a diagnosis, and insisted on going for treatment to a native

\* *Clinical Lectures and Essays*, 342-343.

† *Med.-Chir. Trans.*, 1877, lx, 198.

"doctor," who instead of putting him up in clumsy splints for months would lie him on the ground, cover his leg with mud, and light a small fire on top of the mud. After some hours the mud would be removed, the fracture set, and the limb enclosed in a very neat and light framework of close-fitting strips of bamboo.

Nyande, a little girl of six, was brought to hospital with a large chunk of scalp missing, the mother's story being that a chimpanzee had jumped out of the bush and bitten it off. But the D.C. received an anonymous letter alleging that the assault had really been committed by a member of the Baboon Society who needed some scalp for one of his medicines, that the local chief was at the bottom of the business, and that the mother had been terrorized into giving a false account. All of which was well within the bounds of possibility, but difficult to prove. The M.O. was asked to report on the wound.

Moriwuro was admitted with a strangulated hernia; but while the theatre was being prepared he slipped out again by the back door and could not be induced to return; he died in five days. Bassie, too, having a large pelvic abscess, was coaxed as far as the table and then withdrew his unwilling consent; he also died.

Amara was a leper, and attributed his condition to the action of an enemy. In this district it is generally believed that many of the lepers have had the disease "put on" them; and it is stated on good authority that certain people possess horns containing the medicine which are passed down from father to son. The essential ingredients are parts of a snake and a toad, to which irritating vegetable extracts are added. When this is put in the victim's bed he scratches himself vigorously and so inoculates the disease.

Momo lost part of his thigh to a leopard; the wound was carefully excised, dressed and splinted, but Momo could do better than that, and during the night tore everything off and substituted a liberal coating of his own excreta.

Mrs. N—, a European lady, thought she had been poisoned, and complained of certain distressing symptoms which strongly suggested an overdose of an aphrodisiac. The house was searched, and in the kitchen was found a curious bottle covered with charms, cobwebs and strange patterns containing a sweet-smelling liquid, which was instantly identified by the Dispenser as the common aphrodisiac of the district. It turned out that the cook, threatened with dismissal, had gone to the local medicine-man for something to make his mistress like him again; he was supplied with this stuff, at ten shillings a bottle, and put it in her tea.

In P— district there is a disputed boundary between two chiefdoms; really not very important, but there is a native tradition that it will never be settled by a

white man. During the last five years there District Commissioners have attempted to deal with it. A. is now insane, B. has died of lymphadenoma, and C. is a semi-invalid with a condition of his legs which has baffled everybody.

Alimamy had a large elephantiasis scroti which he wanted removed—his "bosun pulled" as he put it. The usual clinical and pathological investigations showed that he had in addition chronic malaria, tertiary yaws, schistosomeiasis, ankylostomiasis, ascariis, trichurias and ringworm, in spite of which he was surprisingly fit and cheerful. But the clean-up process took some time.

Joe complained of a pain in the belly; the overworked medical officer gave him a prod with one hand while writing "Mist. Alb." with the other, and feeling something very like a spleen in the right iliac fossa went into the matter a little further and found a myelocytic leukaemia, which somehow he did not expect in the African bush. Joe was admitted to hospital, but absconded four days later. (It is by no means uncommon for the medical officer to find on his morning round that half his in-patients have disappeared during the night, taking perhaps a blanket or a sputum mug as a souvenir.)

Bockarie, a schoolboy and the son of an important chief, was as ill as a pneumonia can be with any hope of recovery. His parents had to be informed, but as they would certainly remove him for native treatment as soon as they arrived, the telegram must be so timed that their three days' journey would not bring them in until after the crisis; this was successfully accomplished with ten hours to spare.

Fatmatta had a large myeloid epulis of the lower jaw which her husband wanted removed. As soon as she smelt the chloroform she leaped off the table and out of the hospital. A year later the tumour, much larger, was removed under rectal ether. The native loathes inhaling any anaesthetic, and it is now possible to do nearly everything under spinal or rectal ether, which has the added advantage of preserving the operator from the horrors of chloroform as administered by the average African dispenser.

Alpha, a medical officer's houseboy, had great faith in his master's medicines—more, perhaps, than the master himself—and stole a bottle from the surgery, drinking some himself and passing it round to his friends. Unluckily the bottle contained liq. epispasticus. One of them died, and Alpha himself left hospital to do nine months' hard.

G. L. A.

## CANONBURY TOWER: A RELIC OF ST. BARTHOLOMEW'S PRIORY.

"CANONBURY Tower," one reads, "was formerly the country residence of the priors of St. Bartholomew's, Smithfield." It seemed, then, in a disciple of Rahere, a reasonable and pious curiosity to visit the old place. Permission to view was easily obtained.

Its past may be summed up shortly, for the days of its glory are now mere matter for speculation, and for surmise that hangs on a few known facts and dates. What survives is a heap of old brickwork, incomplete at that, and scarcely picturesque but for the interest with which imagination invests it. Of these facts, dates and remaining bricks, then, imagination may do what it can, beginning, if you will, with the sunny morning rather more than four centuries ago, when the last leather-aproned mediæval workman left the new building and the first prior rode in. It was about an hour's slow riding from Smithfield, through the fields of Clerkenwell and Islington: and one can see the little clerical cavalcade draw up, glancing curiously at the fresh walls and gabled roofs of the prior's pleasant country residence, surrounded by its gardens and orchards. Rahere's monks, however, lost it all within half a century; the Priory was dissolved, and its lands found new owners. From these later but still distant times a few tales linger on: gossip of a girl's flight, for instance (such as attaches to many old houses), with her lover at midnight. You are shown the window from which she climbed, and imagination sees the small cloaked figure, and the slender foot feeling its way down the ivy of the wall; you may picture, if you like, the chill of the night wind, and the fears in the girl's heart of the darkness and the unknown in her adventure. You are shown, too, inside the building the marks of pistol bullets in an old oak panel, and hear the tale of shots fired in the Cavalier days. So you people the room again for yourself, with a little conclave of men in velvet and lace, grouped around the candles and disturbed suddenly by the sound of shots from the road outside, the splintering of windows and the smell of charred wood. Thus, with more or less detail, the history continues; and all the time the streets of London are extending slowly out across the fields, and the rustic landscape is disappearing. In Dr. Johnson's time it was still considered a pleasant country excursion to go to Canonbury by stage-coach: the fare was sixpence, and the air and scenery were considered very fine. Nowadays one goes from Smithfield by L.C.C. tram.

It was a warm, sunny day in the late summer when the

pilgrimage was made. In the little public gardens, on to which the high old-fashioned windows of Canonbury Square look down, the trees were turning an autumnal brown: already enough leaves had fallen to employ a gardener in sweeping them from the paths and lawns, and some children watched him, hoping for a bonfire. The Tower, as one approaches from this direction, stands a short way back from the far side of the gardens, and appears as a bold square structure of red Tudor brick. The remainder of the building, comprising some gabled roofs and walls, is of the same material, in part faced with yellow plaster, and with a creeper, its green leaves growing crimson, running over it. The windows are set irregularly in the walls, and the panes are small and leaded. The door, standing at a slightly lower level than the street, is iron-studded and imposing; so that waiting in the narrow porch after rapping with the old knocker, one is inclined to wonder what shrivelled and mysterious figure (in the tradition of romantic fiction) will draw back the bolts and allow the rusty hinges to swing reluctantly open. But the door, to be honest, is opened by a civil young man, with an apron tied round his waist and his shirt-sleeves rolled up to the elbow in a quite matter-of-fact way. The premises are now occupied by a club, and he is the steward.

The entrance hall is low and not large. It opens on the further side into a little courtyard and garden, rather with the effect of those cool and pleasant Dutch interiors which give you a glimpse through an open door or window of a leafy close beyond. A great mulberry-tree spreads its branches over the lawn: a puppy was playing beneath it, and one remembers that such trees were once common in the neighbourhood. They were introduced by Flemish immigrant weavers in the sixteenth century, during the religious persecutions. From this hall the building lies open before you to explore, so far as it survives successive destructions and alterations. The rooms, of various sizes, are panelled more or less completely in oak: there are, alas, no hidden rooms or secret passages. The panelling is sometimes quite plain, sometimes simply fluted and pilastered, and sometimes again richly carved with details of fruits and flowers, armorial designs and little bearded heads in stiff ruffs, all in high relief. The decorative effect of these interiors is not of the original monkish days, but is due to a certain Sir John Spencer (father of the runaway heiress), a merchant of London who prospered and liked to improve his country place. He was a worthy man, apparently, but choleric: he served as Lord Mayor, and was buried in St. Helen's, Bishopsgate, where his effigy may be seen, though the church is dark. In one of these rooms, and lodged firmly in the wood of the wall, are the pistol bullets of the legend—a relic of

uneasy times when the silver was sold and the estate mortgaged, the family having been royalist in the Civil Wars. The wide staircase leads one eventually up into the Tower itself, the summit of which is occupied by a little room called the Baconian Chamber, from some dim association with the philosopher. Traditionally, too, the room was used by Goldsmith, who without doubt lodged in the house for two impecunious years and wrote *The Traveller* there. Looking down from this dusty little apartment on to the surrounding houses, one can realize the original extent of the place, and see how far it is reduced, since the present streets conform to the line of the old walls. The prior's foundation was rectangular, enclosing a courtyard 120 ft. square, with Canonbury Tower occupying the north-west part; but in 1770 the south wing was pulled down, and the east wing was altered almost out of recognition. Of the old fish-pond, well stocked for Friday's fast, there is now no trace. So, on descending from the tower, the peregrination is completed.

Finally, I suppose, one's thoughts should linger for a while on those distant monkish times, to hear in fancy the faint rustle of a cassock, or catch the faded, far-away tones of religious offices. Some flavour of the old days of courtly manners and fine conversation should remain. But, alas, it was my fate, on stepping abruptly from the front door on to the pavement, to collide with a stoutish gentleman, who let out a gasp and such objurgations as required all my attention to frame a suitable apology. Thus rudely, if one cares to point the moral, does the Present force itself upon us, while Canonbury forgets that its very name (old Canonesburgh) is derived from its association with Rahere's priory in Smithfield.

M. H. CHURCHILL.

## CAN SUCH THINGS BE.

"Apart from the technique of modern surgery it is the human element which makes it an attractive study."  
SIR JOHN BLAND-SUTTON.

ONE are the days when surgeons were thrilled by dramatic struggles with gigantic tumours and triumphed in the successful removal of cysts of incredible dimension. To a modern generation there is little that is dramatic, or indeed spectacular, in the performance of appendicectomies and herniotomies in the daily routine of a large hospital, nor does the stage of the minor operation theatre hold the surprise of romance for the surgical dresser. The exquisite perfection of a highly finished technique, and the ever-

growing and daily vindicated confidence in surgical skill, have placed operations previously beyond the wildest dreams of the most phantastic and reckless mind on the throne of unrivalled safety. There is little that is dramatic or indeed spectacular in the technical literature which is the daily bread of student and surgeon alike. There comes a time when both revolt against the monotony of their diet and ask for a "night out." To both it is something in the nature of a welcome respite to be presented with a book\* such as Gordon-Taylor has recently produced. Handsomely bound, attractively printed, lavishly illustrated, and written in a style elegant, vivid, and at times majestic, *The Dramatic in Surgery* makes delightful and entertaining reading for a couple of idle hours.

To those whose sole acquaintance with the dramatic in surgery is the memory of a case of perforated ulcer glaringly standing out from the black canvas of a night-duty there is a thrill in the author's victory over a megacolon "which contained 28 lb. of faeces and emitted a gas with an odour which might have put an army corps to flight." To them also Grey Turner's successful removal of a hepatoma weighing 2 lb. 3 oz. from a boy of 13 years remains "one of the *acta mirabilia* of surgery."

"When the spoils of surgical warfare are estimated by weight or calculated in terms of cubic capacity, water displacement, or fluid content, gynaecological surgeons are at a great advantage." The book bristles with incidents and records which joyfully clamour for notice and eagerly hold the most earnest attention. Breathlessly we live through dramatic moments and grapple with dramatic opportunities. One of the most brilliant operations in the history of surgery is vividly enacted before our eyes—the extraction during the Great War by Pierre Duval of a rifle bullet from the intrapericardiac portion of the inferior vena cava, six days after the patient had been wounded. The bullet reached its destination by a devious route: it had entered by the left lung, passed through the left ventricle and the interventricular septum, had found its way *via* the auriculo ventricular orifice into the right auricle, and hence had been propelled into the inferior vena cava. The surgeon records the curious sensation of feeling the bullet in midstream in the vena cava slipping between and past his fingers and time and again eluding his grasp.

No less dramatic in character and indeed in effect is the surgery of pulmonary embolism. Trendelenburg's

\* *The Dramatic in Surgery*. By G. Gordon-Taylor, [O.B.E., M.A., F.R.C.S., Surgeon to the Middlesex Hospital. (Bristol: John Wright & Sons, Ltd., 1930.) Pp. 88. With 40 illustrations, 11 of which are fully coloured. Price 12s. 6d. net.

historical attempt in 1907 to extract a pulmonary embolus threatening the life of a woman of 70 years ended in disaster, though subsequent experiments on calves were crowned with success. "From 1908 till 1924 many essayed, but no one triumphed." The victory was won by Kirschlner of Königsberg, who brought "within the realm of successful surgery that which had been regarded as a mortal mishap."

There is much that is dramatic in surgical assaults upon patients at the extremes of life. "The operation of Rammstedt performed in earliest infancy has almost ceased to excite interest; familiarity with the success of the operation has reduced it to the commonplace." The successful operation on a woman of 107 with a strangulated femoral hernia, "fittingly transatlantic in its setting," is little short of miraculous.

There is an element of surprise in the quaint adventure of the man whose full bladder after a Wembley Cup Tie was ruptured by a blow inflicted by an enthusiastic supporter of the rival team. Both victim and assailant were too drunk to appreciate the seriousness of the situation. Forty-eight hours elapsed before the man was admitted to hospital, where several pints of urine were evacuated from his peritoneal cavity. The patient made an uninterrupted recovery.

In a pleasant way we learn from this little volume a great deal of surgery and of medical history, both past and in the making.

The most dramatic rôle in surgery is ever played by the patient fated to undergo an operation. Even in this century an operation on a human being is the most sacred thing in all the world. For man has but one life to lose.

"The body of a man is the plastic material in which an artist works, and no art is worthy of such a medium unless it has in it something of a sacrament" (Lord Moynihan). W. R. B.

### A PARODY BY F. E. JACKSON.

This parody, which was recited by me at the last Old Students' Dinner, was written by F. E. Jackson, a second-year student in 1872, and one of the "Bold Fifteen." The original manuscript was lost, and only came to light in 1930, fifty-eight years after. Of the original fifteen who went to take the degree, as far as I can ascertain, only three are surviving, viz. Adams, who, I am told, is still in practice in Eastbourne, Wharry, who lives at Holsworthy, N. Devon, and myself. In those days women suffering from venereal diseases were treated in Magdalene Ward, and a very troublesome lot they were, as Sir D'Arcy Power informs me that whilst he was House Surgeon he had on one occasion to call in the police to maintain order.

P. H. BENSON, Surg.-Gen., I.M.S. (ret.).  
Santosh, Jersey, C.I.;  
November 16th, 1930.

### THE BOLD FIFTEEN.

**M**EROIC was their valour.  
Immortal shall they be,  
Those brave 300 Spartans  
That held Thermopylae.

\* \* \*  
But bolder yet in this our day  
Were those brave men I ween,  
Who left their homes in England  
And went to take the First M.B.  
In the wilds of Aberdeen.

\* \* \*  
First Godson, of obstetric fame,  
Roberts of sober air,  
Wharry and Hart and Benson too,  
With god-like golden hair.  
From Jersey's microscopic isle  
Came Poignaud, tall of form,  
And Venn, who grew a stubby beard  
To keep his trachea warm.

Jackson, who turned a rusty brown  
From Scotland's summer heat,  
And Nicholls, who will smoke a pipe  
When he walks up Union Street.  
Wilcox, Leftwich, Adams, Lloyd,  
All burnt to various shades,  
Baldock and Dempsey, last not least,  
The loves of ladies' maids.

They left their homes in London,  
Unmindful of their ease;  
To further learning's sacred cause  
They sailed the stormy seas.  
All honour, then, by all be paid  
To this devoted band,

Who guard the name of their old school  
In a strange and foreign land.

Reward shall not be wanting  
The day that they return;

The glowing hearts of all at Bart.'s,  
With welcome warm shall burn.  
The Staff and Treasurer shall come  
And tender them their thanks,  
And give each man a signed blank cheque  
On all the City banks.

Sisters shall come from all the wards,  
To see them home again,  
And the Fountain in the Quad, I ween,  
Will play the best champagne.  
The patients, too, in Magdalene  
Will give a sumptuous ball,  
And the sound of mirth and feasting  
Shall ring thro' Rahere's Hall.

The Royal Academy shall send  
Its foremost men to limn  
Each form of all those brave fifteen,  
Each feature and each limb;  
And all their portraits shall be hung  
With the celebrities;  
Who made old Bart.'s the world-known place  
That all confess it is.  
And in the far-off future,  
When freshmen enter Bart.'s,  
Before they go to lecture  
Or to dissect their parts,  
Into a long procession,  
Shall they be joined to see  
The portraits of the bold fifteen,  
Of intellectual face and mien,  
Who sailed forth to Aberdeen  
To take the First M.B.

### STUDENTS' UNION.

#### RUGBY FOOTBALL CLUB.

##### ST. BARTHOLOMEW'S HOSPITAL v. OLD CRANLEIGHANS.

November 15th, at Winchmore Hill.  
*Result:* Won, 6-3.  
This game was played under good conditions and before a fair crowd of spectators. Bart.'s were the winning side all through, though they had great difficulty in scoring owing to the keen tackling of the Old Boys. The ball came out regularly on the Bart.'s side of the scrum and it was only through the breaking down of passing movements when within an ace of scoring that the Hospital failed to accumulate a much larger score. All the scoring was in the first half, Lewis going over from near the line to score far out; Kirkwood failed with the kick. Then the old Cranleighans scored and the kick again failed. Finally Kirkwood kicked a good penalty from about midway between goal and touch-line.

##### ST. BARTHOLOMEW'S HOSPITAL v. LORQUAY ATHLETIC.

November 22nd, at Torquay.  
*Result:* Lost, 6-0.  
This, a new fixture, was played under the most depressing conditions. Rain fell throughout and the ground was under water in most places. The home side were more used to these conditions and handled the ball more than the Hospital, who, however, had the better of the forward play. In the second half G. F. Petty made a fine run from a quick heel from the scrum, but was tackled by the full back. The outstanding feature of the play was the kicking and handling of T. J. Ryan, who played a brilliant game throughout. The points were scored by a very questionable penalty in front of the goal and a try scored far out after a good run by the right centre.

##### ST. BARTHOLOMEW'S HOSPITAL v. DEVONPORT SERVICES.

November 29th, at Devonport.  
*Result:* Lost, 9-3.  
The Rectory Field was, as usual, extremely heavy going and it took the Hospital some time to settle down after their long train journey. The home team soon scored far out after a fine opening made in the centre. The try remained unconverted. Then after some very fast play, of which the result was about even, a quick heel by the Services gave their centre a chance to cut through, which he took, and a well timed pass sent in the wing for a try, which was unconverted. Soon after this Bart.'s scored a very good try largely as a result of good understanding between Taylor and

Beilby, and a fine opening made by the latter, who passed out for Thomas to score.

In the second half the Hospital gave the Services a very trying time, Williams and Thompson being prominent among the forwards and Taylor kicking with a good judgment and length, so that their line was constantly in danger, but a good defence just kept the Hospital out. Finally a kick to touch was intercepted by the Devonport wing, who just scored in the corner. The try was not converted and the game finished in midfield.

##### ST. BARTHOLOMEW'S HOSPITAL v. KEYHAM.

December 1st, at Devonport.  
*Result:* Lost, 6-8.  
This was played under ideal conditions on the Keyham ground, and the result was largely due to missed opportunities. Bart.'s were without R. M. Williams, but even so the ball came out more on the Hospital side than that of the College. J. T. C. Taylor was the mainstay of the side, and broke away to score on his own in the first half. Thomas scored the other try for the Hospital after a fine run, but play as a whole was ragged and the Hospital entirely lacked the vigour and (at times) brilliance of their play on the Saturday.

##### ST. BARTHOLOMEW'S HOSPITAL v. LONDON WELSH.

December 6th, at Hette Hill.  
*Result:* Lost, 5-11.  
The Hospital were playing a very weak side against the London Welsh, and were to be congratulated on doing as well as they did. Forward and back they gave as good as they got, and it was only the superior speed of the Welsh under the bad conditions existing that gave them the large margin they got.  
Powell scored the Hospital try after a run of two-thirds the length of the field; Kirkwood converted. The forwards as a whole were good, with Thompson and Edwards most prominent.

##### UNITED HOSPITALS HARE AND HOUNDS.

UNITED HOSPITALS HARE AND HOUNDS v. DUBLIN UNIVERSITY.  
November 22nd, at Dublin. (University course of approximately 6½ miles in Phoenix Park.)

There were 14 starters, of whom the Hospitals fielded 6, the minimum number to score. Conditions were very bad. There was a strong wind blowing, and the course was in a waterlogged condition. H. B. Sandiford and J. R. Strong, both of the Hospitals, cut out a fast pace from the start, but were soon forced to drop back as the trail had been blown away. So for the next three miles they waited for the leading Dublin men in order to receive directions. From now on we were treated to some of the worst "snags" imaginable. Two 30-ft. drops down almost perpendicular banks knocked most of the Hospital men out of a straight run. Dublin, knowing their ground well, were enabled to make up many places. A further series of treacherous climbs and falls made the team race a certain win for them.

So for the last two miles it was a struggle for individual placings. J. W. Craig, the Dublin "crack," managed to split the two Hospital men, but Sandiford, running brilliantly, kept him off and won a magnificent race in 41 min. 3 sec. The Dublin team packed excellently and the Hospitals were well beaten, though not without honour.

*Results.*—1. H. B. Sandiford (U.H.H.H.), 41 min. 3 sec.; 2. J. W. Craig (Dublin), 41 min. 15 sec.; 3. J. R. Strong (U.H.H.H.), 41 min. 37 sec.; 4. R. A. French (Dublin), 41 min. 42 sec.; 5. W. J. Craig (Dublin), 41 min. 47 sec.; 6. W. A. Robinson (Dublin), 42 min. 15 sec.  
Dublin University (2. 4. 5. 6. 7. 8), 30 points; United Hospitals (1. 3. 10. 11. 13. 14), 52 points.

##### UNITED HOSPITALS HARE AND HOUNDS v. OXFORD UNIVERSITY "A."

November 29th, at Oxford (University course of 7½ miles).  
There were 16 starters, of whom the Hospitals were running 6. The "Shotover" course was in a very heavy condition, so that slow times were to be expected. On this occasion the Hospitals turned out a strong team, and so were hoping to win. The Hospitals' men, Strong, Sandiford and Harley, the Oxford ex-captain and Blue, adopted their usual tactics of setting up a hot pace at the beginning, and had soon established a 50 yards' lead on the rest. Strong and Sandiford continued to draw away, and at 3 miles the Hospitals were well up. With Harley, Varley and Lee bunched together

behind three of the Oxford team, we were 7 points to the good. Sandford and Strong won as they liked in 46 min. 12 sec., fully 300 yards ahead of Green.

Results.—1, H. B. Sandford (U.H.H.H.) and J. R. Strong (U.H.H.H.), 46 min. 12 sec.; 3, J. S. Green (Oxford), 47 min. 14 sec.; 4, H. C. Harley (U.H.H.H.), 47 min. 24 sec.; 5, C. O. Healey (Oxford), 47 min. 35 sec.; 6, M. J. Albery (Oxford), 47 min. 40 sec.

United Hospitals (1, 2, 4, 9, 10), 26 points; Oxford University (3, 5, 6, 7, 8), 29 points.

#### UNITED HOSPITALS HARE AND HOUNDS v. METROPOLITAN POLICE.

December 10th, at Richmond. There were 23 starters. For the first 2 miles the field was bunched together, but as soon as the rougher country was reached the runners began to fall out behind.

A. Butler and T. Dyke, both of the Police, began to make the pace, but Bliss and Strong, of the Hospitals, took up the challenge. At 4 miles Bliss had dropped back, but Lee (U.H.H.H.), who has begun to find his old form, was now running strongly about 300 yards behind the leaders. With half a mile to go Strong and Dyke made a burst for home, and in a very fierce struggle Strong just managed to win in 36 min. 25 sec. The team match resulted in a tie.

#### UNITED HOSPITALS HARE AND HOUNDS v. SOUTH LONDON HARRIERS.

December 3rd, at Richmond. (Held over the Hospitals' new course in Richmond Park, of approximately 6 miles.)

There were 12 starters. S.L.H. turned out a small but very strong team, and as we held a weak side the result was never in doubt. With a fast start four S.L.H. men with Strong (U.H.H.H.) took the lead, and running fast for three miles were 200 yards ahead of the next bunch. Here the race resolved itself into a struggle between Strong and Humphrys (S.L.H.), winner of the South of the Thames and also the Insurance Championships, Morgan, Poole and Bodley, all of S.L.H. bunching together behind.

After a keen struggle, in which Humphrys beat Strong in the run-in and S.L.H. filled the next three places, Hospitals lost by a margin of 10 points.

## CORRESPONDENCE.

### PROGNOSIS IN LEPROSY.

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

DEAR SIR,—The September number of the JOURNAL, recently to hand, contains an article on the history of leprosy in Britain by Mr. J. Molyneux Jackson. As far as the historical side of the disease goes the author is to be heartily congratulated on this very interesting and instructive paper, but when he deals with the prognosis of leprosy at the present day, he paints a picture so gloomy and so different from the facts as leprologists in the East know them, that one wonders how wide his experience in treatment has been.

Mr. Jackson says there is no specific treatment for leprosy. I am not clear what the definition of specific is, but most of us would allow this term to cover a treatment which may be relied on to cure a disease if applied within a reasonable time after onset, and which, continued for a reasonable period, will leave the patient free from any disability. The modern treatment of leprosy by chaulmoogra oil or its derivatives, fresh air, good food and employment therapy does this in such an enormous majority of cases that I would claim that it may be regarded as a specific treatment. That it does this in the East is beyond dispute; the only question that can be raised is how far the cure is a permanent one. From Cullon, P.I., the largest leprosiarium in the world, 1355 cases have been discharged in the last few years as negative after the most careful and prolonged examination; and although it is true that a small proportion of these cases recur, the number of such is not great. Cases discharged as negative are 20% of the total number of patients in the leprosiarium, but as the large majority of the patients are admitted late in the disease this is hardly a fair test of the treatment. The figure for cure of patients admitted within a year of the onset of the disease is over 80%.

The same story comes from well-organized leprosiaria all over the East with the exception of Honolulu, where treatment has been less successful than in other centres. On a recent visit by the writer of this letter to two leper settlements in Korea with a leper population of some 1300, it was astonishing to see the remarkable progress that the patients were making; indeed it was hardly possible to find a

case in which improvement was not marked, though these cases were all admitted as advanced lepers. The death-rate of only 2% per annum, and this from causes such as typhoid fever unconnected with their disease, fully bore out the writer's personal observation.

Every year now improvements in methods of treatment are being developed and the necessary time for cure is being shortened. It is not the cure, but the length of time that the process takes that is the present handicap. I can see no reason for the pessimistic attitude that Mr. Jackson presents.

I am, etc.,

JAMES L. MAXWELL,  
Medical Adviser to the Mission  
to Lepers,  
Shanghai;  
November 22nd, 1930.

## REVIEWS.

SLEEPING STONES TO SURGERY. By L. BATHE RAWLING, F.R.C.S. (London: H. K. Lewis, 1930.) Pages xvi + 228. 97 illustrations. Price 12s. 6d.

The application of anatomy to surgery is presented in a fascinating manner in this little book. It is naturally not a complete text-book of surgical anatomy, but it presents a series of essays showing how anatomical facts help to elucidate clinical problems.

The book is of value to the student commencing his surgical work, but even more so to the student of anatomy, because it shows how apparently dull details may be of first-class practical importance. In this way the book is of particular value, as it links the pre-clinical study of anatomy with surgery in a way that no other book has done. Bart's should be proud that such a volume has been produced by one of its surgeons, for it marks a real advance in the usual method of teaching.

The book is easy to read and the illustrations are simple and clear, and the illustrations are to be congratulated on her work. Unfortunately a number of errors have occurred in the labelling of the illustrations. These are all small errors which will be corrected in future editions and will in no way detract from the value of the book.

THE DISSECTION OF THE FROG. By R. H. WHITEHOUSE, D.Sc., and A. J. GROVE, D.Sc., M.A. (London: University Tutorial Press, 1930.) Pp. x + 101. Price 2s.

This book has been produced with the avowed intention of providing much fuller instructions for dissecting than are contained in other books on practical zoology. The authors contend that much time is wasted in the laboratory in giving verbal instructions on methods of procedure, and that these instructions can be given better, and in greater detail in print. The practical directions provided are indeed given with a wealth of detail, but while we feel that many teachers will still prefer to issue instructions to their classes in person, this work may be highly recommended to students who are working without supervision.

The interesting and friendly style adopted makes the book easy to read, and there is the clearest internal evidence that the authors have a very wide acquaintance with the difficulties encountered by the average student. The introductory section is full of sound suggestions which we hope may be laid to heart by all concerned. A valuable feature, which might be copied in other quarters, is the inclusion of alternative names to structures. This will be appreciated by the beginner, who is often puzzled by variations in nomenclature.

The book is well provided with simple diagrams, the annotations with which have the great merit of being printed in full. Some of the diagrams fail to a great extent on account of their small size. The covers (which are limp) are stated to be waterproofed. While this may be of value on a laboratory bench, we feel sure that a cover of boards is essential if the book is to stand up to a reasonable amount of hard wear. As the price of the volume is so exceedingly moderate, this, is, no doubt, a matter which could easily be remedied without making its cost excessive.

ELEMENTARY ZOOLOGY FOR MEDICAL STUDENTS. By L. A. BORRADAILE, Sc.D. Second edition. (Humphrey Milford, Oxford University Press, 1930.) Pp. viii + 397. Price 10s. 6d.

We welcome a new edition of this well-known text-book, which was first published in 1923. Intended primarily for the use of students

preparing for the Cambridge First Medical Examination, it has proved its worth and has been widely adopted. It has now been revised and descriptions of additional topics have been inserted to bring it into line with the modified syllabus.

Comment on the subject-matter and mode of treatment is, in this case, superfluous. The reputation of Dr. Borradaile as a teacher of much experience is itself a guarantee of excellence, and we predict for this book a continuance of its career of popularity and usefulness.

MODERN PSYCHOTHERAPY. By EMANUEL MILLER, M.R.C.S., L.R.C.P., D.P.M. (Jonathan Cape, Modern Treatment Series, 1930.) Pp. 131. Price 5s.

In this small work Dr. Miller has given a very readable account of modern psychology. The first half of the book is devoted to an exposition of the general principles and basis of psychology. This is followed by a chapter on the analytical process. Here the methods of Freud, Jung and Adler are dealt with, and an interesting contrast is drawn between the scientific mind, which would naturally attach itself to Freud, as opposed to the mystical, which would adhere to Jung. While emphasis is laid on the preference of analysis as a line of treatment when possible, the various methods of suggestion are described.

The remainder of the book is devoted to the application of psychotherapy, particularly the early variety. In classifying the types of case amenable to the several methods of therapy two main groups are detailed, viz. the psychoses proper, and the psychoneuroses or minor psychoses according to Culpia. It must be mentioned that in the latter group, psychasthenia, so prominent among French writers has been omitted, it being regarded as a *surplus* for several ill-defined states. An appeal is made for the earlier diagnosis and treatment of psychic disorders in the future. It is needless to emphasize this last point, but it may be added that several writers consider even dementia *præcox* to be curable by suitable treatment if detected at a sufficiently early stage.

Perhaps the one critical comment necessary is in regard to the small reference to the endocrine system. The cursory mention of the latter comes as a surprise to those of us who have been taught to regard the sympathetic, parasympathetic and endocrine systems as three legs of a tripod, representing life. These, however, are purely organic systems, but they certainly play a very important part in bridging the gulf which formerly existed between medicine proper and its psychological branch. This close relationship is illustrated in many ways, as, for instance, by the fact that individuals frequently become mentally unbalanced at puberty, during pregnancy, and at the climacteric; it is at these times in life that the sympathetic system is notoriously prone to become upset.

In all but the above particular this book must be recommended for its fullness, clarity, and brevity. A very useful glossary concludes this admirable work.

HISTOLOGY FOR MEDICAL STUDENTS. By H. HARTRIDGE, M.A., M.D., Sc.D., M.R.C.P., F.R.S., and F. HAYNES, M.A. (Humphrey Milford, Oxford University Press, 1930.) Price 15s.

If any theory at all is purveyed at a practical histology class, it is usually found that there is barely time for the average student to stain and mount his sections and to look at the demonstrations and so the real objective—the drawing, labelling and close study of the given tissues—is too often piously dedicated to the dim hereafter. The solution would seem to lie in the combination of the briefest of talks with the use of a concise text-book, illustrated in such a way as to be closely comparable with the section under view, and to serve at the same time as an example of schematic drawing. We do not know of another work on the subject which combines detailed accuracy with these requirements, the most formidable rival to the one under review being illustrated with microphotographs or highly schematic diagrams, and being, moreover, not especially designed for the medical schedule. The sections given out as a routine at the Universities and at this Hospital were used for the drawings of this book.

With the matter expressed in this book there can, we think, be no quarrel. It is thoroughly up-to-date, non-controversial, and obviously written with a first-hand knowledge of the technical side of the subject. So much information is included—a really astonishing amount for so small a space—that a few of the sentences are more than two lines long, giving one a feeling of remorseless haste, and rather detracting from the pleasure of consecutive reading. We do not see how this could easily have been avoided, and in this case it

is probably of little importance. In addition to the histology of the various tissues, the accessories such as section-cutting and staining, microscopy and formulae are excellently described. Tables showing eyepiece magnification, and the different reactions of tissues to various stains, together with an exhaustive collection of hints as to the spotting of sections, make the book especially attractive to the student. The arrangement and make-up, the type, and especially the index, are all good; the only criticism might be that of the system of page-headings (all of the same type and at the same level, whether commencing or continued, heading a chapter or a section). No doubt the level had to remain uniform in order to keep the letter-press opposite the pictures, but variations of type and lateral spacing might have justified the extra trouble involved.

Lastly the illustrations. As suggested above, we fully agree with the use of drawings; coloured drawings are, however, more controversial. It is important that normal histology should conform closely with the illustrations of modern pathological text-books and original papers to be illustrated in black and white. The elementary student is apt to pursue colour rather than form; it is easier to produce a pseudo-artistic effect with a set of blunt chalks than it is with a sharp lead pencil, and still easier to miss the salient features. Further, the histologist appears to stain his sections much more deeply than does the pathologist—a fact which is made more obvious in coloured pictures.

These arguments are adequately met by the authors' terse, "we have made our drawings in colour instead of in black and white in order to represent the specimens as they appeared under the microscope," and chiefly by the combination of flat washes and clear outlining (best shown, perhaps, on p. 284—salivary glands, and p. 97—the heart), which sets a high standard of clear delineation. As there are over 500 such drawings reduced, so that a page will hold as a rule from five to eight, the labour expended and the skill in pre-judging the effect of reduction must have been equally great. A criticism which must be noted is that figs. 94-99 (spleen) and 132-134 (lymphatic glands) are far too dark, and do not correspond with, say, the thymus (figs. 419-420) where pathological sections stained to the degree represented they would be unintelligible.

This slight discrepancy appears to be the only shadow upon an otherwise brilliant partnership. We should like to congratulate the authors, and we would wish them many editions were it not for the arduous labours which might be involved.

## RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEWS MEN.

ALEXANDER, FREDK. W., M.R.C.S.(Eng.), L.R.C.P.(Ed.), D.P.H. "Simple 'Contraptions' for Assisting the Teaching and Learning of Braille. A Note upon the Compulsory Notification of Ophthalmia Neonatorum." *Medical Press and Circular*, December 10th, 1930.

ATILEK, WILFRID, M.D., B.Ch., M.R.C.P. "Amidopyrin in Measles." *British Medical Journal*, December 13th, 1930.

BACH, FRANCIS, M.D. (and WORSTER-DROUGHT, C., M.D., M.R.C.P.). "The Intercalation of Neurosyphilis and Cardiovascular Syphilis Based on the Study of Fifty Cases." *Lancet*, November 22nd, 1930.

BURROWS, HAROLD, C.B.E., M.B., F.R.C.S. "Paralysis of Capillary Blood-Vessels of the Hand following Wounds of Forearm." *Lancet*, November 1st, 1930.

CHOPRA, R. N., M.A., M.D., I.M.S. (and DE, PREMAKUR, B.Sc., M.B.(Cal.), M.R.C.P.(Edin.)). "The Action of a Sympathomimetic Alkaloid in *Sida Cordifolia* (Draca)." *Indian Journal of Medical Research*, October, 1930.

DAVIES, J. H. TWISTON, M.B. (and DRYNAN, A. E., M.D.). "Chronic Ulcer of the Leg Treated by the Method of Dickson Wright." *British Medical Journal*, December 13th, 1930.

DONALDSON, MALCOLM, M.B., F.R.C.S. "Treatment of Glands in Carcinoma of the Cervix." *British Medical Journal*, December 20th, 1930.

DUNDAS GRANT, SIR JAMES, K.B.E., M.D., F.R.C.S. "Suction Exploratory Needle for Exudation into the Tympanum." *Lancet*, November 22nd, 1930.

ELOOD, J., M.B., F.R.C.S. "Intra-peritoneal Gestation with Rectal Hamorrhage." *British Medical Journal*, November 29th, 1930.

- EVANS, E. LAMING, C.R.E., F.R.C.S. "Congenital Dislocation of the Hip." *British Medical Journal*, December 20th, 1930.
- FLETCHER, SIR WALTER, K.B.E., F.R.S., M.D., F.R.C.P. "Address on the Opening of Manson Theatre, Hospital for Tropical Diseases." *British Medical Journal*, November 20th, 1930.
- GORDON-WATSON, SIR CHARLES, K.B.E., C.M.G., F.R.C.S. "Treatment of Cancer of the Rectum with Radium." *British Medical Journal*, December 6th, 1930.
- HEPPER, J. E., M.R.C.S., L.R.C.P. "A New Splint (for Pott's Fracture)." *Lancet*, December 13th, 1930.
- NAPIER, L. L. EVERARD, M.R.C.S., L.R.C.P. "The Artificial Feeding of Sandflies." *Indian Journal of Medical Research*, October, 1930.
- NELSON, H. P., M.B., F.R.C.S. "Irradiation of the Tracheo-Bronchial Lymphatic Glands in the Treatment of Carcinoma of the Lung." *Lancet*, November 22nd, 1930.
- SCOTT, SYDNEY, M.S., F.R.C.S. "The Schoolboy's Ear in Clinical Practice." *Clinical Journal*, November 26th, 1930.
- STRUTHERS, J. A., M.D. "Survey of Some Findings in Five Years' Work on Tuberculosis." *Tubercle*, October, November and December, 1930.
- TISDALL, OLIVER R., M.A., M.B., R.Ch. "The Nirvanol Treatment of Chorea." *Archives of Disease in Childhood*, December, 1930.
- WOOD, W. BURTON, M.A., M.D., M.R.C.P. "Simple Spontaneous Pneumothorax." *Clinical Journal*, December 17th, 1930.

## ACKNOWLEDGMENTS.

The *British Journal of Nursing*—Bulletin de l'Hôpital Saint-Michel—Bulletin de Mémoires de la Société de Médecine de Paris—The *Cambridge University Medical Society Magazine*—The *Clinical Journal*—L'Echo Médical au Nord—The *Epsomian*—Guy's Hospital Gazette—The Hospital—The *Kanya* and *East African Medical Journal*—The *London Hospital Gazette*—Long Island Medical Journal—The *Magazine of the London Royal Free Hospital School of Medicine for Women*—The *Medical Journal of Australia*—The *Midsex Hospital Journal*—The *Nursing Times*—The *Post-Graduate Medical Journal*—The *Queen's Medical Magazine*—The *Royal Dental Hospital Magazine*—St. George's Hospital Gazette—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The *Student*—University College Hospital Magazine—The *University of Toronto Medical Journal*.

## EXAMINATIONS, ETC.

## University of Oxford.

The following degree has been conferred:

D.M. Tisdall, O. R.

M.S. Examination, December, 1930.

Branch I. Surgery.—Phillips, R. F.

M.D. Examination, December, 1930.

Branch I. Medicine. Castledou, L. I. M., Davidson, W. P. M., Posel, M. M.

## University of London.

Third (M.B., B.S.) Examination for Medical Degrees, November, 1930.

Pass.—Barnes, F. G. L., Clark, A., Claxton, E. E., Coltart, W. D., Hartley, K. W. D., Jones, D. S., King, J. F. L., Knight, G. C., Rice, K. A. G., Risk, R. S., Robb-Smith, A. H. T., Vorgette, E. S.

## Supplementary Pass List.

Group I.—Attwood, J. H., Edwards, H. G., Fawcett, R. E. M.  
Group II.—Gibbin, J. H., Hutton, W. A., Pierre, J. H., Ross, K. M.

## Royal College of Surgeons.

The Diploma of Fellow has been conferred on the following:  
Ali, A., Bolton, N. W., Chapman, W. S., Clarke, J. M., Corrigan, C. E., D'Arcy, F. F., Ernst, M. R., Everett, A. D., Hogg, J. C., Hynes, W., Kemble, J. F., Lumsden, K., Millin, T. J., Oiver, L. R., Ray, P. N., Scott Brown, W. G., Stanfield, F. R., Walker, F. H. A., Youssi, H.

## CHANGES OF ADDRESS.

- ANDREWES, C. H., 32, Ossulton Way, Golders Green, N. 2.  
DALE, W. C., Adcock Hospital, Ibadan, Nigeria, W. Africa.  
DICKS, H. V., 30A, Wimpole Street, W. 1. (Tel. Welbeck 8775.)  
ECCLES, W. McADAM, 84, Porchester Terrace, W. 2.  
LEBIANC, L. G., 4, Rue du Casino, Aix-les-Bains, Savoie, France.  
MURRAY, E. G. D., Department of Bacteriology, McGill University, Montreal, Canada.  
NELSON, H. P., Department of Surgery, University of Michigan, Ann Arbor, Michigan, U.S.A.  
NORRISH, R. E., 95, Hillfield Avenue, Hornsey, N. 8.  
THEOBALD, G. W., 8, Elmwood Road, Chiswick, W. 4.

## APPOINTMENT.

JENNINGS, C. M., F.R.C.S., appointed Assistant Medical Officer to Fulham Hospital.

## BIRTHS.

- BURTON WOOD.—On November 29th, 1930, at St. Mark's House, Regent's Park Road, to Lucy, wife of Dr. W. Burton Wood—a son.  
COUCHMAN.—On December 21st, 1930, at Upton-on-Severn, to Doris, wife of Hugh J. Couchman, M.B.—a daughter (Gillian Frances).  
FOOTE.—On December 16th, 1930, to Maureen, wife of Dr. R. K. Foote, The Manor House, Maidenhead—a son.  
THEOBALD.—On December 20th, 1930, at 8, Elmwood Road, Chiswick, to Florence (née Crook), wife of Dr. G. W. Theobald—a daughter.  
WELLS.—On December 5th, 1930, at Barrington Hall, Cambridge, to Rhona, wife of Dr. Arthur Q. Wells—a daughter.

## MARRIAGES.

- GRAY—GADSDON.—On December 2nd, 1930, at Colchester, George Milne Gray, F.R.C.S., son of Mr. and Mrs. George Gray, of Aberdeen, to Philippa Jeanne, daughter of Mr. and Mrs. H. P. Gadsdon, of Clacton.  
MAILER—ANDREW.—On December 6th, 1930, at St. Bartholomew-the-Less, W. Alister R. Mailer, elder son of Dr. and Mrs. William Mailer, to "Molly," second daughter of Mr. and Mrs. Reginald Andrew.

## DEATHS.

- ACRES.—On December 20th, 1930, at his home, "Leasholme," Waldegrave Road, Twickenham, George Charles Johnston Acres, M.R.C.S., L.R.C.P., aged 55.  
BROWNE.—On November 22nd, 1930, at Thornet, Higher Hood, Plymstock, South Devon, Horace Ximenes Browne, M.R.C.S. (Eng.), L.R.C.P. (Edin.), Deputy Inspector-General, R.N.  
ECCLES.—On November 28th, 1930, Coralie, the beloved wife of W. McAdam Eccles, M.S. (Lond.), aged 62.  
FOWLER.—On December 1st, 1930, at 3, College Road, Hampstead, N.W. 3, from an illness contracted during the Great War, Trevor Hayman Fowler, M.R.C.S., L.R.C.P., late Captain, R.A.M.C., elder son of the late Dr. Trevor Fowler, of Northlands, Epping.  
MAY.—On December 20th, 1930, at 275, Stansted Road, Forest Hill, Augustus Square May, M.R.C.S., L.S.A., aged 92.  
PRITCHARD.—On November 27th, 1930, suddenly, at Heathfield, Densbury, Joseph James Gawler Pritchard, M.R.C.S., L.R.C.P., aged 66.  
STIDSTON.—On December 15th, 1930, Charles Algernon Stidston, D.S.O., M.D., beloved husband of Olive Stidston, of 14, Waterloo Road, Wolverhampton, aged 49.  
STOWERS.—On December 17th, 1930, at 28, Regent's Park Road, N.W. 1, James Herbert Stowers, M.D., of 128, Harley Street, W. 1, aged 79.

## NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.  
The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLIAMS, 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. XXXVIII.—No. 5.]

FEBRUARY 1ST, 1931.

PRICE NINEPENCE.

## CALENDAR.

- |         |         |  |
|---------|---------|--|
| Mon.,   | Feb. 2. | —Special Subject: Clinical Lecture by Mr. Bedford Russell.   |
| Tues.,  | 3.      | —Sir Thomas Horder and Mr. L. Bathe Rawling on duty.   |
| Wed.,   | 4.      | —Surgery: Clinical Lecture by Sir Holburt Waring.  |
| Fri.,   | 6.      | —Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  |
| Sat.,   | 7.      | —Hockey Match v. R.M.C. Sandhurst. Away.   |
| Mon.,   | 9.      | —Special Subject: Clinical Lecture by Mr. Just.  |
| Tues.,  | 10.     | —Dr. Gow and Mr. Harold Wilson on duty.  |
| Wed.,   | 11.     | —Surgery: Clinical Lecture by Sir C. Gordon-Watson.  |
|         |         | Hockey Match v. Keble College, Oxford. Home.   |
|         |         | Alpine Club: Dinner at Holborn Restaurant, 7.15 p.m.   |
| Thurs., | 12.     | —Abernethian Society: Mid-Sessional Address by Dr. D. N. Buchanan, 8.30 p.m.   |
| Fri.,   | 13.     | —Prof. Fraser and Prof. Gask on duty.  |
| Sat.,   | 14.     | —Rugby Match v. Bedford. Away.   |
|         |         | Association Match v. Old Aldenhamians. Away.   |
| Mon.,   | 16.     | —Special Subject: Clinical Lecture by Mr. Elmslie. Last day for receiving matter for the March issue of the Journal. |
| Tues.,  | 17.     | —Sir Percival Hartley and Sir Holburt Waring on duty.  |
| Wed.,   | 18.     | —Surgery: Clinical Lecture by Mr. Harold Wilson. Hockey Match v. Epsom. Home.  |
| Fri.,   | 20.     | —Sir Thomas Horder and Mr. L. Bathe Rawling on duty.   |
|         |         | Medicine: Clinical Lecture by Dr. C. M. Hinds Howell.  |
| Sat.,   | 21.     | —Rugby Match v. Devonport Services. Home.  |
|         |         | Association Match v. Keble College. Home.  |
|         |         | Hockey Match v. Mill Hill. Home.   |
| Mon.,   | 23.     | —Special Subject: Clinical Lecture by Mr. Bedford Russell.   |
| Tues.,  | 24.     | —Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  |
| Wed.,   | 25.     | —Surgery: Clinical Lecture by Mr. L. Bathe Rawling.  |
|         |         | Hockey Match v. Kingston Grammar School. Away.   |
| Fri.,   | 27.     | —Dr. Gow and Mr. Harold Wilson on duty.  |
|         |         | Medicine: Clinical Lecture by Sir Thomas Horder.   |
| Sat.,   | 28.     | —Rugby Match v. Old Millhillians. Away.  |
|         |         | Association Match v. Old Malvernians. Home.  |
|         |         | Hockey Match v. Brentwood. Home.   |

## EDITORIAL.

## THE SIR D'ARCY POWER BIRTHDAY VOLUME.

On Wednesday, January 21st, at a meeting held in the Great Hall, Sir D'Arcy Power was presented with a copy of his *Selected Writings* (The Clarendon Press, 1931) by Lord Moynihan, P.R.C.S. We publish on p. 91 a full report of the speeches, sent to us by the Editor of the *British Medical Journal*. It is not, however, by the speeches that those who were present will remember the occasion, so much as by the atmosphere of informality and of friendliness in which they were delivered.

Dr. J. B. HURRY.

We have received a memoir of Jamieson Boyd Hurry, reprinted from his posthumously published book, *The Wood Plant and its Dye* (Oxford University Press). Sympathetically written by Mr. Warren Dawson, himself a well-known Egyptologist, it will be read with interest not only by those who knew Dr. Hurry personally, but by the many who knew him through his books and his philanthropy.

"REP OMNIA."

The selection from the Christmas Shows, dignified by the title of *Rahere's 1930 Revue*, was performed in the Great Hall on Saturday, January 10th. The twenty-two turns followed each other with admirable promptness, and the evening was a complete success, although at one stage there appeared to be some doubt as to whether the performers were behind or in front of the footlights.

During the interval a silver collection, in aid of the Hospital Reconstruction Fund, realized some £14.

We hope, that the Christmas Shows will continue to maintain a standard sufficiently high to merit this "Rep-ping" in the future.

\* \* \*

ABERNETHIAN SOCIETY.

On Thursday, February 12th, the Mid-Sessional Address will be delivered by Dr. D. N. Buchanan on "Hypnotism" with a Practical Demonstration in the Medical and Surgical Theatre at 8.30 p.m.

On Thursday, April 30th, Sir Arthur Keith will deliver an address in honour of the memory of John Abernethy, who died on April 30th, 1831.



A NEW VIEW OF THE HOSPITAL.

ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB.

The next meeting of the Club will be held at the Holborn Restaurant on Wednesday, February 11th, preceded by Dinner (price 5s.) at 7.15 p.m.

Dr. Garrod will read a paper illustrated by lantern-views on Climbing in the Dolomites, and cinematograph films of climbing, ski-ing and other winter sports will be shown.

Will members kindly make a note of this date?

\* \* \*

CENTENARIES AND CINCHONA.

To some the dawn of each day comes as an ever-recurring miracle: to others as yet another excuse for celebrating a centenary. We have celebrated the births

and the deaths of famous men, victories, defeats, the publication of books, the dawn of new conceptions—and lately, under the vigorous stimulus of Dr. Wellcome, the tercentenary of the advent into therapeutics of a drug, quinine.

Dr. Wellcome, lavish of hand as generous of mind, ordained a three-days' festival: from December 7th to 10th the doors of The Wellcome Historical Medical Museum were thrown more than usually wide open, while a crowd of ambassadors, scientists, men of affairs, divines, specialists and humble practitioners of the art of medicine paid tribute to quinine and to the men who made practicable its employment in the struggle against

malaria. Twice a day for three days men, distinguished in their respective walks of life, rose to praise quinine; and during the whole time an unique exhibition of books, pictures, barks, powders, of everything appertaining to the history of the use of quinine testified not only to the interest of the subject, but also to the genius for organization and arrangement possessed by Dr. Wellcome and the members of his staff.

No man is ever allowed to leave the Wellcome Museum empty-handed. The Hickman Centenary last year was made an excuse for the publication of a copiously illustrated souvenir, dealing exhaustively with the life and work of that sad figure in the history of surgical anaesthesia. The Cinchona Tercentenary has enriched our book-shelves with an elaborately annotated and very pleasing catalogue of the exhibition.

Among the sections of the Exhibition we would draw particular attention to that dealing with Malaria. Taken from the Wellcome Museum of Medical Science in Gordon Street, "it offers an example of . . . the synoptical method of museum demonstration. Here the disease is shown in all its aspects—historical, aetiological, pathological, clinical, therapeutic and preventive." The method is used at the Medical Science Museum to display the whole field of medicine in paintings, photomicrographs, actual specimens, wax models, with simple descriptive labels. To visit this Museum is to walk through the covers into the pages of a text-book of medicine—a text-book, moreover, that is kept perpetually up-to-date. No medical student can afford to deny himself this experience.

\* \* \*

NEW YEAR HONOURS.

Congratulations to the following on their appearance in the New Year Honours List:

*Knight Bachelor*—Ambrose Edgar Woodall, M.D., M.Sc., Ch.B., F.R.C.S.  
*C.B.E.*—Major Ernest Blechynden Waggett, D.S.O., T.D., M.A., M.B., B.Ch., M.R.C.S., L.R.C.P.  
*O.B.E.*—Lt.-Col. John William McCoy, I.M.S.

\* \* \*

The Warden requests us to announce that all applications for House Appointments should be made at the College Office before 12 noon on Saturday, February 14th.

THE SIR D'ARCY POWER BIRTHDAY VOLUME.

THE PRESENTATION CEREMONY.

ON Wednesday, January 21st, in the Great Hall of the Hospital, Lord Moynihan, P.R.C.S., presented to Sir D'Arcy Power, on behalf of the subscribers, the specially printed and bound copy of Sir D'Arcy's *Selected Writings*, which has been prepared in honour of his seventy-fifth birthday. A large gathering of subscribers and friends assembled under the Chairmanship of Lord Stanmore, Treasurer of the Hospital.

Through the kindness of the Editor of the *British Medical Journal*, we publish the following account of the ceremony:

LORD MOYNIHAN, in making the presentation, said: A multitude of diverse duties falls to the lot of the President of the Royal College of Surgeons, but I can truthfully say that no more pleasurable obligation has

been laid upon me during my term of office than that which I am asked to fulfil to-day. I am frequently, and perhaps a little imperiously, reminded by my numerous St. Bartholomew's colleagues on the Council of the College, that whereas they enjoy the dignity of membership of your Staff, I am to be regarded only as one of your students. But even that minor office carries to my ears a title of great honour. The members of the Staff of this oldest and most renowned of British hospitals have not always been men of the highest professional distinction, though both you and they might be greatly surprised to hear so gruff a statement made in regard to them; but more often than in the case of any other hospital, they have been men of distinguished character and fine general culture—great even in truancy—who have added to the renown and respect of our profession. I like to think that of three supremely great Englishmen in medicine, Harvey was a physician to this Hospital; Hunter, our patron saint at the College, was a student under that great little gentleman, Percivall Pott; and it is difficult to believe that Lister would have escaped you had he not been a Quaker. I am therefore full of pride at your request to return to what I will venture to call, I hope without arrogance, my old Hospital. The occasion of my return makes a very warm appeal to me; for I am asked to help you in doing honour to an old and beloved colleague. It is, I think, significant and delightful that the initial impulse and the sustaining power of this project came from the younger men, and is associated with the energies of the Osler Club, and I may perhaps be permitted to mention the names of W. R. Bett and A. W. Franklin.

Sir D'Arcy Power, the most eminent medical historian of our day, illustrious son of a distinguished father, is, it is perhaps unnecessary in view of his distinguished career to say, a Yorkshireman. He joined the Council of the Royal College of Surgeons on the same day as myself. He has held many offices, and one, that of Honorary Librarian, has, in view of his high accomplishments, deep and accurate knowledge, and unwearied service for us, been created for him. The fact that he has served his full period upon your Staff is in itself the testimony he would himself most value as to his surgical distinction. Yet when the name of D'Arcy Power comes to my mind, or his familiar image to my eye, I recall on the instant, not his career as a surgeon, not even his unrivalled knowledge of surgical history, from which the *British Journal of Surgery* has continuously and greatly benefited, but his friendliness, his cheery disposition, and his beauty of character. When we call to mind the name and services of our professional friends, we judge them, I think, not by the size of their practice, nor the money they have with so great difficulty

accumulated, nor by their contributions to the science, the craft, or the lore of medicine, but by their character and their influence upon the younger members of our calling, through whom they earn immortality. For it is not by his wealth, nor by his learning, nor even by his wisdom that a man is rightly esteemed, but by his character. Judged by this sternest of all standards, you will all at once agree, D'Arcy Power has been one of the greatest influences in medicine in our day. He has been preminent in counsel, wise in action, eloquent in word, written or spoken, imperturbable and resolute in time of challenge and difficulty, a staunch, loyal, happy friend whom all men have welcomed and trusted and loved.

Lord Moynihan then handed the book to the recipient.

Sir D'ARCY POWER, who was received with long-continued applause, said: My instructions are that I should be brief, very brief indeed, but my feelings are so deep that I can hardly express them at all. I am afraid that Lord Moynihan has spoken with the tongue of partiality and biased friendship. I have not deserved the half of what he has said. All that I can say for myself is that I have had a good memory, and when I have been asked a question I have tried to reply to it from such knowledge as I possess. Sometimes I have been fortunate, sometimes I have been wrong. I have been at many meetings in this Hall, and seen many presentations, but this occasion to me is quite unique. On all previous occasions it has been the presentation of a portrait. I do not know of an occasion on which pupils—if I may use that expression—have given their master a selection from his own writings. I think that must stand absolutely by itself. When a book has been given—and that form of presentation has been adopted on the Continent and in the United States, and occasionally in this country—the contributions in the book have always been made by the pupils themselves. It was thought, I suppose, to be more appropriate that the master should not be reminded of the very poor things that he had often written himself. But this occasion is unique in that the volume presented to me consists of my own writings, and I have to thank, not only the Osler Club, who were the begetters of this beautiful idea, but also Mr. Franklin, and those who have carried it into execution. As I look through the book I can see that it is beautifully produced, as a book-lover would love to have his writings preserved. The paper is good, the inscription goes to my heart, the pages are beautifully set out. *Simplex munditiis*. And I see that the production is in the very best style of the Clarendon Press. Then I notice how excellent is the binding, and there I am sure my sister (Mrs. Loosely), who is a first-rate binder, has evidently been at work, and has put her whole heart into this undertaking and

made it as pleasing as it can be. I feel sure that there is an undercurrent of feeling in all this which will certainly leave a lasting memory of personal affection, making this no stereotyped presentation in any way. It seems to me that in some way quite unknown to myself I have entered into your hearts, and I am quite sure, as we have been taught in other places, that it is better to live in the hearts of men than to rule over their lives and fortunes. I am in that fortunate position with respect to all those who have taken part in the presentation of this volume, whom I thank very heartily.

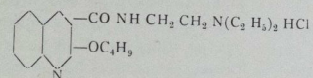
Prof. G. E. GASK said that there had been a large number of letters from subscribers regretting their inability to attend, but he would read only three telegrams, one from the Institute of Medical History in Leipzig, sending heartiest greetings and best wishes to Sir D'Arcy Power; another from Prof. Karl Sudhoff, also of Leipzig; and the third from Sir Robert Jones, all uniting in doing honour to their distinguished friend. Prof. Gask went on to say that he would like to offer the thanks of those assembled to one of the more recent "perpetual students" of St. Bartholomew's—namely, Lord Moynihan—for coming there and giving one of his charming speeches, which had been listened to with so much pleasure. Lord Moynihan had spoken of Sir D'Arcy Power as a surgeon, a medical historian and bibliographer, and Librarian of the Royal College of Surgeons, and nothing could be added to the way in which he had done so. But he himself had known Sir D'Arcy Power for more than thirty years, and he wished to add one small touch of personal reminiscence. He remembered him when he was appointed to the Hospital as Assistant Surgeon, and from that time onwards one of his chief characteristics was his sunny disposition. That characteristic had remained with him through all his long life, had helped him through some great sorrows, and left him with a smile on his face and a merry wit. The work in connection with the volume which had been presented was a great pleasure to all who had been engaged in it. The idea was evolved by the Osler Club, who had borne the brunt of the work. It had been a labour of love. He called upon the gathering to express its thanks to those who had had the presentation in charge, also to Lord Stanmore for presiding, and to Lord Moynihan for making the presentation.

*Sir D'Arcy Power's Selected Writings, 1877-1930*, is published by the Clarendon Press. Five hundred copies were printed, of which two hundred and fifty-three were reserved for the subscribers, and contain a list of subscribers' names; the remainder of the edition is for general sale. A special review of the book will be published in the March issue of the JOURNAL.

## HIGH SPINAL BLOCK ANALGESIA WITH PERCAINE.

THE frequency with which new anaesthetic drugs and novel techniques of administration appear in the medical press is becoming bewildering, but it is comparatively rare that much real advance is made over existing and well-tried methods. An exception, however, appears to have occurred in the introduction of "percaine," for this substance has certain properties which are so far unique among local analgesics (1).

Percaine is *α*-butyl-oxyinchoninic acid diethylethylendiamide hydrochloride with the formula—



and is consequently not related to the cocaine or novocaine group but is a derivative of quinoline. The discovery of the analgesic properties of the drug was made by Karl Meischer, and it is now manufactured by the Society of Chemical Industry in Basle. Percaine forms colourless crystals which readily dissolve in water, producing a neutral solution. This may be repeatedly boiled for sterilization provided that there is no trace of alkali in the water. For safety's sake 5 minims of dilute HCl is added to each litre of solution.

The special features of percaine are its extreme potency and its duration of action. It is approximately twenty times stronger than novocaine and cocaine used in a dilution of 1 in 2000, while analgesia persists for at least 3 hours, and has been recorded for 10 hours. Percaine is a slight vaso-dilator, and for infiltration analgesia it is necessary to add adrenalin in the same way as when novocaine is employed. The maximum amount of the solid drug which may be injected into an adult at one time is 0.2 gram., which represents 400 c.c. of a 1 in 2000 solution—a volume which should be adequate for the most enthusiastic anaesthetist!

It is, however, as a spinal analgesic that percaine excels. In the last few years a great deal has been written (some of it quite unsound) on the subject of spinal analgesia, and it is unfortunate that the exaggerated claims made for certain techniques and preparations should have tended to discredit a valuable method. Mr. Howard Jones, Senior Anaesthetist to Charing Cross Hospital, has done a great deal of work upon the mechanism of spinal block with special reference to percaine (2), and it is his technique which I propose to describe.

Before discussing the application of percaine to spinal analgesia it may be well to recapitulate some of the characteristics of the cerebro-spinal fluid. This is believed to be secreted by the choroid plexuses and in the perivascular spaces of the pia mater, and to be absorbed near the caudal end of the dural sac. Its amount has been variously estimated at between 60 and 150 c.c., and its specific gravity is usually between 1.004 and 1.008 (3). This wide variation renders the employment of an exactly isobaric solution impossible. The cerebro-spinal pressure is normally about 10 mm. Hg. The rate of absorption of injected fluids is high, e. g. 580 c.c. have been introduced into a dog within two hours (Duret).

The extreme dilutions in which percaine is effective have made it possible for the first time to employ low specific gravity solutions by simply using hypotonic saline, since the minute weight of the dissolved drug makes no appreciable difference. For example, percaine in a 1 in 1500 solution in 0.5% saline has a specific gravity of 1.00345 at 35.5° C. This is practically always hypobaric, i. e. its specific gravity is lower than that of cerebro-spinal fluid. The essential feature of the new technique is that the subarachnoid space is treated in exactly the same way as other tissues in an infiltration analgesia, in that a relatively forcible injection of a large volume of a dilute solution is made; no fluid is withdrawn, and the level of analgesia is determined entirely by the amount of fluid injected. This is obviously more accurate than the older method of injecting a small volume of a concentrated solution of stovaine or novocaine, since even if such a solution be artificially "lightened," the heavier constituents will become subject to gravitational diffusion when admixture with cerebro-spinal fluid takes place, and the result must be uncertain.

### TECHNIQUE OF ADMINISTRATION.

For all ordinary purposes a hypobaric solution is employed, and this can now be obtained ready sterilized in ampoules, each of which contains 20 c.c. of 1 in 1500 percaine in 0.5% saline.

About half an hour before operation the patient's eyes are lightly bandaged, his ears are plugged with wool and he is given a hypodermic injection containing not more than morphia gr.  $\frac{1}{4}$  and hyoscine gr.  $\frac{1}{100}$ . The reason for the small dose will be seen later. The patient is then placed on his side with his knees drawn up and the lumbar puncture performed. A 9 cm. stainless steel needle 1.2 mm. in diameter and with a 45° bevel ensures a practically painless puncture, and the extremely small hole reduces subsequent leakage to a minimum.

For most abdominal operations the puncture should be made between L1 and L2, no cerebro spinal fluid is withdrawn, and the injection is made from a 20 c.c. Record syringe. High abdominal operations, such as gastrectomy or cholecystectomy, require a block up to D3 or D4, and this is usually attained by an injection of 15 c.c. For low operations such as prostatectomy, appendicectomy or hysterectomy a block up to D8 or D9 is sufficient, and this should result from 12 c.c. of solution. Simple caudal block can be obtained by injecting 6 c.c. between L4 and L5. These doses are calculated for a man of average build; a tall man will require slightly more and a short woman slightly less quantities.

The solution is injected slowly, the needle is withdrawn, and ephedrin gr. 1½ is injected intramuscularly. The patient is then turned on to his face and the table given a slight tilt with the head down. This position will soak the posterior roots and should be maintained for about 5 minutes. If this manoeuvre be omitted an anterior root block only may take place, *i. e.* the patient will develop motor paralysis without analgesia. The patient is next turned on to his back, and may now be placed in any degree of Trendelenburg or in the lithotomy position, but on no account must a "feet-down" slope be allowed. This may be resented by a surgeon about to operate upon the gall-bladder, but the absolute relaxation more than compensates for the unusual position. The site of operation is next prepared, the towels arranged, and the highest towel clip allowed to penetrate the skin. If no protest follows, the operation should be started. It is a great mistake to ask the patient if he feels anything as he will certainly say so if he does, and the question will tend to destroy his confidence.

It need hardly be added that the strictest asepsis must be observed during the injection. All syringes and needles must be boiled for at least 20 minutes in water without sodium bicarbonate, and the ampoules must have been kept in spirit for at least 24 hours.

#### OBSERVATIONS DURING OPERATION.

*Comfort of patient.*—Analgesia is usually perfect and the patient often sleeps throughout the operation. Several factors, however, may render him uncomfortable:

(1) The "head-down" position in a hot and stuffy theatre may give rise to a stifling sensation, which can be greatly mitigated by sponging the face with cold water, and by allowing a weak air blast from a fan or pump to play on the face. In the new theatres of this hospital a rubber tube from the "air-plus" cock on the pillar provides a convenient air current.

(2) The patient may complain of feeling parched or faint. A small swab soaked in dilute brandy and placed in his mouth to suck will relieve both conditions.

(3) Nausea and even vomiting may occur if the surgeon exerts undue traction on the stomach. This is due to impulses passing along the gastric branches of the vagi, and can be reduced by injecting a small quantity of percaïne solution under the peritoneum in front of and behind the abdominal portion of the oesophagus, if the stomach can be brought down sufficiently for this proceeding to be carried out.

*Blood-pressure.*—It is a mistake to take frequent blood-pressure readings as this disturbs a patient greatly, and sufficient information can be obtained by the observation of his colour and the characteristics of his pulse. A slight drop in pressure is inevitable in high analgesias when splanchnic block is complete owing to the vaso-motor paralysis, but it is less than when novocaine or stovaine is used, as the percaïne is less toxic when absorbed into the blood-stream. A steeper tilt to the table will usually check an excessive fall of pressure, but a second dose of ephedrin or pituitrin produces little or no effect.

*Respiration* is usually shallow and regular but must always be watched for impending failure. This is less likely to occur from phrenic paralysis than from fatigue of the respiratory centre, caused by the anoxæmia resulting from imperfect lung ventilation due to the temporary paralysis of most of the intercostal muscles (10). The administration of a CO<sub>2</sub>-O<sub>2</sub> mixture will rapidly restore regular breathing unless the centre has already been badly narcotized by large doses of morphia, avertin or similar drugs. In this connection it might be observed that a patient will actually be safer from respiratory failure if he is having N<sub>2</sub>O + O<sub>2</sub> with partial rebreathing than if no inhalation anaesthesia is being administered. At the same time, the transmitted movements to the abdominal viscera may be excessive, since the diaphragm will have a larger excursion to compensate for the intercostal paralysis, and this may be inconvenient to the surgeon.

#### RESULTS.

We may now pass to a consideration of the first sixty cases anaesthetized by the writer with the method described. It should be observed that only "high" blocks are included in this series, *i. e.* operations in which the abdominal incision was expected to extend to near the costal margin. It is possible, by using slightly larger doses, to do low thoracotomies or thoracoplasties by the same method, but since pure N<sub>2</sub>O-O<sub>2</sub> anaesthesia

gives such excellent results in thoracic surgery (4) spinal block seems hardly justifiable.

*The age of the patients* varied from a girl of 18 who had an abdominal sympathectomy performed for Hirschsprung's disease, to an old gentleman of 80 who suffered an almost complete gastrectomy for carcinoma. The latter patient successfully survived his operation, but unfortunately had an enlarged prostate which necessitated frequent catheterization, and he eventually developed ascending pyelo-nephritis and died of uræmia.

*The type of operation* in most cases was partial gastrectomy, gastro-enterostomy or cholecystectomy. The remainder were mainly inspections of inoperable growths.

*The time of operation* varied from 19 minutes to 3 hours 2 minutes, the average being 1 hour 40 minutes. In no case did the analgesia pass off before the conclusion of the operation. This is, of course, in marked contrast to spinal blocks with stovaine, novocaine or tropacocaine (5) and (8).

*Degree of analgesia.*—In no case did analgesia fail to develop and in no case did a patient feel actual pain. Severe traction on the stomach was the usual cause of discomfort and nausea. In every case in which vagal block was attempted the discomfort passed off: in the others, inhalation of N<sub>2</sub>O + O<sub>2</sub> was given (6 cases=10%). With the exception of one particularly nervous man no inhalation anaesthesia was given to the other patients (53 cases=88%).

*Post-operative condition of patients.*—This was, on the average, better than would be expected after pure inhalation anaesthesia. Several patients after partial gastrectomy had pulse-rates identical with those at the start. It was particularly noticeable that proceedings which usually give rise to signs of shock (*e. g.* the insertion of mechanical retractors and eversion of the liver) had little or no apparent effect when the protection of splanchnic block (which obtains with this technique) was afforded.

*Mortality.*—There has been no immediate mortality in this series. As regards remote mortality, it is exceedingly difficult to apportion the fair degree of blame to the anaesthesia. Four patients have died within a week of operation (6.6%). All were regarded as poor risks, and in one case the operation was actually abandoned as being unjustifiable after the injection had been given. Another case developed broncho-pneumonia which terminated fatally. It is worthy of note in passing that he had had no inhalation anaesthesia.

*After-effects.*—The only after-effects which can be directly attributed to the spinal analgesia have been headaches. These have been severe in three cases, and one other patient complained of pain in the back of his

neck which persisted for ten days. These sequels are, of course, common to all varieties of spinal analgesia and may indeed occur after a simple lumbar puncture. The exact cause still remains obscure, but it is apparently due to some disparity between the intracranial and spinal pressures. The very fine needles used minimize subsequent leakage of cerebro-spinal fluid and have probably contributed to the relative rarity of headaches (6.6%). It is said that the condition can always be relieved temporarily and often permanently by the intravenous injection of 20 c.c. of 50% glucose solution.

There is another matter which might be referred to under "after-effects" and that is the remembrance of events by the patient. Although the amnesia afforded by the hyoscine is often complete some patients remember more than is desirable, and loud conversation and the jangling of instruments should be avoided. One patient, on being asked how she had fared, replied, "I didn't feel anything at all, but I got rather alarmed when Mr. — (the surgeon) told Mr. — (the house-surgeon) that he was the clumsiest assistant he had ever seen!"

#### COMPARISON WITH OTHER METHODS.

The only other types of local analgesia which can give comparable results are (i) combined splanchnic and abdominal wall field block, and (ii) combined splanchnic and para-vertebral block—methods which have already been tried out (6). The high spinal percaïne method possesses the following advantages over either of these:

- (1) The analgesia is more certain and complete.
- (2) The technique is easier and takes less time.
- (3) The volume of solution used is less than one-fifth, with consequent reduction of toxicity from absorption.

#### CONCLUSION.

It is admitted that 60 cases are quite inadequate for any generalization, yet the results obtained agree substantially with those of many series done elsewhere (7), and it seems just to conclude that high spinal analgesia with percaïne is one of the best methods at present known for high abdominal surgery.

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C. LANGTON HEWER.

### WINGED SCAPULA.

WINGED scapula constitutes a favourite short case at most of the qualifying examinations in surgery, and this article may be considered to be the direct outcome of a recent personal experience of such a case in the above circumstances. Anyone who has attained the standard which will allow of his presenting himself for such an examination must have seen at least one case, if not numbers of them. Recognition of the condition is easy, but one gathers from the the “small talk” of the stairway and cloak room at Examination Hall that considerable distress is caused by too close questioning as to the aetiology of the condition, the diagnosis of the muscle paralysed, etc. It is a pity to allow examiners to score so easily; hence the writer hopes that the following short exposition of the subject may be of interest to all.

The first reported case of an isolated paralysis of the serratus magnus was made by Velpeau, and published in his *Traité d'Anatomie Chirurgicale* in 1835. Some thirty-four years later, Duchenne, writing in his work on the physiology of movement, classifies these paralyses as (a) isolated and (b) associated, according to whether the nerve of Bell alone is affected, or the nerve involvement is more extensive. A more recent classification is that of (a) central, (b) peripheral origin. Numbers of cases were published in this country, Germany and France after attention was drawn to the condition by Duchenne. In 1907 Henri Claude and Descamps reviewed the literature then available, and could only find 26 authentic cases of isolated paralysis, the greater bulk being associated paralyses either badly observed or carelessly examined, and so reported as isolated cases. Since then numbers of cases have been reported

from time to time. Von Eiselberg first attempted the operative treatment of the condition in 1898.

#### ÆTIOLOGY.

The condition is most common in males aged 25 to 40 years, and usually occurs on the right side; Deroeque reports a case of pure peripheral paralysis on the left side. It is apparently rare as an isolated lesion, most cases presenting a partially affected trapezius.

Trauma plays a considerable part: wounds in the neck; carrying heavy weights upon the shoulder; continuous use of the scapular muscles. A paralysis occurring in patients whose work consists in carrying

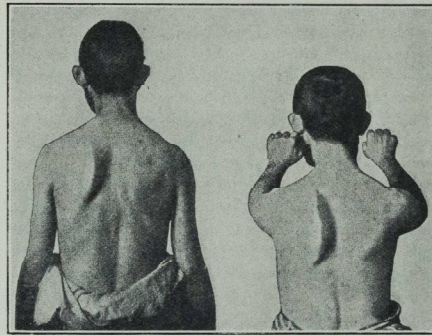


FIG. 1.

FIG. 2.

FIG. 1.—Paralysis of the serratus magnus on the left side. The patient is at rest. The prominent border of the scapula is well shown. (Henri Claude.)

FIG. 2. The same case showing the increase of prominence of the border of the scapula on asking the patient to raise the arms in front of him. (Henri Claude.)

heavy loads upon the shoulder would appear to be due to the exposed position of the nerve of Bell as it crosses the scalenus medius muscle in the neck. Skillern reports a case in a young man whose work involved continuous full extension of the arm and shoulder some 800 times per night. Paralysis follows injury to the nerve in operation for carcinoma of the breast.

Other causes are compression by tumours in the neck; involvement by inflammation, e.g. cervical Pott's disease, with abscess formation; involvement of the anterior horn-cells by polio-myelitis.

Inflammation of the sub-scapular bursa is a cause of palsy of the posterior nerve of Bell; this is often

overlooked. The nerve runs down the sub-scapularis in contact with this bursa.

Acute specific fevers, such as typhoid, are occasionally followed by the development of this palsy.

#### SIGNS AND SYMPTOMS.

(1) Deformity of the shoulder: The antagonist trapezius, rhomboids and levator angulæ scapulae, being unopposed and free to act, produce the deviation of the scapula, whilst the serratus magnus, freed from its taskmaster, the nerve of Bell, lies dormant upon the chest-wall. Thus the spinal border of the scapula of the affected side is closer to the median line than on the normal side, and is more prominent, particularly at its inferior angle, the whole scapula being drawn upwards a varying amount, in different cases, due to the pull of the unopposed trapezius.

This deformity is greatly exaggerated when the patient brings his arm forward to the horizontal in front of him, or attempts to cross his arms behind him. The “winging” due to the action of the trapezius will disappear on the patient passing his arm above his head.

(2) Thoracic deformities: Souques described these in 1908. The thoracic wall is more prominent in front and somewhat retracted behind, the whole tending to be more prominent in front on the affected side.

(3) A double scoliosis is occasionally seen in long-standing cases; one is a cervico-dorsal and the other dorso-lumbar.

(4) Diminution and impairment of muscular force, consequent upon the insufficient fixation of the scapula, are apparent, and may be the sole complaint of the patient.

(4) The electrical reactions of the paralysed muscle are those of degeneration.

#### DIAGNOSIS.

Congenital elevation of the scapula must be excluded, likewise elevation due to paralysis of the trapezius. An effort should be made to locate the cause centrally or peripherally, as this materially affects the prognosis; those of central origin are usually progressive, whilst the peripheral are stationary.

Neuropathic types of atrophy beginning in the shoulder-girdle must be distinguished. The myopathic atrophies, such as syringomyelia, may give rise to a similar condition, but usually diagnosis presents very little difficulty. Henri Claude, Vigoureux and Lhermitte published a paper on muscular atrophy following cervical and thoracic injuries presenting all the characters of localized myopathies, in which paralysis of the serratus magnus was a prominent feature.

#### TREATMENT.

The conservative treatment by massage, faradism and re-education would not appear to be very effective. This disability in a bread winner seems to call for some more permanent method of treatment, i.e. operative. Incomplete injury, of course, does not call for operative treatment, and will probably yield to the more conservative methods. With the reaction of degeneration present operative treatment must be considered, and except where the nerve has been injured at operation, suture is out of the question.

In 1898 Von Eiselberg attempted the operative treatment of this malady by a costo-scapular fixation. Unfortunately his case thus treated suffered great pain, and he was forced to abandon the idea of treating any further cases by this method.

In 1904 Duval attempted to perform a musculotendon graft, but was forced to give this up owing to the insufficiency of available grafting material.

In 1908 Mencièr came back to von Eiselberg's original plan, and succeeded in suturing, sub-periosteally, the scapula to the fifth, sixth and seventh ribs. The arm of the affected side was immobilized after operation for a sufficient length of time for adhesion to the chest-wall to occur. The treatment was successful and the patient suffered no pain. Mencièr considered that the pain in von Eiselberg's case was due to damage or involvement of the costal nerves in the operation or the sutures.

In 1914 Skillern suggested the inosculation of the proximal end of a healthy nerve to the distal end of the injured long thoracic nerve. Choice of such a nerve was made of the short sub-scapular nerve, because it is the least important of the three sub-scapular nerves and is derived from the fifth and sixth cervical roots, the long thoracic coming from the same two roots in addition to the cervical seventh. The short sub-scapular has two branches, and thus one of these may be utilized without materially affecting its functions.

Choyce, in his *System of Surgery*, suggests transplantation of the sterno-costal portion of the pectoralis major into the inferior angle of the scapula.

Mathieu divides the third and fourth ribs near to the spine, and attaches the border of the scapula to their proximal extremities.

Thus three types of operative treatment are available:

- (1) Nerve-grafts.
- (2) Fixation.
- (3) Muscle grafts.

Much of the above information has been obtained by reference to the following sources, and also from Henri Claude's excellent text-book of *Nervous Diseases*, vol. i, and Choyce's *System of Surgery*, vol. iii.

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 A. ANDREASSEN.

## THE AFFAIR OF NUMBER 989 HARLEY STREET.

(With apologies to the late Sir Arthur Conan Doyle.)

**T**HE task of reading for a medical qualification, which Sherlock Holmes set himself, proved, I am inclined to think, a more formidable one than he had at first realized. To men of genius, great intellectual efforts may be comparatively easy. But at the age when my friend began his medical studies, his mind, although not altogether rigid, had not that elasticity which makes academic achievements commoner in younger men. We are all familiar with the brilliant young men who in their earlier days take one degree after another; but while in later life they attain a high degree of wisdom and maturity, it is unusual for them to wander far from their own particular line of work. For instance, it is rare for a middle aged practitioner to turn aside from medicine and take a degree in music, whatever talent he may have as an amateur. And so it was with Holmes. To be frank, he found his work very difficult. He was excused only part of his first examination, but the mechanics and botany tried him sorely. He strove manfully with old examination papers which I lent him. Such questions as estimating the thrust of a weight against a gate-legged table, given

$w = 14$  lb. and gravity  $g = 32$  ft. per sec. per sec., the work done by a dog in drawing a man of 14 st. on a sleigh given the coefficient of friction of ice and the speed of the dog, and the relative importance of the xylem and phloem in the stem of the adult geranium made him wax cynical, and it was in vain that I stressed their practical value to the practitioner.

"Are you ever likely to draw a 14-stone man along the ice?" he hooted in a rage. "No," I replied, "but I have dragged a bed along a cottage floor bearing the weight of an 18-stone woman, which is worse. The pull was transmitted through a fetus and a pair of Milne-Murray's axis traction forceps. I learned the force of thrust of a kitchen table when the head of the fetus came off and I shot backwards, sustaining a large hæmatoma over the occiput."

I have seen Holmes almost maniacal, trying to learn the foramina of the skull. He made full use of mnemonics. Later, the involved and somewhat hypothetical bio-chemistry of infection and immunity made him foam with rage. To read a lengthy chapter of theorizing on agglutinogens, epitoxoids and the polypeptide conception of the complementophile groups, and then see at the end, "these views are, however, now considered untenable," drove him into a gibbering passion which astonished me, long though I have known him.

Even in the matter of dress he had become a trifle stereotyped. I have been in the Hospital quadrangle after lunch and seen amongst the white-coated dressers the prominent figure of Holmes towering above the rest, clad in his Inverness cape and peaked shooting-cap, lost in the moody contemplation of his thoughts. Above all he was very sensitive to ridicule. His chief, Sir William Laye, harrowed him mercilessly; it was this severe school which had made of his dressers some of the finest medical men of the generation. But Holmes resented it. They were constantly at war. Consequently the rounds were crowded with students from all parts who came to see the battle between the fiery surgeon and his austere dresser. It was in vain that I warned Holmes that he was laying up a store of trouble for the future. He fought equally fiercely with the sisters. With the nurses, however, he was his old genial self, charming and considerate.

On one occasion, after hearing a learned discourse during the afternoon round on a female patient with obscure abdominal symptoms, my friend re-appeared at midnight in a cab, arrayed in his dressing-gown, with books and a plentiful supply of tobacco. Making his way to the ward, he installed himself at the bed-side and prepared to spend the night there in solving the diagnosis after the fashion of his all-night brooding upon his criminal cases. Nothing could move him—nurses,

night superintendents, house surgeon, steward, all tried in vain, until at last Sir William was brought out of bed by telephone. They say that the sight of Holmes's fine features in the dim light of the ward, half-hid in a haze of smoke, called forth a flow of eloquence which made the nurses flee into the kitchen and slam the door. The house surgeon copied it word for word into his note-book. Holmes was routed, and his chief went back to Harley Street still fuming.

Time drew on, until one winter evening I called upon my friend to learn the result of his examination. I found him deathly pale sitting before his fire, and clutching in a frenzied grip the notorious pink paper, the "return ticket" issued to those who have failed. I gave one glance through the half-open door, then closed it silently and went home. I learned afterwards that he had had a hot argument with Sir William, who was marking in his "viva." It arose over a huge ovarian cyst. Holmes picked it up and shook it in his chief's face in proving his point. Unluckily it burst in my friend's fierce clutch and drenched the surgeon with its contents.

Next day, when I returned from my morning round, my wife told me that she had been pestered by an elderly man, who had applied at my house for the office of butler; it was in vain that she repeated that I needed no such servant, and she only rid herself of him by promising that I would see him later in the day. Punctually at 4.30 he arrived; and I went through to my waiting-room to find a typical butler, dignified and slightly round-shouldered, with white hair and side-whiskers. I could get no reasonable explanation from him why he persisted in seeking employment with me. We argued for ten minutes.

"I have been recently employed as butler by Lord Bankhead and I have excellent references from 'is lordship," he repeated.

"Why did you leave?" I asked.

"Look what a lot it would add to your practice if I came," he remarked, ignoring my question.

"My practice does not need your aid, thank you."

"Your personal appearance would benefit too, sir," he continued; "your coat could do with being brushed and pressed."

This was too much for me. I sprang up from my chair in a rage.

"I see now why the marquis dismissed you, you impudent old bounder," I shouted; "get out, before I kick you down the steps."

"Really, really, Watson, they'll hear you in the street"—and in the well-known voice and transformed face I recognized Sherlock Holmes.

"Holmes, you villain," I said, shaking my fist at him,

"it would have served you right if I had blacked your eye; what is the meaning of this?"

"It is tea-time I believe, and I see I have interrupted you in the act of making toast—"

"How on earth—?" I began.

"Pah—perfectly obvious," he explained; "your face is as red as a piece of raw meat, you have crumbs on your trousers, a pat of butter stuck on your left elbow, and the prongs of the toasting-fork, which you hastily slipped up the inside of your jacket when I rang the bell, are sticking up above your collar at the back."

"Marvellous, my dear Holmes," I exclaimed.

"Elementary, my dear Watson," he retorted. "But to come to business; if you will invite me to try some of your excellent toast, I will tell you my plans."

"Certainly," I cried; "my wife is at home, and seeing that you are so suitably attired, I think the least you can do is to wait upon us at tea."

I knew Holmes's acting of old. Many years previously when we were together crocodile hunting in the East, we happened to be staying on the borders of a native state in which affairs were turbulent. The imminent inauguration, however, of a new political scheme was looked upon as the only hope of avoiding a crisis—perhaps a revolution. Great consternation prevailed because the ruling prince (whose presence was essential to the success of the project) was found the previous night hopelessly incapacitated as the result of an ill-timed debauch. They appealed to Holmes, and offered him an enormous sum for his advice. He refused any fee, but set to work at once. He impersonated the prince in a masterly disguise. He spent the night in consultation with the political leaders, and discarding the speech which they had already prepared, he insisted upon writing one himself in the native language. Early next morning he went down to the great assembly, dressed in all the panoply of state, the central figure of a procession dazzling in its barbaric splendour. The proceedings were delayed forty-five minutes or so owing to the fact that my friend was somewhat sick in the prince's robing-room following his unaccustomed ride on an elephant. However, he soon recovered, and the members of that glittering concourse listened spellbound for two hours to what was described as "a masterly dissertation, an inaugural address which summed up adequately and for all time the sources of discord, and was at once eloquent, constructive, visionary, and a *tour de force* of oriental oratory." Its effect was immediate, peaceful negotiations followed, and Holmes has over his mantelpiece a richly jewelled scimitar, the mark of gratitude of that Ethiopian potentate. Such was his delight, the dusky prince offered him the pick of his harem, which my friend refused with a smile.

As we sat at tea he told me of his scheme. "In accordance with tradition, my dear Watson, our chief has invited his dressers to dinner to-morrow night. I have been left out!" and he looked at me with indignation, his mouth bulging with toast, butter dripping off the point of his finely chiselled chin—

"—but I intend to be there! I have sent a fictitious letter this afternoon to his butler, requesting his immediate presence in a small town called Wallasey, not far from Liverpool. There he will be met by a solicitor, who, after proving his identity, will hand him a sum of money left by an anonymous benefactor. I have enclosed his railway fare, and that will prove to his satisfaction that the money will be forthcoming. You, Watson, must be the solicitor, and I will give you five pounds for the fellow. You cannot miss him; he takes snuff, limps slightly on the left leg, and wears a wig of white wavy hair. Meanwhile, although Sir William cannot refuse the old man's request for a day off he will be left without a butler, and it will be too late to communicate with his guests and postpone the dinner. As luck will have it, I shall call upon him, seeking employment with my 'hexcellent' references from Lord Bankhead, at present on the Lido: he will jump at the opportunity and engage me for the night. There will be some fun, Watson, you mark my words!"—and Holmes dipped his toast in his tea and ate it with a relish such as I had not seen since he started medicine.

"Come and have breakfast with me the morning after the dinner my dear fellow," he said as we parted, "and I hope to have a good story for you."

I made the journey to Wallasey as he directed me, travelling by the same train as the butler; as I recognized him on the platform at Euston I had no difficulty in carrying out my share, he showed me Holmes's letter, and after a judicious questioning I gave him his small bequest and we both came back, he in the fore part of the train, myself at the back. I called upon Holmes at breakfast-time next morning; he was in high spirits, chuckling to himself, rubbing his hands together, and every now and then leaping a few inches into the air.

"Aha! here you are, Watson, punctual as ever," he cried; "let us see what the excellent Mrs. Hudson has provided for us," and we drew our chairs up to the table and fell to on an appetizing meal of trifle, lobster mayonnaise, omelettes and delicious coffee. Although it was comparatively early, he chatted racyly throughout the meal, and knew thoroughly the important pieces of the morning's newspapers. He had the obituary column, share markets, divorce-court proceedings and fat-stock prices at his finger-tips. Pigs were up in Lostwithiel, down a trifle at Llanely and so on. Finally he

asked me how I had fared, and gave me a brief word or two of praise which were so rare, yet meant so much.

"And what about your evening?" I asked.

"Aha!" he said, "take an armchair and I will tell you. I went round and deceived him as successfully as I deceived you. He took me on at once, and set me to work immediately washing his car. I worked like a black, my dear fellow; I am sure Sir William ought to have been a slave-driver. Every now and then he would come through and bellow at me in order to keep me at it. Then came the dinner. I admitted the guests and took their hats and coats in the hall. Not one recognized me. Before they went in I said, 'Excuse me, gentlemen, but Sir William is on the top of 'is form to-night bubbling over with 'igh spirits. He and me 'as arranged a little by-play at dinner for your entertainment, so I must give you doo warning not to be surprised at what may 'appen or to interfere with the fun.' 'Rather not!' they replied, and I showed them into the drawing-room.

"Dinner began punctually: just before, I went up to the bath-room, put the plugs in the wash bowl and bath and turned on all the taps. Consequently the surgeon and his guests were all seated when I came down, and Sir William was beating the gong for me with a walking-stick. I marched in sedately and bowed. My chief, as you know, has a habit of shouting for everything at once.

"Come on you doddering old fool!" he began, "you're late already. Bring the soup!—Where are the tomatoes?—I want a siphon!—Push the table up a bit this way!—Why can't I have the soup up here?" "One moment, sir," I said, "one thing at a time—tomato coming sir," and seizing a large one from the sideboard I spun round and hurled it at him with terrific force. It caught him full in his evening shirt and burst, scattering acids and juice far and wide. As he leapt up with a roar a second met him in his open mouth and he sat down again, spluttering. The dressers, amazed at the speed of events, yelled their applause, banging on the table with the cutlery.

"Table coming up, sir," I called, and grasping the bottom I shoved it up with the force of a mediæval battering ram. Sir William was presiding in a high-backed oak armchair, and the end of the table hit him just above the waist. He went over backwards with a glorious crash.

"Soup coming, sir," I cried, and followed by a howl of mirth I hurried up to where the host was grovelling and kicking under his chair and poured the whole tureen of hot soup over his head. By this time the dressers were helpless; the house surgeon was crumpled up in his seat, screeching hysterically like a cockatoo,

with tears rolling down his face. The chief assistant was lying across the table with his head in the dessert yelling 'O atta boy!' like an alarm clock. I hate those American expressions, Watson; furthermore, I had many an old score to settle with him, so I stopped his tune with a resounding thud in the ear from a pineapple. I never realized before what a wonderful weapon is a pineapple—the spikes are very effective. A few well-directed jets from a soda-siphon caused the host to go to earth completely under the table and howl for the police. I went out quickly, and locking them all in, put the key in my pocket. Looking up I saw the first cascades of water from the bath-room coming downstairs. I removed the main fuse from its place in a box in the hall, plunging the whole house into darkness, locked the front door and walked down the street. Seeing a telephone box I summoned the fire brigade and an ambulance. I have often heard, Watson, of the speed with which the brigade answers calls, and I can tell you that this time they were admirable—they were on the scene in four minutes. Despite the dark, the din proceeding from the dining-room showed them where the trouble lay. They had just connected two lines of hose and directed both at the window as the bottom sash flew up and Sir William's figure appeared bellowing for aid: the water caught him full and back he went. I heard the dressers cheering as I pushed through the crowd and came home to a quiet supper. A successful evening, Watson," he said as he lit a cigar. "I sent a note this morning telling my chief that it he will call here at 10.30, I may have some interesting information for him concerning last night's occurrences. He is due now, and if I am not mistaken that is our visitor's ring. Don't go away, Watson!"

The door opened, and Mrs. Hudson announced "Sir William Lave." He stood and glared around with his hat on, as was his custom. "Good-morning, Sir William," said Holmes blandly, "pray allow Mrs. Hudson to take your hat," and he lifted his chief's head-gear off his head, so clumsily, however, that it fell on the floor.

The landlady retrieved it and retired.

"This is my friend, Dr. Watson, an old student at St. Debora's Hospital—you may speak quite freely before him."

"What have you to tell me?" asked the surgeon.

"I am a detective as well as your dresser," began Holmes, "and I have traced what I believe is some of your property," and he handed his visitor two keys and the main fuse. Sir William snatched them eagerly.

"Ha! then you know this hooligan?"

"Yes," said Holmes; "you made an unfortunate

choice of butler. I must give you a little advice before you choose your next."

"Mind your own business!"

"Quite so," said my friend genially, "but may I offer my own services. I have had no little experience, for I 'ave been recently employed as butler by Lord Bankhead and I 'ave hexcellent references from 'is lordship."

Sir William stood thunderstruck with amazement as Holmes's voice took on the well-known character of his former butler; he then snatched up his walking-stick and sprang at my friend with a roar like a bull elephant. But Holmes was expecting it; in a flash he had unsheathed the jewelled scimitar from its scabbard and whirled its glittering blade round his head until it sang. The discomfited knight retreated a few paces.

"I'll have you arrested for assault!" he shouted.

"As you please," and Holmes shrugged his shoulders. "At present the only official press account states that a false alarm of fire was given last night by some malicious person as being at the house of Sir William Lave, the famous Harley Street surgeon. I can imagine the headlines in a few days' time—'HARLEY STREET SURGEON RAGGED IN HIS OWN HOUSE BY A STUDENT.' Think of your reception at hospital; at present Dr. Watson and yourself are the only others who know the real identity of your butler; as long as I am allowed to continue at hospital as before they need be the only ones who shall ever know."

Sir William breathed deeply, snorted, began to rave, then gave up the fight.

"All right, go on," he said.

"Another small matter arises," said Holmes; "the incident has provided your dressers with an excellent subject for their Christmas concert. The house surgeon rang me up early this morning and told me all about it; he said how sorry he was that I had missed it all. However, I have a little talent in acting, which they are kind enough to recognize, and they have offered me the part of the butler, which you will be interested to hear I have accepted. Dr. Watson has been invited and we shall no doubt see you there."

Sir William left the room and stamped out of the house, slamming the door behind him. Holmes waved him a cheery "Au revoir" from the window and threw his hat after him into the street.

"Strange," he mused as he sheathed his scimitar, "if I had chosen the lady from the princely harem, however devoted she might have been, I doubt whether she could have saved me from that murderous onslaught as this weapon did."

"You villain," I said, "I have no doubt she would

have kept you out of such an escapade altogether if she were worthy of the name of wife."

\* \* \*

The Christmas entertainment was a great success. It was later remodelled and enlarged, and under the title of "The Battling Butler of Harley Street" ran for no less than six nights in the Great Hall, playing to a crowded house drawn from all over. Scores of Sir William's old dressers came to see it. The Patron of the hospital and the Lord Mayor were among others of one distinguished audience. The unerring skill with which Holmes threw the initial tomato never failed to raise a scream of applause from the delighted spectators.

My friend is at present on holiday in the Upper Engadine; his examination begins next week, but he has not done a stroke of work for it. He says that having shown the court of examiners a sample of his mettle when displeased, he is bound to get through. Holmes may be right, but knowing Sir William as I do, I very much doubt it.

F. W. J. W.

## ANENT ANATOMY.



live in an era of unrest. In all spheres of human activity there is a turbulence, unique in the history of our civilization. Particularly is this the case in the world of science. Things are in a constant state of flux. We go to bed in a rectilinear, three-dimensional world, and awake to find it changed (although it looks just the same) into a curvilinear, four, five, or even six-dimensional one. Who has done this dastardly thing? The force of gravity, for so long an institution in our midst, if not quite exploded as a myth has, at least, had serious doubt thrown upon it. Einstein has displaced Newton, just as Newton dispossessed Galileo. Again, the atom is no longer the conventional "billiard ball" of our schooldays. It has now been found to consist of "a wave." It remains to be seen whether it will prove to be a "permanent wave," or yet another scientific mirage.

Every few centuries a new demigod arises. He has a look round and begins to smash things—just as we are getting nicely used to them. He startles the world with some new heterodoxy, which becomes, for the time being, the science of the age. One wonders how much of one's beliefs and knowledge is based upon fact, and how much on the particular "credo" which happens to be fashionable at the moment.

When a new pedestal falls, the reverberation is heard

to the very ends of the earth; but do men feel alarm that for centuries they have been worshipping false gods, or contrition that men have been persecuted or burnt as heretics for professing disbelief? Not at all! Another Colossus is set up, and who can tell whether it, too, will prove to have feet of clay? As Pope says:

"One prospect lost, another still we gain;  
And not a vanity is given in vain . . ."

We are now reaching a stage, in some branches of science, when most of us have to admit our complete inability to understand the metaphysical ramblings of a handful of specialists.

In our own profession, too, we are not without our "lars" and "penates" which are destined to crumble and die. How much of what we now believe will survive the century? It is all very well to be told—

"Trace science then with modesty thy guide;  
First strip off all her equipage of pride;  
Deduct what is but vanity, or dress  
Of learning's luxury, or idleness;  
Or tricks to show the stretch of human brain . . ."

How are we to know which is which until the crash comes?

A few months ago Sir Almroth Wright, lecturing at a northern university to a post-graduate class, made the statement that nearly all antiseptics are quite useless, and that the traditional dab of iodine to a cut is a fetish savouring of witchcraft. He gave one the impression that the little bacilli almost sit up on their hind legs and beg for it. What *are* we to believe?

Occasionally, but not often, science does reach some sort of finality. It is then possible to say, "At last! Here we have facts, reality, truth, which will endure for ever!" Obviously this can only be the case in collateral branches of science. The fundamental issues are inexhaustible and infinite as the universe is infinite.

The science of anatomy, for example, is an expression of pure fact. It has been lifted clear of the quagmire of polemics. Its basis is more solid than that of mathematics, in which theorems and postulates depend upon the adoption of certain axioms.

When a branch of science reaches the stage of finality, it becomes, to a large extent, dead as an intellectual exercise. It loses an intrinsic spiritual value. There seems no further room for development. It resembles a meteor which has blazed its way magnificently across the heavens, and comes to earth a cold and lifeless stone; but as in the meteorite lies a key to the whole of the mystery of the Universe, so, on the cold dry bones of anatomical knowledge, is built up the whole of physiology, medicine and surgery.

Perhaps it is not quite correct to say that anatomy has yielded up all its uncertainties to scientific probings.

In some respects it can still lead one on to broader issues. It has, in conjunction with physiology, a great teleological significance. There is also the mystery of variations from the normal, while the whole evolutionary vista is opened up by a study of the many rudimentary structures in which the body abounds. In these respects the anatomist can still exercise his atrophying imaginative faculties.

The study of vestiges demonstrates the undeniably lowly origin of mankind. It is a perpetual curb to human arrogance. The captain of industry is laid low with appendicitis! The eminent scientist, who believes himself hot on the trail of the enigma of the Universe, can, and often does, prove himself an ape, without the additional incrimination of a large Darwinian tubercle! Even in the human eye, which has been called "the window of the soul," there is a relic of the reptilian nictitating membrane, in the shape of the semilunar fold!

It is now many hundreds of years since anatomy was a matter for speculation. It seems incredible, in these days when anatomical study has been brought to such a stage of perfection, that every minute ramification of a nerve or tiny residual muscle fasciculus is duly noted and recorded, that for so many years such abysmal ignorance should have existed concerning "the delicate organization of the human interior." This was no doubt due to the opposition raised by the ecclesiastical authorities, who held that dissection of human cadavers was inconsistent with the doctrine of material resurrection. The *Talmud* describes a "bone of Luz" which, although never definitely located, was supposed to be a sort of imperishable seed or nucleus from which the dead body would be resurrected. Modern text-books (admittedly more pictorial than picturesque) make no mention of this important bone, and candidates for examination are reminded that as its existence is apocryphal at best, reference to it at "*vivas*" is best avoided.

Galen, the Greek physician who lived about 200 A.D., derived his knowledge of anatomy from the pig, the ape and the ox. Being a philosopher as well, and noting the hog-like, ape-like and ox-like attributes of so many of his fellow-men, perhaps he was justified, to a certain extent, in believing that their anatomical structure coincided as well. Galen described a multi-lobed liver, a segmented sternum, and a horned uterus. The mystery of the circulation of the blood was a closed book to him. Alas! Galen would not have passed his Primary Fellowship! Does not this mean that we should look up more to our Primary Fellows? For is not each, in a manner of speaking, greater than Galen?

It was not until the middle of the sixteenth century

that the light of knowledge began to pierce the tenebrosity of Galenic tradition. This was the time of Sylvius and Vesalius, although the former was a staunch Galenist, and regarded the latter as a madman and a heretic.

Vesalius actually dissected the human cadaver, thereby laying the foundation of modern anatomical knowledge. He is said definitely to have disposed of the "bone of Luz" and the missing rib of Adam on the flimsy grounds that he discovered neither. In any case, if Eve was the result of a divine resection of one of Adam's ribs, Cain and Abel and the rest of us would still show no mutilation, for the reason that acquired characteristics are not transmitted to the offspring. However, Vesalius hadn't heard of Mendelism—and for a very good reason! Still, great as Vesalius was, it fell to the lot of a Bart.'s man, some eighty years later, to explain the mystery of how the blood gets from the right to the left side of the heart.

The discoveries of Vesalius, and later of Fallopius and Harvey, greatly stimulated anatomical study. The Church, finding the tide of universal opinion rising, granted permits for the occasional dissection of executed criminals. This dissection, which was in part a religious ceremony, was known as "making an anatomy." The learned physicians and their acolytes foregathered, and after a preliminary oration, sang in chorus. Then came the dissection, which was actually performed by a menial, while the chief Physician pointed out the organs with a long wand, and recited passages from Galen—for Galen's teachings continued to be regarded as inspired long after Vesalius had exploded them as unfounded. *The dissection was followed by a banquet!*

One cannot help deploring the decline in ceremonial which is so characteristic of the present day. The commencement of a new anatomical session is not heralded in any way. The air, perhaps, is a little less noisome; there is a certain proliferation of clean white coats, destined soon to lose their pristine beauty. There is no oration, no singing, and no burning of incense (for there is no ceremonial significance in the burning of the fragrant herbs of Wills and Bondman!). Certainly there is no banquet. No goodly viands are provided to celebrate a task well done; no good red wine to assuage the formalin-laden oesophagi of the weary dissectors. Instead there is a brain-searching catechism and a life and death struggle with a modern descendant of Cesare Borgia.

Many were the vicissitudes of the young science of anatomy. The need of bodies for dissection greatly exceeded the supply. It is axiomatic in human affairs that somehow such a disproportion cannot remain. This is true whether it be bodies or beer! A balance

must be established, or an attempt made to establish it. So it was that enterprising gentlemen, throughout the country, undertook to provide bodies for dissection. They robbed graveyards, and earned for themselves the name of "resurrectionists." Famed by this success, two zealous fellows, Burke and Hare respectively (full of an ardent wish to benefit humanity), conceived the very sound idea that by compression of the mouth and external nares, and making inaccessible the supply of air to the lungs, people who were not dead already could be rendered so (and fit subjects for dissection). It was a distinct advance in technique, and these worthy fellows provided much good material. However, an ungrateful nation hanged Burke in 1829. Nowadays the beneficent working of the Anatomy Act make such nefarious practices unnecessary, and our Burkes and Hares have turned to bootlegging and other essential industries.

Anatomical knowledge is perhaps one of the least decorative of subjects. It is unmentionable, for instance, in polite non-medical society. Post-prandially, when, over the port, literature, music and art come into their own, it would be a ghastly solecism to contribute the fact (no matter how *apropos*) that in the act of sitting the weight of the body is distributed on the tuber ischii; or that the replete gentleman (the one monopolizing the fire) who is holding forth so eloquently on neo-Kharsivan art, is only enabled to do so by the strength and integrity of his Poupert's ligaments.

The layman, on the other hand, is not so reticent in this respect. He experiences a delicious horror in the contemplation (mental) of his interior. It is the horror of the unknown. He is ready to speculate, or even to rationalize. Surely there must be *two* tubes for swallowing, one for solids and one for liquids; and what can the function of the uvula (he doesn't call it that) be but to separate the two constituents. The patient who takes clandestine peeps at his charts when Sister's back is turned will doubtless, in years to come, assure his panel doctor that when he fell from the scaffolding he fractured his "diblum and tidlum" (tibia and fibula), or that he is suffering with "locomotive and taxi" (locomotor ataxy). Perhaps it is not strange that people should be curious concerning the means by which we live. Anyhow, "a little knowledge" in this respect is more amusing than "dangerous," and we can afford to smile indulgently. Let us be thankful for our own more complete knowledge, so laboriously acquired—and so easily forgotten!

JOHN LANDON.

## THE FOURTH WALL.

By A. A. MILNE.

Presented by the Amateur Dramatic Society in the Great Hall, January 6th–9th, 1931.

### CHARACTERS IN THE ORDER OF THEIR APPEARANCE.

Jimmy Ludgrove . . . . .	KEITH VARTAN.
Susan Cunningham . . . . .	VIOLET TODD.
Adams . . . . .	DERRICK COLTART.
Edward Laverick . . . . .	ROBERT CROSS.
Edward Carter . . . . .	STEPHEN HADFIELD.
Major Fothergill . . . . .	CLIVE BARNES.
Mrs. Fulverton-Fane . . . . .	WENDY COLLARD.
Jane West . . . . .	MARGARET NEVILLE.
Arthur Ludgrove . . . . .	HAROLD RODGERS.
P. C. Mallet . . . . .	ROWLAND TAYLOR.
"Sergeant" Mallet . . . . .	JOHN NUNN.

The Play produced by STANHOPE FURBER.

Across the quiet of a Sussex house-party creeps a suggestive atmosphere of impending tragedy. Edward Carter, debonair and well-intentioned, suggests to Ludgrove, his host, that Edward Laverick is one of two criminals for whose imprisonment in Africa Ludgrove had been responsible, and who now is disguising behind his love of birds a murderous design upon the life of his host. Comes Laverick in true colours, and events move rapidly. Forewarned, Ludgrove covers his assailant with his revolver. Carter, the friend in need, rings for the police, turns Ludgrove's gun upon its unsuspecting owner two feet from the telephone receiver and Ludgrove has committed suicide.

This much through the fourth wall we see: alas! we cannot be summoned as witnesses by even that most efficient Sergeant Mallet from Scotland Yard. So suicide it has to be—while of unsound mind, of course. But the obvious conclusion drawn from undisputed facts never satisfies a woman with a prejudice. At midnight, before the astonished gaze of all of us who had been present at the murder, Ludgrove's ward, "knowing" that her guardian could not have committed suicide, finds her clues and reconstructs the case against—two murderers.

Next morning Carter realizes that his guilt has been discovered, and after a dramatic duel with Ludgrove's ward, he falls into the hands—or handcuffs—of Sergeant Mallet, foiled by a woman's wit and a piece of blotting-paper.

Stephen Hadfield (Edward Carter) plays the jaunty villain with a convincing air. It must have disappointed him that his victim had not time to realize the beauty of his plotted revenge, or ears to hear his apostrophe.

## STUDENTS' UNION.

### RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. R.M.A.

Result: Won, 20–8.

December 10th, at Woolwich.  
Played in a dense fog, this game was rather a one-sided affair. The Hospital, strengthened by the return of J. A. Nunn and C. B. Prowse, proved too experienced for the "Shop." The forwards established their superiority early, and the ball came back regularly. The outsidemen made good use of their opportunities. Yeungman, who scored two tries, made a fine run of more than half the length of the field to score under the post. Kirkwood converted. Other scorers were Powell (2), Jenkinson (1). Kirkwood scored a penalty goal.

ST. BARTHOLOMEW'S HOSPITAL v. NORTHAMPTON.

Result: Lost, 17–6.

December 13th, at Northampton.  
Played on a very heavy ground, this game resulted in a win for the home side by 17 points to 6. The lighter Bart.'s pack held their opponents and got their share of the ball in the set scrums, but the backs were outplayed by their opposite numbers, except Taylor, who had an exciting duel with Millward at the base of the scrum. Among the forwards Thompson, Harvey and Mundy played a fine game, and Harvey scored a try from a good charge down. The other scorer was Powell, who punted over the head of the full-back, and gathering in his stride, raced over to score far out. The concluding stages of the game found Northampton pressing and a great duel took place between the forwards.

ST. BARTHOLOMEW'S HOSPITAL v. HARLEQUINS.

Result: Lost, 21–0.

January 3rd, at Winchmore Hill.  
Bart.'s were without J. T. C. Taylor (who was away for the International Trial), Williams and Jenkins (on the injured list), but during the first half they put up a memorable struggle. A feature of this half and indeed of the whole game was the kicking of T. J. Ryan, the Bart.'s full back, who handled a wet, heavy ball with the utmost composure and kicked a very good length. The substitutes played well on the whole, and the score would have been much smaller if Bart.'s had not felt the effects of Christmas and fallen off in zeal towards the end. At half-time the score was only 8–0 against

ST. BARTHOLOMEW'S HOSPITAL v. COVENTRY.

Result: Lost 22–8.

January 17th, at Coventry.  
The ground was in good condition, but a very strong wind blew throughout the game. Bart.'s won the toss and took advantage of the wind in the first half, during which the side showed improved form. The Hospital were rather unfortunate to be in arrears at half-time, Coventry replying to a try by Mundy, which was converted by Ryan, with two unconverted tries. With the wind in their faces Bart.'s played up strongly and again took the lead, when a great run by Thomas gave Prowse the opportunity to score an unconverted try. Shortly afterwards Coventry scored a third unconverted try, and the scores remained at 9–8 for a considerable time. Towards the end, however, the superior weight and training of the home team began to tell, and these facts, coupled with some rather foolish errors by Bart.'s, led to three more tries being recorded against the Hospital during the last quarter of an hour.

Thompson, Mundy and Briggs were the pick of the Hospital forwards, while Baker showed promising form on his first appearance. J. T. C. Taylor was in excellent form at scrum-half and quite overshadowed Gascoigne.

His flash of temper in the last act revealed his true cruelty of disposition, in spite of which we found him a likeable enough fellow. Perhaps the greatest compliment that we can pay him is to say that he stood up well to the acting of Miss Violet Todd.

The Society was indeed lucky to engage the services of Miss Violet Todd, whose Susan Cunningham was a thoroughly excellent piece of acting. The "midnight" scene was hers absolutely, and her verbal duel with Hadfield "next morning" was the best thing in the show.

John Nunn showed great talent in his presentation of "Sergeant" Mallet, fortunately on holiday at the scene of the crime. He took charge of Act II and made a first-rate job of it.

These three were the chief parts, the other eight characters having only brief appearances. The real excellence of the production none the less owed much to the skill with which these parts were acted. Miss Wendy Collard was a delightful Mrs. Fulverton-Fane, and Miss Margaret Neville, as Jane West, had a glorious opportunity in the last act, of which she made full use.

Keith Vartan (Jimmy Ludgrove), as the victim's son, was not too happily cast, and his handling of the "midnight" scene was not altogether convincing. Derrick Coltart (Adams) gave us an admirable butler, and remembering his legal skill last year, we wished that he had had a larger part. Robert Cross (Edward Laverick), with his weird appearance and nervous utterance, provided a good contrast to his brother conspirator. Clive Barnes was Major Fothergill to perfection and took the house by storm. Harold Rodgers (Arthur Ludgrove) was unfortunately sacrificed when we had hardly got to know him; but he died beautifully. Rowland Taylor (P. C. Mallet) purveyed some magnificent comic relief: appearance and manner were excellent.

As for the producer, Mr. Stanhope Furber, with such material and with his O.U.D.S. experience, no wonder that he triumphed. Much in these productions depends on the ability of the producer to keep his actors together. Well done, Mr. Furber.

Two questions we have to ask:

- (1) Why was no official photograph of the show taken?
- (2) Why was the Hospital Musical Society *mechanized*?

The Amateur Dramatic Society is to be heartily congratulated upon its performance. The Society may have done things as well as this before, but one and all who saw the show are of opinion that it has never done anything better.

## HOCKEY CLUB.

## ST. BARTHOLOMEW'S HOSPITAL v. SITTINGBOURNE.

January 10th, at Sittingbourne.  
With snow the day before, a hard frost during the night and a fog in the morning, this match would probably have been scratched had not our opponents assured us they were anxious for a game, and that the weather conditions were better down in Kent.

By the afternoon the fog had lifted and the sun was out; but, the ground being white with snow, we had to play with a red ball. It took us some little while to get into the game, and before half-time Sittingbourne had scored; but we were pressing hard early in the second half when Heasman made us level with a good first-time shot. Jameson Evans had bad luck in just missing the post, and soon after this Sittingbourne scored again. Unfortunately their forwards then tried several long through-passes from which they scored two more goals. This should be a lesson to us to try these passes more often ourselves.

Snell at right half played well and the backs put up a very good defence, although the hard and slippery ground made it a difficult game for them.

Team: H. L. Hodgkinson (goal); F. C. Henton-White, P. M. Wright (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); C. A. Brockbank, L. P. Jameson Evans, A. J. Owston, L. Heasman, D. Gale (forwards).

## ST. BARTHOLOMEW'S HOSPITAL v. GLOUCESTERSHIRE REGIMENT.

January 14th, at Gravesend.  
This most enjoyable but rather scrappy game we just managed to win 7-6. Playing well together at the start, by half-time we were leading 4-1. After this the play became somewhat ragged, owing, perhaps, partly to the number of penalties for offside that were given against us, and partly to the happy crowd on the touchline supporting our opponents.

Owston played well at centre-forward, giving us five of our goals, the other two coming from Heasman and Iliff.

Team: J. L. D. Roberts (goal); F. C. Henton-White, D. Gale (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); C. A. Brockbank, L. P. Jameson Evans, A. J. Owston, L. Heasman, E. W. Burstal (forwards).

## ST. BARTHOLOMEW'S HOSPITAL v. READING UNIVERSITY.

January 17th, at Reading.  
This game, on a fine sunny afternoon, on a ground in excellent condition, resulted in a win for the Hospital 3-1. The play at first was very even. Our forwards, although often attacking, were unable to score, and our own goal had several narrow escapes from short-corners following penalties given in the circle. Hay-Shunker, after a long run down the field with Symonds, scored for us a moment before the whistle blew at half-time. Burstal and Jameson Evans gave us two more goals in the second half and Reading scored once just before the end.

Throughout the game our two outside players, taking the ball right up the wings several times; the two backs played hard, and Hodgkinson, in goal, made several good clearances.

Team: H. L. Hodgkinson (goal); C. A. Brockbank, D. Gale (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); R. T. Davidson, L. P. Jameson Evans, E. W. Burstal, C. L. Hay-Shunker, J. Symonds (forwards).

## ACKNOWLEDGMENTS.

The Birmingham Medical Review—The British Journal of Nursing—The Broadway—Bulletins et Mémoires de la Société de Médecine de Paris—L'Echo Médical du Nord—Les Echos de la Médecine—Guy's Hospital Gazette—The Hospital—The Kenya and East African Medical Journal—Leprosy Review—The London Hospital Gazette—The Medical College Magazine (Calcutta)—The Medical Journal of Australia—Medical Times and Lone Island Medical Journal—The Midland Hospital Journal—The Nursing Times—The Queen's Medical Magazine—The Royal Dental Hospital Magazine—St. George's Hospital Gazette—The St. Thomas's Hospital Gazette—The Student—The University of Toronto Medical Journal.

## REVIEWS.

SAINT BARTHOLOMEW'S HOSPITAL REPORTS. Vol. LXII. (London: John Murray, 1930.) Pp. xxv + 277. Illustrated. Price 15s. to subscribers; 21s. to non-subscribers.

The latest volume of the Hospital Reports is well up to the high standard expected of it.

The contents of the volume are as follows:

"In Memoriam: Sir Anthony Bowlby," by Mr. W. Girling Ball.  
"The New Surgical and Operation Blocks of St. Bartholomew's Hospital," by Mr. T. A. Lodge, F.R.I.B.A.  
"An Unusual Case of Tuberculous Meningitis," by Sir Thomas Horder.

"The Therapeutic Use of Diuretics in Cardiac Œdema," by Prof. Francis R. Plasec.

"Supra-renal Carcinoma and Virilism in Women," by Dr. W. Langdon Brown and Mr. W. Girling Ball.

"Metastatic Carcinoma of the Choroid," by Mr. R. Foster Moore and Dr. Geoffrey Evans.

"The Problem of the Ætiology of Hodgkin's Disease," by Dr. M. H. Gordon.

"The Application of Ovarian Physiology to Clinical Gynaecology," by Dr. Wilfred Shaw.

"The Period of Disability in Ambulatory Fractures," by Mr. Rupert S. Corbett.

"The Diagnosis of Bronchial Carcinoma," by Drs. Maxwell and Nicholson.

"Serum Treatment of Lobar Pneumonia," by Drs. Richard Armstrong and Johnson.

"Experimental Endocarditis Produced by Inoculation of Streptococcus Pyogenes," by Drs. Richard Armstrong and Roles.

"The Clinical Value of Transduodenal Biliary Drainage (Baly Scholarship Report)," by Dr. H. V. Dicks.

"Perforated Gastric and Duodenal Ulcers," by Mr. R. W. Raven.

In addition, there is a supplementary volume which ought to be of considerable value, and which is given to all subscribers free of charge. It deals with deep X-ray therapy in malignant disease and is written by Walter M. Levitt, and it is a report of the investigation carried out in 1924-29 under the direction of the St. Bartholomew's Hospital Cancer Research Committee.

The material, which is written by members of the Staff, chief assistants and house surgeons, is intended as a précis of the work done in the Hospital each year.

The Editorial Committee are anxious to increase the number of subscribers. The subscription for the volume is 15s. annually, and so non-subscribers the price is one guinea. Those who wish to subscribe should send their names to Mr. Girling Ball or to Dr. Geoffrey Evans, the Editors, or to Mr. R. C. Elmslie, the Treasurer, 1A, Portland Place, W. 1.

A TEXTBOOK FOR MENTAL NURSES. By ELIZABETH L. MACAULAY, O.B.E. (London: Faber & Faber, 1930.) Pp. 276. Illustrated. Price 6s.

This book is remarkable for its conciseness and its enormous range of matter. Miss Macaulay has provided what would easily serve for a text book of nursing for general nurses with special reference to mental disease. Of 276 pages, one chapter of 44 pages is devoted to mental diseases proper. This, however, is sufficient, for in a work of this size, intended for nurses, wordy theorizing on the mind and its diseases is not called for. Moreover, throughout the book, the scheme has been to treat general diseases and their aspects arising as complications in mental patients.

It is interesting to note that treatment by the shock of cold shower-baths was in use in England as late as 1914. The introductory parts on etiquette, hygiene, admission of patients and private nursing are well expressed. It is still stated that raw eggs and beet-tee may be given *per rectum* in nutrient enemata, although physiologists have shown that little other than solutions of crystalloids are absorbed.

The chapter on cookery is variable and attractive. Any reader's mouth will water on reading it.

In describing paracentesis abdominis it would be better to include novocaine for local anaesthesia rather than an ethyl chloride spray.

The authoress is delightfully frank, and the statement that "the factors to be taken into account in estimating the safety of anaesthetics are (i) the anaesthetist . . ." is rarely included in anaesthetic books; again, ethyl chloride spray is recommended as a local anaesthetic, novocaine being omitted.

The section on lotions is most useful: many nurses will feel thankful for the formulae for mixing these.

The classification of poisons is not a good one. It is confusing to make use of "corrosives" and "alkalis" in the main groups and then include "corrosive alkalis" under the latter group. Arsenic and lead are also put under the heading of "Alkalis."

In infectious diseases it is made to appear that "suppuration" is a characteristic of non-specific fevers as contrasted with specific ones. Otherwise the chapter is excellent. On p. 170, in discussing hæmorrhage from typhoid ulcer, surely the sentence should be re-written—"treatment is to further clotting, not to prevent it." The part on tuberculosis would well serve as a model for larger books.

The chapter on mental diseases, which the authoress presumably enjoyed writing more than any other, is commendably well balanced; she is to be congratulated on her restraint in keeping it within such reasonable bounds. A few pages of illustrations of useful appliances conclude the book, which can be recommended without hesitation to any nurse.

MORE RUTHLESS RHYMES FOR HEARTLESS HOMES. By HARRY GRAHAM. Illustrated by RIDGEWELL. (London: Edward Arnold & Co., 1930.) Price 3s. 6d. net.

Here is something for inclusion in the new pharmacopoeia of laughter. Mr. Graham's ruthless rhymes and Ridgewell's ruthless drawings are just what their old admirers would expect. Even the Index is an excuse for further jesting. *Rep. Mistura, please.*

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

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COBSI, H., F.R.C.S. "Pseudo-pelade of Broca." *Proceedings of the Royal Society of Medicine*, December, 1930.

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KETTLE, E. H., M.D. "The Relation of Dust to Infection." *Proceedings of the Royal Society of Medicine*, November, 1930.

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LLOYD, ERIC I., M.B., F.R.C.S. "2 Endothelioma of Foot." *Proceedings of the Royal Society of Medicine*, December, 1930.

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- WEBER, F. PARKES, M.D., F.R.C.P. "Telangiectasis Macularis Eruptiva Perstans—probably a Telangiectatic Variety of Urticaria Pigmentosa in an Adult." *Proceedings of the Royal Society of Medicine*, December, 1930.
- "Alopecia Totalis in a Young Woman." *Proceedings of the Royal Society of Medicine*, December, 1930.
- "Alopecia Totalis in a Boy after Slight Nervous Shock." *Proceedings of the Royal Society of Medicine*, December, 1930.
- (and SCHOLTZ, M., M.D.). "Anæmic Type of Hæmolytic Jaundice without Familial History." *Proceedings of the Royal Society of Medicine*, November, 1930.
- "Lesion of Both Auditory Nerves together with Several Other Cranial Nerves on the Left Side." *Proceedings of the Royal Society of Medicine*, December, 1930.
- "Anæmia with Splenomegaly." *Proceedings of the Royal Society of Medicine*, December, 1930.
- "Simple Achlorhydric Anæmia (L. J. Witts)." *Proceedings of the Royal Society of Medicine*, December, 1930.
- WOOLLAKI, H. H., M.D. "The Innervation of the Ocular Muscles." *Journal of Anatomy*, January, 1931.
- "The Growth of the Brain of the Australian Aboriginal." *Journal of Anatomy*, January, 1931.
- YATES, A. LOWNDES, M.D., F.R.C.S.(Edin.). "Repair in the Middle Ear." *Proceedings of the Royal Society of Medicine*, October, 1930.
- "Demonstration of Sound Records." *Proceedings of the Royal Society of Medicine*, October, 1930.

## EXAMINATIONS, ETC.

## University of Cambridge.

- First Examination for Medical and Surgical Degrees, December, 1930.*
- Part II. *Mechanics*.—Jones, D. W. G.
- Second Examination for Medical and Surgical Degrees, December, 1930.*
- Part I. *Organic Chemistry*.—Jones, D. W. G.
- Part II. *Human Anatomy and Physiology*.—Crosse, J. H. J.
- Third Examination for Medical and Surgical Degrees, December, 1930.*
- Part I. *Surgery, Midwifery and Gynaecology*.—Bell, W. D., Boston, F. K., Buckland, H. S., Gracet, G. H. A., Kersley, G. D., Lane, C. R. T., McGavin, D. B., Morrell, F. H., Scott, P. G., Stamp, T. C.
- Part II. *Principles and Practice of Physic, Pathology and Pharmacology*.—Barnes, C. O., Cross, R. M. S., Fordham, M. S. M., Harrison, J. O., Nicholson, W. A., Taylor, H.

## University of London.

- First Examination for Medical Degrees, December, 1930.*
- Pass.—Anderson, C., Baker, F. J. S., Bangay, E. B. D., Braithwaite, R. F., Dale, L. F., Dalley, G., Dancer, J. B., Dastur, H. K., Dransfield, C. M., Harvey, M. W., Jones, S. A., Mullick, S., Nairac, M. L., Prothero, D. A., Stoddart, W., Taylor, G. R.

## University of Liverpool.

The following Diploma has been conferred:  
D.T.M.—Hawking, F.

## Conjoint Examination Board.

- Pre-Medical Examination, January, 1931.*
- Chemistry*.—Force Jones, R. J., Sugden, K. H.
- Physics*.—Sugden, K. H.
- Biology*.—Jopling, W. H., Sugden, K. H.
- First Examination for Medical Degrees, January, 1931.*
- Anatomy and Physiology*.—Bressler, D. M., Fletcher, C., Lyons, R., Ranganathan, K. S.

*Anatomy*.—de Freitas, A. J. S., French, J., Palmer, T. I.

*Physiology*.—Cooper, H., Jenkins, J. K. R., Kelnar, I., Noordin, R. M., Rassim, H. S.

*Materia Medica and Pharmacology*.—Clark, E. M., Cutlack, A. R., Davidson, R. T., Dodson, E. E., Hay-Shunker, C. L., Sablin, N. S., Saunders, S. B. H., Vacher, A., Wilson, J. S. H., Woodforde, A. R., Wright, P. M.

## Royal College of Surgeons.

The following were successful at the examination held for the *Primary Fellowship*:  
Bryer, M., Davies, D. O., Lee, H. B., Raven, R. W., Shackman, R., Sinclair, C. G., Swain, V. A. J.

## APPOINTMENT.

WARD, W. ROY, M.B., B.S.(Lond.), appointed Senior Medical Officer to the Radium Institute, London.

## CHANGES OF ADDRESS.

GANDY, T. H., Brook House, Chubbury, Aston on Clun, Shropshire.

GIBBINS, H. B., 5, Southdown House, Silverdale Road, Eastbourne.

POSEL, M. M., P.O. Box 5868, Johannesburg, South Africa.

WARD, W. ROY, 71, Harley Street, W. 1. (Tel. Welbeck 4027.)

## BIRTHS.

ANDERSON.—On January 12th, 1931, at Ribblesdale House, Hornsey, N. 8, to Ivy ("Billie") (née Bilton), wife of Roy Shirras Anderson, M.R.C.S., L.R.C.P.—a daughter (prematurely), who died the following day.

CLAXTON.—On December 31st, 1930, to Muriel, wife of Dr. E. E. Claxton, The First House, Radnor Park Road, Folkestone—a son.

EMMONS.—On December 30th, 1930, at 36, Hyde Park Gardens, W. 2, to Ann and Robert V. B. Emons—a son.

POTTS.—On January 8th, 1931, to Nancy (née Hepworth), wife of Dr. J. L. Potts, of Wilton Road, Salisbury—a daughter.

VISICK.—On January 16th, 1931, at 25, High Petergate, York, to Christine (née Ruegg), and Arthur Visick—a daughter.

## MARRIAGES.

CROSS—SPENCER.—On January 21st, 1931, at Dundee, Flight Lieutenant B. W. Cross, Royal Air Force Medical Service, elder son of Dr. and Mrs. E. W. Cross, of Leytonstone, to Elizabeth Vera Spencer (née Warmolts).

MACDONALD—NEWBY-SIMONDS.—On January 19th, 1931, at St. Michael's Church, Bournemouth, by the Rev. Canon E. Moor, Vicar of St. Michael's, A. Robertson Macdonald, M.B., second son of the late Alex. Macdonald, of Highgate, to Joan, daughter of the late W. Newby-Simonds, of Birmingham.

## DEATHS.

AINGER.—On January 24th, 1931, at 7, Cadogan Place, S.W. 1, William Bradshaw Ainger, F.R.C.S.

BULL.—On December 27th, 1930, at Woodburn, Bucks, Agnes Bull (late Sister Faith), wife of the Rev. A. A. Bull.

## 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. C. J. WILLIAMS, 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.

Vol. XXXVIII. — No. 6.]

MARCH 1ST, 1931.

PRICE NINEPENCE.

## CALENDAR.

- Mon., Mar. 2.—Special Subject: Clinical Lecture by Mr. Higgs.
- Tues., " 3.—Prof. Fraser and Prof. Gask on duty.
- Wed., " 4.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.  
Hockey Match v. Staff College.
- Fri., " 6.—Sir Percival Hartley and Sir Holburt Waring on duty.  
Medicine: Clinical Lecture by Dr. C. M. Hinds Howell.
- Sat., " 7.—Rugby Match v. O.M.T.'s. Home.  
Association Match v. University College. Home.  
Hockey Match v. St. Lawrence College.
- Mon., " 9.—Special Subject: Clinical Lecture by Mr. Bedford Russell.
- Tues., " 10.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
- Wed., " 11.—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
- Fri., " 13.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.
- Sat., " 14.—Rugby Match v. London Irish. Home.  
Association Match v. St. Thomas's Hospital. Home.  
Hockey Match v. Old Felstedians. Home.
- Mon., " 16.—Special Subject: Clinical Lecture by Mr. Just.
- Tues., " 17.—Dr. Gow and Mr. Harold Brentwood on duty.
- Thurs., " 19.—Last day for receiving matter for the April issue of the Journal.
- Fri., " 20.—Prof. Fraser and Prof. Gask on duty.
- Sat., " 21.—Rugby Match v. London Scottish. Home.  
Association Match v. Old Brentwoods. Home.
- Tues., " 24.—Sir Percival Hartley and Sir Holburt Waring on duty.
- Fri., " 27.—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
- Sat., " 28.—Rugby Match v. Plymouth Albion. Away.
- Mon., " 30.—Rugby Match v. St. Ives. Away.
- Tues., " 31.—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.  
Rugby Match v. Bristol. Away.

## EDITORIAL.

## JOHN ABERNETHY BROADCASTS.

Three years ago William Harvey might have been seen on "the silver screen" neatly experimenting in honour of his own *De Motu Cordis*. Daily, for some weeks past, has one of our penny contemporaries translated the stirring episodes of history into modern jargonese. And now Dr. Abernethy has broadcasted. For a brief quarter of an hour those who wished might tap his consulting-room secrets, might hear him, bullying the rich for their gluttony and their pride, and the poor for their credulity and their gratitude.

So the newspaper paragraph, the cinema and the wireless, the three new sense-organs that the twentieth century has imposed upon us, play their part in popularizing history. The day of the private auscultation of history's heart-beats is gone; the giant phonendoscope, one chest-piece and a loud-speaker, is the modern mode. Though mildly we regret the change, yet we are glad that Abernethy was prevailed upon to broadcast. He came through the ordeal, slightly distorted, perhaps, but with credit, and it is comforting to know that, outside the school that he founded, his name has still, one hundred years after his death, for the world at large, a meaning.

## MORE "BOOKS BY BART'S MEN."

Sir Archibald Garrod has just published a new book, *The Inborn Factors in Disease* (Oxford University Press). In it he surveys the history of "diathesis" and discusses the underlying principles of predisposition. A review of this stimulating book will appear in a later issue.

In the present JOURNAL will be found reviews of Dr. Geoffrey Bourne's "broadly conceived and attractively written" *Introduction to Medical History and Case-taking*, and of Sir D'Arcy Power's *Selected Writings*. Rumour

has it that the Staff of the Hospital, active and consulting, is seething with literary activity, and several more books are to be expected shortly.

\* \* \*

A REMARKABLE TRIBUTE TO SIR HOLBURT WARING.

The following paragraph, which appeared recently in a well-known weekly paper, seems to merit reprinting: "Sir Holburt Waring, the famous surgeon of St. Bartholomew's Hospital, tells his students that no man should practise medicine without knowing what pain really means. His method of overcoming this handicap is probably unique. Every student who passes through his hands must submit to one of two tests: he must suffer without anaesthetic the removal of a toenail, or he must insert and remove a stomach tube.

"But no student who submits to these drastic tests of his courage may doubt the like quality in the famous examiner. Once Sir Holburt demonstrated his own attitude to physical suffering by removing his own appendix himself without anaesthetics!"

We have not been able to verify the truth of these statements.

\* \* \*

ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB.

The second meeting of the Club was held at the Holborn Restaurant on Wednesday, February 11th, at 7.15 p.m. After an excellent dinner, the Chairman, Prof. Gask, reported on the proposed Whitsun expedition to the Snowdon district, whither the energetic Secretary, Mr. G. H. Bradshaw, had already penetrated to reserve hotel accommodation. Further details would be announced later. The company then proceeded to the serious business of the evening, to hear (and to see) an illustrated lecture by Dr. L. P. Garrod on climbing in the Tyrol, and to watch a series of Kodak Alpine films. The enthusiastic attendance at both of the meetings held so far must be most gratifying to the founders, with its promise of a long and successful career for the Club. After a few more dinners Everest itself will hold no terrors for the members.

\* \* \*

EPSOM COLLEGE FOUNDATION.

The attention of all Bart.'s men who are Governors of Epsom College is called to the fact that the sons of two Bart.'s men are seeking election to Foundation Scholarships.

John Ridley Prentice is the eldest son of the late Dr. Hugh R. Prentice, who died in February, 1926, at the early age of 45. Educated at St. Bartholomew's, Dr. Prentice devoted himself particularly to neurology, and after being R.M.O. at the National Hospital, was elected to the staff of the Dreadnought Hospital, the West End

Hospital for Nervous Diseases and the Belgrave Hospital. During the war he held a commission in the Royal Navy.

Hugh Frederick Steele-Smith is the son of W. Steele-Smith, who was educated at Bristol and St. Bartholomew's, and after being in practice in Kent and in Manchester was compelled to give up in 1916 owing to ill-health.

\* \* \*

TENTH DECENNIAL CLUB.

The Tenth Decennial Club Dinner will be held as usual on the second Friday in May, *i.e.* May 8th. Dr. C. N. Binney will be in the Chair. Notices giving further details will be circulated later. Secretaries: Mr. Reginald M. Vick, Dr. Arnold W. Stott.

\* \* \*

BUSY BEES.

The Bart.'s Busy Bees held their annual Christmas Party in the Great Hall on Wednesday, January 14th. It was attended by nearly 300 Bees, and the Committee's thanks for its enormous success are particularly due to Mr. Vick for a delightful talk, Mr. Patrick Playfair for his conjuring, and to all the ladies who gave their help and time. A financial report will be found in *Deisuan*—the Bees' journal, published in May.

\* \* \*

Prof. F. R. Fraser will deliver a lecture on "The Hospital: Its Place in the Medical Curriculum," before the Cambridge University Medical Society, on Wednesday, March 11th.

\* \* \*

"B.M.A." ADDRESS.

Dr. Hector Charles Cameron, M.D., F.R.C.P., will deliver an address on "Children in Hospital and in the Home: A Contrast," at the British Medical Association House, Tavistock Square, on Tuesday, March 10th, 1931, at 5.30 p.m. The lecture is intended for those soon to be and those recently qualified.

\* \* \*

Sir George Newman, K.C.B., M.D., F.R.C.P., D.P.H., has been appointed a Fellow of King's College, London.

\* \* \*

The Julius Mickle Fellowship for 1931 has been awarded to Dr. C. H. Andrewes, M.B., B.S., M.D.

\* \* \*

Dr. A. A. Miles and Dr. E. T. C. Spooner have been appointed University Demonstrators in Pathology at Cambridge.

\* \* \*

Congratulations to the Rugby XV on their victory over Guy's, a stirring account of which appears on p. 124.

STOP PRESS.—Bart.'s v. King's, 16—3. Good luck on March 18th.

AVERTIN.

A REPORT OF 170 CASES.

"Sleep that knits up the ravelled sleeve of care,  
The death of each day's life, sore labour's bath,  
Dalm of hurt minds."—*Macbeth*, Act II, Scene 2.



In olden days the Elixir of Life gilded the dreams of alchemist and physician alike; nowadays the physician thinks in terms of ductless glands, and the scientist dwells upon the meaning of reality. And yet each one strives to wrest secrets from Nature for the good of humanity and the advancement of knowledge. Time alone sifts these discoveries, and eventually those things which were hailed as perfect are relegated to their proper realm, and each has its appointed place. So with avertin: the drug was originally recommended as a substitute for inhalation anaesthesia; it was said to prevent vomiting entirely, and to be that perfect anaesthetic that all anaesthetists desire and yet so far have not obtained. It is no longer attempted to obtain full anaesthesia with avertin, but a deep sleep is aimed at which renders nitrous oxide oxygen an adequate adjuvant to produce satisfactory anaesthesia. With regard to vomiting, one can almost guarantee absence of this distressing occurrence if gas oxygen only is used, but if ether has to be added to produce full relaxation then the risk of sickness increases with the amount of ether inhaled.

Patients fear the anaesthetic more than anything else, and their apprehension is due to a horror of suffocation. This fear on the part of the patient can be banished entirely by the use of avertin, the patient just falling asleep in her own bed amidst familiar surroundings, and waking up as from a normal sleep.

PREPARATION AND METHOD OF USE.

Tribromethyl alcohol is a white crystalline solid, soluble in water with difficulty. It is sold commercially in liquid form dissolved in amylene hydrate, 1 c.c. of the fluid being equivalent to 1 gm. of solid avertin. Heat causes decomposition to hydrobromic acid and dibromoacetaldehyde. Both these substances are very irritant, so that care must be exercised in the preparation. The manufacturers quite rightly emphasize this risk of decomposition, and one felt at first that this was a very serious drawback to the use of the drug. However, the writer has carried out tests, and found that only after repeated boiling did hydrobromic acid make its appearance. The required dose of avertin is added to distilled water sufficient to make a 3% solution. The distilled water should be warmed to 100–105° F. before

adding the avertin, and into this should be dropped sufficient Congo red 1 in 1000 to make the fluid just faintly pink. This latter is added as an indicator, the solution turning blue if hydrobromic acid is formed. If the distilled water be not warmed first the avertin will separate out, and then much shaking will be necessary to obtain complete solution. The preparation does not really take more than five minutes.

DOSAGE.

This is based on the patient's body-weight, and experience is necessary in this matter, for other factors enter in as well. Elderly and feeble patients require less, and children need relatively more. There seems to be a minimal effective dose, so that the less the patient weighs the more avertin per kg. body-weight is required. For instance, a child of 3 st. in weight will need 0.1 gm. avertin per kg. body weight, whereas an adult of 16 st. will require only .07 to .08 gm. per kg.

For general use the writer recommends a dose of .08 gm. per kg., and for those patients with hyperthyroidism 0.1 to 0.11 gm. per kg.

Morphine  $\frac{1}{2}$  gr. is given 1½ hours before operation, and the avertin fluid in solution is run *in per rectum* one hour before operation.

Children are not given any preliminary morphine, and the dose of avertin used is 0.1 gm. per kg. body-weight, and is given at least half an hour before coming to the theatre.

PREPARATION AND POSITION OF PATIENT.

It is preferable to give an enema the night before operation, but this is by no means absolutely necessary. If the rectum be full, absorption is slow, and the drug may fail to act. Glucose by mouth is recommended during the 24 hours preceding operation.

The patient is placed on her left side with the buttocks well raised so as to encourage the fluid to run well up the bowel. It is at this stage that the patient should be relieved of any dentures! The solution is run in through an ordinary rubber catheter with funnel attached, and usually the avertin can be allowed to enter quite quickly, as the bulk seldom exceeds 200 c.c. One need not spend more than five minutes over this procedure, and the patient is usually asleep within ten minutes. Speech gets thicker and thicker, and sleep comes quite suddenly. The patient should not be disturbed now for half an hour, when a small hypodermic dose (gr.  $\frac{1}{150}$ ) of atropine may be given.

The appearance of the patient at this stage resembles



normal sleep. Respiration is easy and quiet, there is no cyanosis, and the pupil is pin-point whether morphia has been given or not. The corneal reflex is sometimes absent, or very sluggish.

Cyanosis is due to imperfect airway or overdose. It need hardly be stressed that the patient should never be left, for there is a remote possibility that the tongue may slip back and obstruct the airway.

#### CHOICE OF ANÆSTHETIC.

Nitrous oxide and oxygen suffices for everything except upper abdominal operations; and the oxygen percentage is not critical. Anæsthesia can be maintained with ease, and no cyanosis should be allowed. As respiration is sometimes rather depressed carbon dioxide is recommended for stimulation of the respiratory centre, so as to enable sufficient ether to be absorbed to obtain relaxation. Local infiltration of the abdominal wall proves a most satisfactory combination. Spinal anæsthesia should be used with extreme caution.

#### INDICATIONS.

For the very nervous individual, be he child or adult, avertin and nitrous oxide oxygen offer an almost ideal combination. Post-operative excitement is very rare indeed.

Avertin is indicated particularly in patients who are known to be very sick after anæsthetics. It is pathetic to see how grateful such patients are who have avertin under these circumstances, and not a little gratifying to the anæsthetist for the extra time and trouble taken. With nervous children particularly avertin is at its best, for they frequently awaken loudly demanding food!

#### CONTRA-INDICATIONS.

As avertin is excreted by the kidney it is contra-indicated in severe renal disease, and there is some evidence of its having a toxic action upon the liver, so that it should not be used where liver damage is suspected.

Hæmorrhoids and fissure in ano are no bar to the use of avertin, but when operations are to be performed on the rectum or anus it is necessary to wash out the lower bowel immediately prior to the commencement of the operation.

#### DURATION OF POST-OPERATIVE SLEEP.

This is very variable. It depends largely upon the dose used. Usually the patient sleeps for some 3 hours

after operation, and memory returns to the patient one hour after this. The patient may apparently be fully round and talk quite intelligently, and yet remember nothing of this conversation a few hours later. Some patients come round almost immediately, and others sleep for 5 or 6 hours.

#### FAILURES.

"Sleep that cometh to all came not to him."

Some five or six cases of this series have not been asleep on coming to the theatre. In two, certainly, the dosage was on the small side. In two others the rectum was loaded with faces. Four of them did not remember coming to the theatre.

#### COMPLICATIONS.

In another country death has followed the use of avertin, but this was due to the attempt to obtain full surgical anæsthesia. Given in the small doses as used now, the writer feels confident that no trouble will ensue, provided the preliminary use of morphine is cut down to a minimum. The writer has had one death in this series; this was a patient who had been given avertin in combination with a high spinal anæsthetic. She collapsed and died some eight hours after a long and very difficult exploration of the gall-bladder region. Pulmonary complications have been markedly absent, except in the case of one man who was definitely a bronchitic, and he had a slight attack of bronchitis following his operation.

#### POST-OPERATIVE EXCITEMENT.

One patient was really violent afterwards for about a quarter of an hour. He was a man who had had his sciatic nerve stretched. It was his second dose of avertin within eight days, and yet after the first dose (injection of sciatic nerve with normal saline) he was quite normal. After the injection of morphine he soon became quiet.

	Vomit once or twice.	Vomit more than twice.	No vomit at all.
Total cases . . . . .	170	43 (26.3%)	127 (73.7%)
Cases where nitrous oxide and oxygen only was used . . . . .	100	17 (17%)	83 (83%)
Cases where ether was used as well in greater or lesser amount (i.e. upper abdominals, excluding gastrostomies and appendicectomies) . . . . .	25	7 (28%)	18 (72%)

Total.	Vomit once or twice.	Vomit more than twice.	No vomit at all.
Breasts . . . . .	20	6 (30%)	14 (70%)
Appendices . . . . .	18	8 (44%)	10 (56%)
Hernias . . . . .	21	1 (5%)	20 (95%)
Gastrostomies . . . . .	7	1 (14%)	6 (86%)
Thyroids . . . . .	23	5 (22%)	18 (78%)
Upper abdomen* . . . . .	35	7 (20%)	28 (80%)

These results tend to demonstrate that the addition of ether causes a rise in the incidence of vomiting. The presence of blood in the stomach after gastro-enterostomy is apt to precipitate sickness, but on comparing the results of gastro-enterostomy with those obtained with cholecystectomy it would appear that the presence of blood in the stomach as a cause of vomiting is negligible, as compared with the stimulation of the sympathetic by traction on and around the gall-bladder, and by the fact that more ether is required to maintain relaxation under these circumstances. The figures are self-explanatory, and the writer ventures to suggest that the results show that avertin definitely decreases the amount of after-sickness. He finds that patients are now demanding this drug and are most enthusiastic about it. There is no difficulty in using it as a routine in hospital, thanks to the active co-operation of the nursing staff involved.

#### CONCLUSIONS.

1. Avertin is a great advance, and in proper dosage is quite safe.
2. The dosage recommended .08 gm. per kg. body-weight, with preliminary morphine  $\frac{1}{4}$  gm., or .1 gm. per kg. body-weight if no morphine used.
3. Nitrous oxide oxygen is necessary to complete the anæsthesia.
4. The likelihood of vomiting depends largely on the amount of ether used.
5. Vomiting is absent in most patients: its absence can almost be guaranteed if nitrous oxide oxygen only be used.
6. It is strongly recommended for the patient who has a history of being very sick after ordinary anæsthesia, and for the highly nervous individual.

The writer has attempted to give in the foregoing some description of the technique of avertin administration, and to put on record the results as accurately as possible. It seems that with avertin the patient is sick only once or twice, if at all, whereas with ordinary

\* Cholecystectomies, gastro-enterostomies and gastrectomies, excluding gastrostomies. Of these 6 were combined spinal percaïn and avertin. 3 were sick and 3 were not. (One died some hours later of collapse.)

general anæsthesia the patient is much more uncomfortable and vomits more frequently. Patients are now asking for avertin after once having had it.

Truly "The old order changeth, yielding place to new."

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FRANKIS T. EVANS.

#### VARICOSE VEINS: THE CONTRA-INDICATIONS TO INJECTION TREATMENT.

**D**URING the course of the past few years injection treatment of varicose veins has entirely replaced operative measures. Yet the very success and simplicity of the new method have brought with them the danger of over-enthusiasm. It is under these circumstances that one is at times confronted with an attitude of mind on the part of the medical adviser which may be briefly summed up—"Here's a varicose vein, let's inject it!" When it is remembered that approximately 10% of all varicose vein cases presenting themselves for treatment have conditions which either temporarily or permanently render them entirely unsuitable subjects for injection therapy, it is obvious that such an uncritical outlook can only bring discredit on an established and valuable method of treatment.

In every case where injection treatment is contemplated a detailed case-history must always be taken, and the information gained from this will, as a general rule, enable the surgeon to eliminate many of the unsuitable cases. As regards the clinical examination, this should always be a complete one in every case where the history suggests that the varicose condition may be the result of some previous disease or associated

with some serious systemic disease. The points of special importance in the history and in the clinical examination are more fully discussed later.

If, on the other hand, varicose veins are treated as mere trivialities and ordinary clinical care disregarded, then unsuitable cases are bound to be given injections, with the result that patients are made worse by treatment or are subjected to grave risks.

The present article in no way discusses the question of the merits or demerits of the various solutions in current use for bringing about thrombosis, and the contra-indications mentioned are contra-indications to all forms of injection treatment. These are discussed under the following headings:

- A. Permanent contra-indications.
- B. Temporary contra-indications.
- C. Conditions where caution is necessary.

#### A. PERMANENT CONTRA-INDICATIONS.

In the majority of cases varicose veins are primary or idiopathic, but in a certain proportion of cases they are secondary or compensatory, and develop as the result of obstruction of the deep veins of the limb. It is to this latter group of cases that attention is especially directed here.

The deep veins of the lower limb may become thrombosed from a variety of causes, the most important being white leg, typhoid fever, and as a post-operative complication. No matter in which of these ways the obstruction of the deep veins is brought about, the onset of the condition is associated with pain in the limb, a variable degree of swelling and œdema of the foot, leg, and possibly lower part of the thigh. In the course of time the acute symptoms subside, but for years, or even permanently, the affected limb is larger than its fellow, is painful and weak, and tends to increase in size from œdema towards the end of the day.

At the same time a collateral venous circulation is established to help in getting rid of the blood from the deeper parts of the limb. This collateral circulation may be in deeper veins which are not thrombosed, or it may be in the superficial veins of the limb, which then often become varicose as the result of the extra work thrown upon them. The femoral veins in such cases being impervious, the superficial varicose veins have to run above Poupart's ligament before they can anastomose with veins of the trunk. It is not unusual under these circumstances to find a varicose condition of the superficial circumflex iliac, the superficial epigastric, or the superficial external pudic veins, with the blood-flow passing in a reverse direction to the normal. For example, in a patient recently seen who had had deep

thrombosis of both legs following appendicectomy, the varicose internal saphenous veins of both limbs drained directly into varicose superficial epigastric veins which reached as high as the fourth intercostal spaces.

In cases such as these where the history is suggestive of a thrombosis in the deep veins, or where dilated veins are present above Poupart's ligament, or where œdema is present in the foot or leg, injections are absolutely and permanently contra-indicated. The varicose process must be recognized as a compensatory one, and any interference with it by obstructing superficial venous channels is only likely further seriously to incommode a severely damaged circulation which is doing its best to carry on. Should injections be given in these cases, the pain and œdema are almost certain to be increased, and at worst may lead to actual gangrene of the limb.

On rare occasions patients are seen where the history of deep thrombosis appears certain, but where no physical signs of a damaged circulation can be made out on examination. Such cases are wisely left alone, and in no case should treatment be considered without seeking a second opinion.

1. *White leg.*—In practice this is by far the commonest permanent contra-indication to injection treatment, and in every female patient the question of pregnancies and their complications should be elicited fully in the history. The onset of the condition may occur during the first few days after labour, or it may be delayed for ten or fourteen days, till the time the patient is beginning to get about again. The term itself is usually understood by the majority of women.

2. *Typhoid fever.*—The typhoid group of infections is not a common one, but it is in practice rather surprising to find the number of patients of the older generation who have had the disease at some time or another. Both arterial and venous thrombi may occur either during the active stage of the disease or during convalescence, and the complications are ones which must always be borne in mind.

3. *Post-operative thrombosis.*—Though this may follow any surgical procedure, it is most often seen after abdominal operations. In its symptomatology and clinical course it does not differ from the other types described.

4. *Subacute phlebitis involving superficial and deep veins.*—This condition differs from the preceding in that the main vein of the limb is not obstructed, but there is a localized thrombosis of both superficial and deep veins. From the point of view of the patient the history is usually one of long-standing varicose veins, which at some time or other began to get very painful, hard and swollen in a localized area. The symptoms persist, and the area of their extent gradually increases. Clinical examination reveals palpable thrombosed veins

over a certain area, usually the lower part of the calf, with a variable degree of brawny œdema of the tissues around, the whole region being definitely but not acutely tender, and in most instances well demarcated from the adjacent healthy tissues. The underlying pathological change in such cases is a mild phlebitis which never entirely undergoes resolution, but gradually leads to the thrombosis of the superficial and deep communicating veins in a given area of the limb. Where this condition is present, treatment of non-thrombosed veins by injections either leads to no improvement in the condition, or may actually aggravate the symptoms.

#### B. TEMPORARY CONTRA-INDICATIONS.

1. *Acute phlebitis.*—This may follow trauma, or it may occur spontaneously as the result of a low-grade infection. In practice it is quite impossible to say how far these two elements are determining factors in any given case. Hence all cases of phlebitis of the superficial veins must, therefore, be regarded as having an actual or potential infective element. Injection treatment during the course of phlebitis will thus merely add fuel to the flames, and as infected clots are softer and much more liable to detachment than those occurring after therapeutic thrombosis, embolic accidents may occur. It is certain that some of the recorded cases of pulmonary emboli which have occurred after injection treatment have arisen through injections having been given soon after an attack of phlebitis.

If the rule of always allowing an interval of at least six months to elapse after the subsidence of the acute symptoms of the phlebitis before carrying out injections is strictly adhered to, such risks are avoided. Even if the varicosities are bilateral and the phlebitis unilateral, it is unwise to treat the apparently healthy limb until this interval has elapsed.

Patients are occasionally seen who give a history of recurrent attacks of phlebitis every few months. Before considering the question of injection all possible causes of focal sepsis must be sought and eradicated. In some cases the frequency of the attacks of phlebitis is such that injection treatment should never be given. For example, a young woman referred to the writer for treatment gave a history of eleven attacks of phlebitis in the lower limbs and four in the upper limbs. During the course of two of these attacks she had had symptoms and signs indicative of small pulmonary emboli. In addition to the above there had also been a bilateral white leg following the birth of a child. Excluding for the moment the latter complication, which entirely contra-indicated any form of injection treatment, to give injections to a patient of this type would be to incur

grave risks. Such patients should be regarded as thrombus and embolus factories and avoided like the plague!

2. *Pregnancy.*—In general the injection treatment of varicose veins during pregnancy is not recommended, but it should be delayed until this is terminated, when the veins are smaller and much more easily dealt with. When, however, veins are causing definite hardship to the patient and rendering life a misery, some of them may be justifiably treated, but quinine must not be used.

3. *Sepsis.*—The ordinary complications such as varicose dermatitis and ulcer are not included here, but local infective processes such as furuncles, etc., in the area adjacent to the veins are intended. Whenever these latter are present, injections should be delayed until all infection has resolved.

#### C. CONDITIONS WHERE CAUTION IS NECESSARY.

1. *Cardiac disease.*—There is no reason why cases of compensated cardiac disease should be denied treatment, and in practice they respond normally. On the other hand, if there are any indications of failing compensation, injection must on no account be carried out.

2. *High blood-pressure.*—Other things being equal, a considerable increase in blood-pressure does not contra-indicate treatment. Varicose veins may at times give rise to symptoms indistinguishable from those of intermittent claudication, and in several cases of this type where varicose veins were associated with blood-pressures over 200 mm. Hg, the cure of the veins led to the relief of the symptoms.

3. *Renal disease.*—Provided no signs of renal failure are present treatment is not contra-indicated.

4. *Diabetes.*—This disease does not contra-indicate treatment, but in carrying it out the most stringent precautions to prevent anything in the nature of sepsis must be adopted.

5. *Age.*—Advanced age alone is no contra-indication to injection. The only questions to be considered are the degree of activity of which the patient is capable, the extent of the symptoms referable to the veins, and the amount of improvement likely to arise from their cure.

#### SUMMARY.

1. A certain proportion of patients with varicose veins are either permanently or temporarily unsuitable subjects for injection treatment, and the carrying out of injections in such patients may lead to serious complications.

2. These cases may readily be eliminated by careful history-taking and thorough clinical examination.

3. In taking the history of varicose vein patients, special importance is attached to the occurrence of white-leg, typhoid fever, post-operative thrombosis, phlebitis in all its forms, and, of course, serious systemic diseases.

4. In carrying out the clinical examination the discovery of any of the following should put one on one's guard—local or general oedema of one or both legs, evidence of active or recent phlebitis, and the presence of varicose veins above Poupart's ligament.

5. Finally it may be pointed out that uncomplicated varicose veins never cause any oedema. Only in the presence of dermatitis, ulceration, phlebitis, periostitis or deep thrombosis does oedema arise secondarily.

REGINALD T. PAYNE.

## A TREATMENT OF MIGRAINE.



MIGRAINE is a common malady. Its aetiology is little understood, and its treatment has so far been unsatisfactory.

There is a definite migraine diathesis which is met with in several members of successive generations of the same family. It is a notable fact that sufferers from migraine are alert, intelligent people, and are commonly professional men and women. The disease remains with them from early childhood through adolescence, until old age sometimes brings relief. It occurs with equal frequency in both sexes.

Nothing incapacitates so completely as this distressing hemicrania. Sufferers seek relief in dieting, they visit specialists, are tested for defects of vision and the vast majority get little relief.

Recently Hurst has stated that the chemical constitution of the body-fluids is not exactly the same in all healthy individuals. He believes that the slight variations from the normal form the basis of the congenital and often the inherited tendency to develop certain diseases. He considers that the asthma diathesis is caused by a slight permanent deviation from the normal blood chemistry, resulting in a disturbed balance of the "vagal-sympathetic-bronchial" nervous system. Many authorities place asthma, epilepsy and migraine in the same category because of their symptomatic similarities.

All sufferers can trace their migraine to early infancy. Frequent unaccountable bilious attacks can be remembered. The migraine childhood is punctuated by paroxysmal metabolic disturbances with violent headache, which is relieved only by acid release phe-

nomena. The vomit and urine at the height of an attack are highly acid. Ketonuria and dyspnoea also occur. When sufficient acid has been eliminated the patient recovers but still remains the so-called acidosis patient and awaits the next attack. This cyclical vomiting slowly changes through adolescence to the adult migraine.

Migraine is due, in my opinion, to an inborn error of metabolism. There is a state of chronic metabolic disturbance causing an increased hydrogen ion content of the blood, with the subsequent permanent slight reduction of the sodium bicarbonate alkali reserve. It is known that acidosis causes a reduction of available calcium, which results always in an excitability of the nervous system.

Nervous excitability due to hypocalcemia is well demonstrated in the convulsions of rickets and the spasmophilia of tetany. Migraine occurs in chronic nephritis as a symptom of uraemia where acidosis and hypocalcemia are known to be present. It is certain that the acidosis effect on the alkali reserve is accumulative, and that the periodic attacks are an effort of Nature to relieve the excessive acid. Occasionally the attack is determined by some factor that further upsets this disturbed metabolism, such as a dietetic error or physical or nervous fatigue.

Asthma is due to nervous excitability affecting the vagal-sympathetic control of the bronchial tubes. Migraine is due to nervous excitability especially selecting the cervical sympathetic plexus.

The cervical sympathetic trunk is closely connected with the coeliac plexus and the vagus nerves. It joins with the cervical nerves to supply the sensory branches over the neck and shoulders. Fibres pass along the carotid arteries to act as vaso-constrictors. Certain other fibres pass along the internal carotid artery to reach the Gasserian ganglion, passing through to the ophthalmic division of the fifth nerve. These latter fibres are excitatory to the fifth nerve as a whole and to the ophthalmic branch in particular. The intense ophthalmic pain in migraine is due to the stimulation of these sensory fibres.

According to my experience the typical migraine attack may be divided into three stages:

*Stage I.*—The patient retires to bed with a feeling of fatigue, sleeps heavily, and wakes with the knowledge of an impending headache. The sympathetic nervous system is profoundly affected. He feels limp and languid, his blood-pressure and temperature are low. His face is pale and sometimes sweating. Anorexia and a vague throbbing at the back of the eyeball announce the onset of an attack.

As the morning progresses the cervical sympathetic

excitation causes spasm of the internal carotid and its branches. These comprise the retinal and facial arteries, the terminal branches to the frontal lobes, and the Rolandic and speech centres. Intellectual activity is arrested. Paræsthesias, hemi- and monoplegias and aphasia may occur.

Examination by the ophthalmoscope shows the retinal arteries to be in a state of spasm. Vaso-constrictor fibres can be traced to these small arteries which do not anastomose with each other. This lack of anastomosis causes an absolute loss of nutrition to groups of retinal cells during this stage. All degrees of visual disturbances may thus occur, from general mistiness, scotomata and hemianopia to complete blindness. Visual recovery is always complete at the end of stage II.

There is also intense ophthalmic pain, with dilatation of the pupil and retraction of the upper lid, accompanied by increased ocular tension and photophobia. It requires a conscious effort on the part of the patient to close the eye, and the orbicularis palpebrarum may even be in a state of spasm. The pain becomes a hemicrania due to involvement of the rest of the fifth nerve, and may extend through the cervical plexus over the neck and shoulder.

*Stage II.*—After hours have been passed in a state of psychological and physical collapse the vagus comes into action, and the excessive acid is disposed of by vomiting.

The kidneys excrete highly acid urine and the patient drops into a deep sleep. That there is a close connection between the ophthalmic sensory system and the vomiting centre is well shown in acute glaucoma.

*Stage III.*—The arterial spasm is released and the whole carotid system is engorged with blood. This is analogous to the venous congestion seen in Raynaud's disease when the initial arterial spasm passes off.

A study of the anatomy of the cavernous sinus explains the ophthalmoplegia which sometimes follows migraine. The cavernous sinus becomes engorged with blood, and compresses the cranial nerves found on its outer margin. The third, fourth and sixth nerves lie between the sinus and its firm outer covering of dura mater. Diplopia and strabismus may result, but recovery always occurs. In thrombosis of the cavernous sinus these nerves are often permanently affected. The following day finds the patient recovered but still asthenic.

Many variations of migraine may occur. The headaches may be bilateral. Minor attacks occur without vomiting or headache, causing slight visual disturbance and transient motor or sensory phenomena. The attacks may be at two or three days' interval, at week-ends, several months apart, or continuous, since the degree of acidosis varies with the individual patient.

## TREATMENT.

It is necessary to give sodium bicarbonate and calcium to correct the disturbed metabolism. This is given in tablet or cachet form early in the morning. No food should be taken for an hour afterwards in order to prevent any saponification of calcium.

R Calcium lactate . . . . . gr. x  
Sodium bicarbonate . . . . . gr. x  
*Fiat cachet.*

Two cachets should be taken daily for three months, and thereafter one cachet daily.

The following cases have been taken from a series I have treated by this method during the last three years:

CASE 1.—Mrs. S—, æt. 54. Bilious attacks in childhood. Migraine in adult life aggravated by menopause at 47. Typical migraine at four weekly intervals with involvement of the speech centre. During the attacks she was incapacitated for two days. Between attacks she also suffered from morning headaches and anorexia with sickness every two or three days. A nervous, intelligent patient who had had various investigations and courses of treatment without relief. Started cachets in January, 1929, and has had no migraine since.

CASE 2.—Mr. P—, æt. 50; organ builder. Cyclical vomiting in childhood. Severe migraine since adolescence. His attacks were left-sided, with aphasia and right hemi-paresis. Often in a state of coma for hours. On one occasion he was severely burnt on the leg through slipping in the fire during coma. He had no knowledge of this accident until afterwards. Daily morning headaches with anorexia. Commenced treatment two years ago. No migraine or headaches since. He has gained 16 lb. in weight.

CASE 3.—Miss F—, æt. 45; magistrate. Bilious vomiting in childhood, followed by migraine in adult life. Severe attacks lasting two days. Completely incapacitated. Attacks occurred at 4-6 weeks' interval. No migraine for two years.

CASE 4.—Mrs. C—, æt. 40. Bilious attacks in childhood followed by migraine in adult life. Severe attacks lasting two days at four weeks' interval. This patient has had numerous investigations and rigid dieting. No migraine for two years.

CASE 5.—Master S—, æt. 7. Cyclical vomiting at 6 weeks' interval with collapse, and ketonuria. A nervous child of the negative type. One cachet each morning has relieved him for 12 months.

In conclusion, migraine is due to a congenital and often inherited error of metabolism, causing a permanent slight acidosis with a resultant diminution of the alkali blood reserve and blood calcium. This acidosis effect

is accumulative, causing a paroxysmal excitability of the sympathetic nervous system especially involving the cervical plexus. This condition may be corrected by the addition of sodium bicarbonate and calcium lactate to the daily menu.

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RICHARD W. TAYLOR.

### SQUAMOUS-CELL CARCINOMA OF THE RENAL PELVIS.

**S**QUAMOUS-CELL carcinoma is stated to be the rarest of all types of malignant growths of the renal pelvis. As far as can be ascertained only three have been reported from this Hospital; all of these were reported by Mr. Geoffrey Keynes in 1924; up to that time only 60 cases appeared in the literature on this subject. Since then 6 more cases have been recorded, five by Scholl and Foulds from the Mayo Clinic, and one by J. A. Rowen and G. A. Bennett, of the Peter Bent Brigham Hospital, Boston. This brings up the number of cases to 65.

There has been considerable discussion as to their mode of origin, but nearly all authorities agree that it is the result of some localized chronic irritation.

In the literature numerous cases have been ascribed to long-standing renal calculi, but Miller and Herbst have shown that of 54 cases examined 10 only can be attributed to renal calculi. Mock, on the other hand, quotes 14.8% as the true figure for the presence of stone, whilst Albarran puts it as low as 6.2%. It is necessary, therefore, to look for some other predisposing cause.

Numerous writers have suggested long-standing infection as a possible cause. Cumming has shown that the normal transitional epithelium can become replaced by a many-layered coating of stratified squamous epithelium with superficial keratinization. This condition, leukoplakia, he states, is associated with infection, stone, and hydronephrosis. Other writers suggest that leukoplakia is a definite forerunner of the squamous-cell carcinoma of the renal pelvis. It seems possible that the condition as described by Cumming might easily be a stage immediately previous to that of malignant change.

It follows that the three associated conditions, namely

infection, stone and hydronephrosis, must also be taken into consideration. This view is further strengthened by the fact that in the majority of cases bacterial infection was present in some form or other. Hydronephrosis, however, was not so common.

Miller and Herbst state that growths of the renal pelvis are common amongst aniline and chemical workers, such growths being usually transitional-celled papilloma or carcinoma arising from such papilloma.

The most constant symptom is that of painless hematuria, and it may be present for a considerable time before any pain is felt.

Prognosis is extremely bad in all cases; the patients rarely live more than six months after operation.

Distant metastases are common in the majority of cases, and show the same structure (Schmorl).

Mrs. J. S—, a pallid woman, *et. 59*, boarding-house keeper, was admitted to St. Bartholomew's Hospital on September 30th, 1930. She gave the following history:

In February, 1902, she was operated on by Sir Holburt Wiring for dermoid cyst of the left ovary. At operation the cyst was found to contain hair and sebaceous material. The pedicle was transfixed and the cyst removed. It was further noticed that the cyst was pressing on the left ureter and that a left hydronephrosis was present. This was reduced by pressure with the hand. Patient made an uninterrupted recovery.

In 1920 she noticed a lump the size of an egg in the left loin. It gave her no pain or discomfort. In 1925 her urine began to give her trouble. Her urine was pale, scanty, very thick and smelt badly. The lump in her loin was larger, but it still gave her no pain or discomfort. Her frequency at this time was D/N = 4/5-6. The condition then had continued, the lump had gradually grown larger, until in August, 1930, she began to feel ill. There was no change in her urine. Her frequency was now D/N = 2-3/3-6. There was no vomiting or nausea, but there was a loss of weight and of appetite. She felt weak and tired, and above all she had in her left loin a dull aching pain which did not radiate downwards. Her periods, which had been normal, ceased at the age of 40. There was no discharge at any time.

#### Condition on Examination.

**Abdomen.**—Left paramedian subumbilical scar present and sound. The abdomen was full in the left loin and left hypogastrium. On palpation there was a smooth tense tumour. It had deep, rounded margins. Edges were well defined but the contours were not quite regular. It was egg-shaped and measured 7 in. by 5 in. Fluctuation was present. It was tender, and was only just moveable in all directions. It did not arise from the pelvis, and it could be pushed into the loin and palpated bimanually. The long axis pointed downwards and inwards from the loin. It was dull to percussion.

**Urine.**—Thick and whitish; yellow deposit; foul odour; acid. Sp. gr. 1017; albumen + +. Blood and pus microscopically.

On September 16th, 1930, an operation for drainage of a pyonephrosis was performed by Mr. Geoffrey Keynes. A large amount of thick, flocculent, foul-smelling pus was withdrawn.

**After operation.**—A hard mass was palpated on the left side. It was irregular in shape, the surface was nodular, and it had well-defined edges and was moveable. It was 5 in. by 4 in. in size. An X-ray examination showed that there was an enormous branched, laminated calculus lying in the left loin.

A second operation for nephrectomy was performed by Mr. Geoffrey Keynes on October 24th, 1930. This, however, proved to be impossible owing to the numerous adhesions of the kidney to the surrounding structures. Instead, the calculus, weighing 93 grms., was removed. After the operation the patient made a good recovery until November 13th, when she complained of incontinence of urine and of tæces. This condition gradually grew worse and she died on November 23rd. During the later stages wasting was very apparent.

#### Post-Mortem Examination.

On November 24th a post-mortem examination was made, the report being as follows: Body of an extremely emaciated woman. Scar of oblique lumbar incision on left side. Healed except at lower end.

Congestion of both bases of lungs. No secondary deposits in the pleurae.

**Peritoneum.**—**Alimentary canal:** No free fluid. The whole of the visceral and peritoneal surface was covered with small gelatinous grey nodules  $\frac{1}{4}$  to  $\frac{1}{2}$  in. in diameter, coils of small intestine being lightly adherent to each other, and in one or two places to the parietal peritoneum of the anterior abdominal wall.

**Liver:** Slightly enlarged, containing secondary carcinomatous deposits.

**Spleen:** Deposits on surface.

**Right kidney:** Slightly enlarged. Cut surface showed small ragged growth near upper pole. Pyelitis present.

**Left kidney** was represented by a large greyish mass 7 in.  $\times$  3 in., which was found on section to consist of growth, necrotic in places

with similar structure proves that it was a malignant change, and incidentally is in keeping with Schmorl's evidence.

In this case the three aetiological factors cited in the literature were all present. The size, weight, and striking lamination of the calculus removed at operation seems to show that the latter had been present for a considerable number of years. It would be interesting to know whether it was present in 1902 (the time of her previous operation), but since X-rays were hardly known at that time, no photograph was taken.

The hydronephrosis, on the other hand, as can be seen from the clinical history, was present in 1902, but

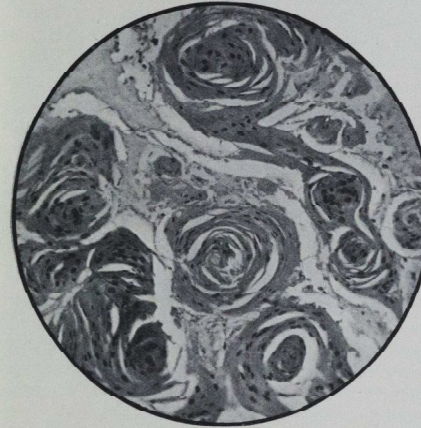


FIG. 1.—A SECTION THROUGH THE LEFT KIDNEY SHOWING THE EXCEPTIONAL FORMATION OF CELL-NESTS AND KERATINIZATION.  $\times$  180.

and completely replacing renal substance. In the centre of this mass, representing what had been pelvis and calyces, was an irregular cavity with ragged walls, which had contained the calculus removed at operation. The whole mass was densely adherent to the surrounding structures—vertebral column, muscles of posterior abdominal wall and peritoneum, all of which were extensively infiltrated.

**Right kidney** (removed at operation).

**Right ovary** atrophic.

#### Histological Report.

**Left kidney.**—Kidney substance almost entirely replaced by squamous-cell carcinoma, which shows an exceptional amount of cell-nest formation and keratinization (Fig. 1).

**Right kidney.**—Pyelitis present.

**Peritoneum.**—Secondary deposits with cell-nest formation and keratinization (Fig. 2).

**Liver.**—Smular secondary deposits.

The histological evidence in this case leaves no doubt that this is a case of squamous-cell carcinoma of the renal pelvis. The formation of the distant metastases

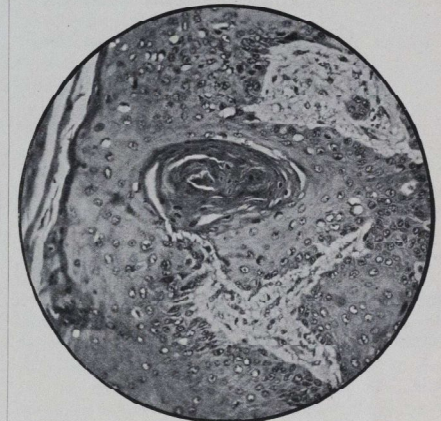


FIG. 2.—A SECTION THROUGH A PERITONEAL METASTASIS SHOWING SIMILAR ATYPICAL GROWTHS.  $\times$  180.

reduced. Whether this condition returned is impossible to say, but it has been known to occur.

Whether the carcinoma was present in 1920 is a matter of conjecture. The literature states that these carcinomata are rarely slow growing; more probably the swelling in the groin was of another nature, *i. e.* pyonephrosis, stone or hydronephrosis.

However, the state of the urine in 1925 leaves no doubt that the pyonephrosis was then in existence and had continued to be present.

It is interesting to note also that pyelitis was present in the right kidney. If the histological report had stated leukoplakia was present, there might have been some justification in saying that a malignant change was taking place as outlined by Cumming. Bilateral carcinoma of the kidney have been recorded. Pyelitis, however, is not a sufficient proof.


In conclusion, I should like to thank Mr. Geoffrey Keynes for his kindness in allowing me to publish these notes, and Dr. Cullinan for obtaining the accompanying photographs and histological report.

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E. M. DARMADY.

### SIR D'ARCY POWER'S SELECTED WRITINGS.\*

IR D'Arcy Power is an unassuming man, and probably it had never occurred to him that it might be worth while to collect and reprint some of his very numerous and scattered writings. The Bart's Nucleus of The Osler Club of London may therefore congratulate itself on its cleverness in seeing that Sir D'Arcy's seventy-fifth birthday might be most happily celebrated by presenting him with a volume of his own writings rather than with a *Festschrift* of the superfluous German type. The affection and respect of the donors is perfectly expressed in the volume before us, and the world is enriched by a collection of medical historical writings which perfectly reflects the author's character and interests. Sir D'Arcy Power's learning and wide reading sit upon him with the lightness of a feather, and who would have guessed the fact, revealed to us by the industrious compilers of the short-title Bibliography printed at the end of the book, that he has been guilty of at least 609 contributions to literature (and is probably still adding to his guilt)? With such a wealth of materials the Selection Committee, composed of the Bart's Nucleus, overlaid with a bevy of their elders gathered from various sources, can have had no easy task. Their duty was to cream the milk, but

\* *Sir D'Arcy Power Selected Writings, 1877-1930.* (Oxford: The Clarendon Press, 1931.) Pp. x + 368. Illustrated. 25s. net.


the cream could not be made into butter, and much of it must have been rejected for lack of space. The result is a richly filled volume which will commend itself to almost any palate. As might be anticipated, Surgery, Harvey, and St. Bartholomew's Hospital are well represented, but many other interests find a place.

John Hunter, the subject of the first paper, though a surgeon, was primarily a scientist, an honest scientist, moreover, who was notoriously abused, and fell a victim to his habit of experimenting on himself. Although the book is a compilation from scattered sources it preserves a certain continuity of subject and the general history of surgery is surveyed from several different angles in the next four papers, on fourteenth century practice, episodes in the history of Bart's, surgical education under Vicary, and the fees of our ancestors. Sir D'Arcy Power has varied his achievements by being President of the Bibliographical Society, and this side is represented by the sixth paper on three sixteenth-century books connected with London Hospitals. The interest of the books, however, is far from being merely bibliographical. The seventeenth century is given a good run in the persons of William Harvey, John Ward and Samuel Pepys. The two papers on Harvey give the results of much original research and are of the first importance. John Ward was the author of a voluminous diary, recently sold by the Medical Society of London to an American dealer for a very large sum. It contained some references to Shakespeare, which perhaps accounted for much of its monetary value, but it also had many things of medical interest, and Sir D'Arcy was the first to make a really detailed examination of the manuscript, some of the results being given in his address reprinted here. As for poor Mr. Pepys, Sir D'Arcy has diagnosed what was wrong with his eyes and has prescribed the correct glasses, but unfortunately more than 230 years too late to enable him to continue his *Diary*. The history of The Royal College of Surgeons, of which Sir D'Arcy has so long been an active servant, is surveyed in the eleventh paper, and the remainder of the book is given up to more strictly surgical subjects. Sir D'Arcy's numerous articles on eponyms contributed to the *British Journal of Surgery* are represented by one on Spencer Wells' forceps. Surgical history is further developed in an account of the relation of surgery to comparative medicine, and of how the British tradition came to America. Sir D'Arcy's more technical contributions on surgery are limited to the last two papers on the wiring of aneurysms and on cancer of the tongue. It may be true, as Lord Moynihan hinted in his remarks when making the presentation, that Sir D'Arcy is represented by this book chiefly as a truant from the

strict path of surgical practice, but had he not been truant he would not have been the beloved figure that we see looking at us from the frontispiece and passing gaily through the pages of this book. His contribution to pure surgery might have been greater, but to the humanities he would not have added so much, and it is as the humanistic historian that he will be remembered. There can be no doubt that this book will keep his memory green for many years to come. It is excellently printed, bound and illustrated, and is so attractive in every way that it may be doubted whether the 253 subscribers have left enough copies over to satisfy the demand among those who were unwise enough not to join their ranks. Sr. D.

### INDEED THE IDOLS.

"Depart from the highway and transplant thyself in some enclosed ground, for it is hard for a tree which stands by the wayside to keep her fruit till it be ripe."

HEN day by day enthusiastic men and women are adding, sometimes with plodding precision, sometimes with dramatic suddenness, to the sum total of medical wisdom, it is not surprising if day by day new specialties spring fully armed out of Apollo's forehead. Each has its own department in hospital and consulting practice, and ever attracts fresh and eager minds to its loyal service. But what Daniel will arise to interpret the mystic writing on the wall of one of our youngest specialties, that of medical librarianship? Cruelly neglected by student, practitioner and consultant alike, to each and all it offers so much and it means so little. How rarely are we privileged successfully to put our difficulties, great and small, real and imagined, before our colleagues, teachers, and "betters," whose sympathy may be endless, but whose time, patience and mental resources are after all strictly limited! In the ideal republic of medicine the librarian would play a truly indispensable rôle. *Exoriare aliquis nostris ex ossibus . . .* Time is in travail. Who can predict what rare fruit it may in the end produce? This country is the noble guardian of some of the finest medical libraries in the world, which strangely lack high priests who by the earnestness of their devotion and by the warmth of their sympathy attract the congregation. Seekers after the Hidden Wisdom are ever received most courteously and indeed like honoured guests, but how often do they not depart empty-handed from these mausoleums of dead ideas!

Visitors to the Library of the Royal College of Surgeons of England saw little of their distinguished late librarian.

Though he did not altogether shun visitors, the mantle of reserve, idiosyncrasy and mental inertia weighed heavily on his bent shoulders, and the depth of his feeling and the fineness of his intellect too often lay hidden behind the mask of cynical aloofness. And yet his cynicism was rarely destructive, but usually of a purely intellectual kind. Indeed there were occasions when he grew almost expansive and his conversation became a rare delight.

Victor Gustave Plarr, born in Alsace under the French flag, came to England at the age of seven. The hand of heredity and the magic touch of Oxford led him into the pleasant fields of literature, which he adopted as a profession. He made a scanty living by writing verse, contributing articles to the Press, and translating from the Greek and French. As a journalist he never became successful, for his wares were not such as were prized in the market-place. As a poet he failed to impress his generation, and to-day takes his place with the minor poets. In 1890, King's College, London, offered Plarr his first post, the shelter of its Library, and, seven years later, he became Librarian of the Royal College of Surgeons. As Librarian he failed to attain that height of greatness and efficiency which his opportunities so richly promised, though he rendered valuable service to the College and to the profession at large by bringing the Library Catalogue up-to-date, and by compiling a hand-list of the manuscripts in its possession. His artistic and uncertain temperament constantly led him into bypaths, and prevented him from concentrating on the work that is nearest. He lacked that scientific accuracy and concentration which Osler calls the ballast of the boat. The strength and the weakness of his character he displayed to the full in the biographical dictionary of the Fellows of the Royal College of Surgeons, which he was asked to prepare in 1912. Face to face with this encyclopaedic undertaking—the most ambitious and momentous in his life—he found himself in the glorious company of wise professional leaders who had ever fostered the growth of their craft, and of silent workers of the ranks who little expected that the curiosity of future ages should comment upon their ashes. To him the lives of both were a moving tale of dreams and aspirations, of disappointment and failure—a tale which for him held a deeper interest than the faithful record of their achievements. Tenderly sensitive to the lights and shades of life's landscape, he was, as Sir Arthur Keith has said of him, "a spectator who sank himself in his surroundings and watched life go by—sometimes with a wry smile." He loved to depart from the high road, to linger by the still waters, and to explore the kindly spots of hill and vale. As he wandered with Epicurus on his right and with Epictetus on his left,

illness overtook him, and, his work unfinished, he disappeared into the night. Though ever beyond the distant hills his eyes had feasted on the vista of the promised land, his was the tragic fate of Moses of old. Future historians will say of him that the Delectable Mountains of artistic perfection he was not destined to scale. His biographical sketches were curiously imperfect documents, pickled in irony, sweetened with regret. Here and there the briefest of entries—mere records of birth and death. Here and there pious obituary notices of men upon whose tombs the echo of eulogy had scarcely died away. Here and there arrestingly fine pen-pictures of a man with his thoughts and dreams, painted with reverence and delicate charm. It was left to the scholarly care of Sir D'Arcy Power, Mr. W. G. Spencer and Prof. G. E. Gask to verify Plarr's references, to rectify his mistakes, to show impatience where his caprice had been too leisurely, and to be eloquent where he had been but careless in his brevity. Thus *Plarr's Lives* have been produced—a work which students of medical history appreciate as a never-failing source of much varied and interesting information, and students of human nature as a worthy monument to one who has set a new fashion in medical biography.

W. R. B.

### THE DISILLUSIONED DOCTOR.



SICK of drugs and sick of diet  
How to keep my patients quiet!  
Serums, vaccines and syringes  
Cease to ease their pangs and twinges.  
Colloid states of precious metals  
Now replace old roots and petals.  
Macerations of the tissues  
Check the flow of bloody issues,  
Thin the fat, make old men younger,  
Stay the diabetic's hunger.  
Little children when they pray,  
Praise the ultra-violet ray,  
Yet the world goes round and round,  
Worms still fatten in the ground.

H. MUIR EVANS.

### DIABOLISMUS.



THE collection of antique spoons, the study of medicine, the flying of kites are hobbies usually harmless, sometimes even beneficial; but, given what we may term the Diabolic diathesis acting in a suitable environment, the collector turns his attention to modern spoons and ceases to be a welcome week-end guest, the doctor begins to write weekly articles on the treatment of varicose veins, and the kite-flier is found brooding over rockets and the nearer planets. Such syndromes as these are termed collectively *Diabolismus*, or Toxic Hobby.

A few of the commoner forms of this disease must be called to mind before we embark on a rather more detailed study of one of the less known but more interesting.

*Diabolismus regalis antiquus* needs no description, for who does not know the Golf Fiend? For him, as for most of these cases, there is little treatment. One must guard, if possible, against any rapid reduction of his handicap, for this is apt to produce a severe exacerbation of his symptoms. Tremor of the hands and a trace of foot-drop at the end of a long spell of wet weather should be disregarded.

*Diabolismus pontis*, a condition most commonly found in elderly women, is interesting for the curious contrast it presents to general paralysis of the insane. The crisp speech, the immobile lips, the "austere regard of control," the mental acuteness *increasing pari passu* with moral deterioration, and, above all, the delusions of penury make the Bridge Fiend a very exact antithesis of the expansive male who is the type of general paralysis.

*Diabolismus venatorius* is a distressing familial form, endemic in Leicestershire, and quite uncommon in the out-patient department of the greater hospitals. This form, too, leaves its mark upon the character. As in acute alcoholism, the patient regards all who are not similarly afflicted as abnormal, the objects of profound distrust: but the advent of a fellow-sufferer or of a horse may elicit a shrill cry of "Yoi-oicks!" or worse, a story of a thirteen-mile run without a check. An almost constant accompaniment is a partial colour-blindness for scarlet, which the patient persists in regarding as pink.

The *Diabolus philatelicus*, or Stamp Fiend, is a more pleasant subject for contemplation. The syndrome commonly shows itself first in middle childhood, and in about 80% of cases leads to a spontaneous cure at the age of 12 to 14. In children it may give rise to attacks of stamp-mount dyspepsia—a rare complication unknown in the adult, who has a high tolerance for gum

taken by mouth. If the symptoms persist beyond the age of thirty they may be regarded as incurable. Yet they have little effect on the general health, and the sufferer may remain a happy and useful member of society. One case, indeed, which has been under my care for some years, is that of a churchwarden.

Only two cases have so far been recorded of the *Diabolismus of Rabelais*, of which the only symptom is a tendency to collect and mount in cases handles labelled PULL. The syndrome appears to be confined to adolescence: it runs a benign course and is self-limiting in one or two years.

Slightly less rare, and perhaps the most interesting of all forms of this disease, is *Diabolismus locomotivus* ("d. chemin de fer"). The Train Fiend (or *Schnellzug diabolus*) is invariably a male. At the age of about three he frequently exhibits a significant prodromal symptom—a desire to become an engine-driver. More often than not this will pass off and the disease appear arrested. Three or four years later, however, it may be noticed that the railway-lines commonly found in a corner of the child's nursery are spreading, first over the whole floor-surface of the nursery, then gradually further out onto the landing. If they can be checked here, there is every hope of the patient's recovery in a year or two, but if he is allowed to invade a second or third room with his rail-system or—a still more ominous sign—if he is found nailing his rails to the floor-boards, there is a grave danger that the disease-process may run on into adult life. What has been in childhood a turbulent but narrow stream of consciousness, fed only by the images of a few models, becomes suddenly a broad river swollen by an ever-widening conception of the vast railway-systems of the world.

From now on the mature Train Fiend will exhibit a number of curious symptoms, of which (to adapt the great lines of Lewis Carroll)—

"The first is his fondness for railway-trains,  
Which he frequently follows about;  
He believes that they add to the beauty of scenes—  
A sentiment open to doubt."

He may enter a train, for instance, at Paddington, travel rapidly to Birmingham, and there cross to the "down" platform just in time to catch a return train to London: all this to see a particular train pass through the junction or to catch a glimpse of a new type of engine which he has traced to its home shed. Sometimes he may be found in a corner seat on the Flying Scotsman or the Cornish Riviera; here he sits, stop-watch in hand, peering at the edge of the permanent way, where, every fifteen seconds or so, the white quarter-mile posts flash by. (It is to be noted that he spurns the information which the accommodating Mr. Carter has coupled with

his glad news of Little Liver Pills. "Not very accurate" is his usual comment.)

Thus, or from genial drivers in the more penetrable engine-sheds, he gathers his facts. With these at his finger-tips he seeks the company of his fellow-fiends, and it is when two or three are gathered together that this *Diabolismus* takes on its most dramatic form. An outbreak may occur at any social gathering, be it at a private view or on a raft in mid-Atlantic. A few quiet words are exchanged, and suddenly the air is clangorous with technicalities, as the victims stand and cast superheaters and Westinghouse brakes, King Arthurs and Pacifics, C-class tanks and 4-6-2's in one another's teeth. Death has not been known to occur during these acute attacks, although cerebral hæmorrhage sometimes appears imminent in plethoric types of Train Fiend. At the end of one such flare-up of symptoms which I was privileged to witness, two of these men remembered for the first time that they had seen each other for some years at the same public school, simply because they both claimed to have been "brought up" on the same stretch of railway-line. The school, it seems, had fed and lodged them, while the Great Western Railway, all unconscious, provided their education.

Some clinicians have classed the *Bradshaw* Fiend with the Train Fiend. This is an error, for the two types, although closely related, are distinct. The Train Fiend is no mere statistician; to him the *Railway Magazine* is the true Bible, and *Bradshaw* a mere Book of Hours. Motor omnibuses and the Air Mails are minor objects of worship—(perhaps because they resemble trains in their grouping into "routes" and their attempt to adhere to a schedule. Uncertainty provides constant stimuli). Private motor cars he regards with interest, but not with reverence; his own is but the means to hasten to his platform and engine-shed devotions. A typical case was that of a young Scotsman who drove forty miles in a borrowed car to spend a long afternoon on Reading station. When he returned, his only words were: "Think, man, two Pacifics in one afternoon!"

There is no treatment. A series of long sea-voyages may be advised, but seldom prevents the return of either symptoms or patient.

W.

### ACKNOWLEDGMENTS.

*The British Journal of Nursing—The British Journal of Venereal Diseases—Bulletins et Mémoires de la Société de Médecine de Paris—Charing Cross Hospital Gazette—The Clinical Journal—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital—The Kenya and East African Medical Journal—King's College Hospital Gazette—The Leech—Medical Times and Long Island Medical Journal—The Nursing Times—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—Uppsala Läkartidningens Förhandlingar.*

## ABERNETHIAN SOCIETY.

A Clinical Evening was held in the Abernethian Room on Thursday, January 15th, at 5.30 p.m., the Vice-President, Mr. J. S. MacVine, being in the chair.

The minutes of the previous meeting were read and confirmed and the following cases were then shown:

Mr. Westwood: A case of pyopneumothorax.

Mr. Hayward: A case of actinomycosis of the lungs.

Mr. Cusack: A case of polycythaemia and the result of treatment with phenyl hydrazine.

Mr. Kersley: A case of diverticulum of the small intestine.

Discussion followed each case, in which Messrs. Prowse, Oakley, Deard, Ishmael, Keele and Pavcutt took part.

A vote of thanks to those members who had shown cases was proposed by the Chairman and carried unanimously.

## STUDENTS' UNION.

## RUGBY FOOTBALL CLUB.

## Hospitals' Cup.

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

Result: Won 8—0.

February 17th, at Richmond.

On club form and the opinion of most followers of the game Guy's were almost certain to win, but, as is usual in cup-ties, the brilliance of individuals, especially behind the scrum, can be discounted by determined tackling.

At first the quickness of the Guy's backs repeatedly started dangerous-looking movements, until it was to be noticed that they were only on the rarest occasions able to shake free the swarms of spoilers who fastened on every passing movement. Johnson, on the left wing, one of the Guy's stars, was quite unable to slip D. M. Thomas, who brought him to earth with amazing vigour and ruled him out as far as try-scoring was concerned. There was no score in the first half, partly owing to the fact that both forwards and backs were too busy discouraging Guy's to risk any opening-up of the game; it became, indeed, what the historians would call a soldiers' battle with very heavy casualties.

In the second half, however, things brightened up, and Taylor tried his famous steal-away, kicked past the full back and would have scored but for an illegal tackle by the full back. Unfortunately the penalty kick failed. Then Nunn, in the middle of another attacking movement, punted ahead, and Prowse, following up, took the ball well and, with a good pass, sent Thomas down the right wing. At just the right moment Thomas gave Nunn an inside pass and he raced over to score a try, which crushed the Guy's supporters and elated those of Bart's to a state of frenzy. Ryan converted with a good kick. Windsor Lewis now tried to set up an attack, following a penalty, by a touch into his own hands and a quick pass out to his centres. The Bart's backs were on the alert, however, and an interception by Petty sent them in full cry to the Guy's line. Petty was tackled before reaching it but the ball went loose, and Thomas, with commendable presence of mind, did not attempt to pick up, but dribbled over and touched down.

Among the forwards R. N. Williams was perhaps the best of a most lively and determined pack, all of whom worked like heroes.

Bart's thus finished the winners by 8—0 and qualified for the semi-final on March 3rd.

Team: T. J. Ryan (back); D. M. Thomas, G. F. Petty, C. B. Prowse, J. D. Powell (three-quarters); J. A. Nunn, J. T. C. Taylor (capt.) (halves); R. N. Williams, V. C. Thompson, H. D. Robertson, B. S. Lewis, J. R. K. Jenkins, E. M. Darmady, R. Mundy, G. D. S. Briggs (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. BRIDGWATER ALBION.

Result: Won, 6—0.

January 31st, at Bridgwater.

This was a new fixture, and turned out to be a very enjoyable one in spite of deplorable weather conditions. Bart's were the superior side from the start, and after ten minutes Pirie ran over from a good passing movement to score far out. The kick was a very difficult one and Ryan failed.

Towards the end of the first half Taylor exploited his steal-away and scored a good try. Ryan could not convert.

The second half resolved into a desperate struggle by the home team to score with the help of wind, hill and rain, and a dour defence, with occasional attacks by Bart's.

The game, however, ended without further score, leaving Bart's the winners by 6 points to nil.

ST. BARTHOLOMEW'S HOSPITAL v. OLD PAULINES.

Result: Won, 16—6.

January 24th, at Winchmore Hill.

This was a rather scrappy game, owing to the slippery ball and freezing wind, but under the circumstances the Bart's handling was quite creditable. Thomas and Powell scored tries for Bart's in the first half, the former after a strong run, and Ryan converted.

The Old Boys kicked a penalty goal, after three or four attempts, each nearer the Bart's goal.

In the second half Powell and Prowse scored for Bart's and Ryan converted the latter. The try by Powell was the result of a good movement between Prowse and Powell, the ball changing hands several times. Bart's thus finished the winners of a rather unenjoyable game, packed with penalties on both sides.

## ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. ST. JOHN'S COLLEGE.

January 24th, at Cambridge.

This match resulted in a win for St. John's by 4 goals to 1. The score rather flattered the winners, as the play was very evenly divided. Bart's scored first through Dransfield, and at half-time the score was 2—1 in St. John's favour. Bart's made many attacks on the John's goal in the second half, but weak shooting was the cause of our failure to score.

ST. BARTHOLOMEW'S HOSPITAL v. EMMANUEL COLLEGE.

January 31st, at Winchmore Hill.

In this game, played on muddy ground, the Emmanuel forwards were too fast for the Hospital defence, and at half-time the visitors were winning 2—0. In the second half the Bart's forwards failed to combine and could not get away. Emmanuel scored two more goals and kept the Hospital on the defence for the greater part of the game.

## First Round Inter-Hospitals Cup.

ST. BARTHOLOMEW'S HOSPITAL v. KING'S COLLEGE HOSPITAL.

February 3rd, at Winchmore Hill.

This match resulted in a rather easy win for Bart's by 8 goals to 2. Bart's scored first, then King's drew level, and for a time play was very even. Then Bart's forwards combined very well and the score at half-time was 3—1 in our favour. In the second half Bart's were definitely superior and kept King's on the defensive all the time. Five more goals were scored for Bart's.

Scorers: Dransfield 4, Wheeler 1, Hughes 1, Shackman 2.

Team: E. E. Brown (goal); D. R. S. Howell, H. J. Roache (backs); J. Crumbie, C. A. Keane (capt.), G. H. Brookman (halves); R. G. Gilbert, R. Shackman, C. M. Dransfield, F. E. Wheeler, J. Hughes (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. DOWNING COLLEGE, CAMBRIDGE.

At Winchmore Hill on February 7th.

This match resulted in a draw, 3—3. The play was very fast and even for the whole of the game; half-time the score was 1—1. In the second half Bart's did most of the attacking and were unlucky

in not scoring more. Goals were scored by C. M. Dransfield (2) and H. J. Roache (1).

Team: R. A. Wenger (goal); J. Crumbie, D. R. S. Howell (backs); A. Hollinrake, C. A. Keane (capt.), G. H. Brookman (halves); R. G. Gilbert, R. Shackman, C. M. Dransfield, F. E. Wheeler, H. J. Roache (forwards).

## First Round Junior Inter-Hospitals' Cup.

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

February 12th, at Chiswick.

Bart's won the toss and, kicking with the wind, attacked vigorously for the first 10 minutes, but without result. Mid-field play followed, but after about 20 minutes' play Jackson cleverly intercepted a backward pass by one of Thomas's backs, and scored a good goal. Bart's attacked for most of the first half, but failed to press home their advantage, half-time being reached with the score 1—0 in our favour.

Thomas's, with the wind in their favour, attacked hard for the first 15 minutes of the second half, but our defence played superbly, particularly the half-backs. After about 20 minutes McAskie, who played in his best form throughout, scored a very good goal from a pass from McKenzie. This goal proved the turning-point in the game, Bart's attacking consistently during the remainder; further good goals were obtained by McAskie and Jackson. Result: Bart's 4, St. Thomas's 0. This was a very good performance of our 2nd XI, every man playing in irresistible fashion.

Team: D. J. Johnson (goal); G. A. Mendow, K. McGladdery (backs); L. A. Hiscock, A. E. Owlett, A. Hollinrake (halves); J. K. McKenzie, W. A. Owen, B. F. Jackson, L. McAskie, S. Barrigrasser (forwards).

## HOCKEY CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. ST. ALBANS.

Result: Drawn, 2—2.

January 24th, at St. Albans.

This very close game quite properly ended in a draw. We were fortunate in having Roles to take Jameson Evans's place at inside right. Doing most of the attacking at first, we had two goals to our credit through Heasman and Owston before our opponents had scored. Later, after making some changes in their forward line St. Albans became dangerous, and by ten minutes before time they had managed to draw level. These last ten minutes were exciting; more than once they would have scored again had not Gale and Henton-White, our backs, and Smallhorn, who was taking Hodgkinson's place in goal, put up a stout defence. The two out-sides, Symonds and Davidson, played excellently, centres from them being responsible for each of our two goals.

Team: T. Smallhorn (goal); F. C. Henton-White, D. Gale (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); R. T. Davidson, F. C. Roles, A. J. Owston, L. Heasman, J. Symonds (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. R.N. and R.M., CHATHAM.

Result: Won, 7—2.

January 31st, at Chatham.

With a full team out for the first time since Christmas it was encouraging to win this match by so large a margin. Our game seemed to be greatly improved, the ball was swinging about from wing to wing in a way we like to see, and the forwards, passing through the opposing backs, gave themselves plenty of chances, most of which they took. Owston scored three of our goals, being unfortunate to miss another, a fine shot, which passed just over the cross-bar, over a fence and out of the ground; Heasman scored twice, and Davidson and Symonds one goal each.

Team: H. L. Hodgkinson (goal); F. C. Henton-White, P. M. Wright (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); R. T. Davidson, L. P. Jameson Evans, A. J. Owston, L. Heasman, J. Symonds (forwards).

## FIRST ROUND INTER-HOSPITAL CUP.

ST. BARTHOLOMEW'S HOSPITAL v. CHARING CROSS AND ROYAL DENTAL HOSPITALS.

Result: Won, 4—1.

February 4th, at Winchmore Hill.

The first ten minutes of this game gave us many anxious moments, as we were slow in getting together and their forwards several times looked like scoring. But soon we made up for the bad start, our forwards playing excellently, giving each other long through passes and following them up well.

Owston scored our first two goals. Soon after this our opponents scored, after a run down the wing by their right outside, a misunderstanding amongst our defence leaving two men unmarked. Our backs were hard pressed for the next few minutes, being nearly beaten once again, Hodgkinson just saving a shot from in front of goal by timing it round the post with his knee. This was fortunate for us, if they had drawn level at this point the result might well have been very different.

Our third goal came from Hay-Shunker, and just before half-time a fourth from Jameson Evans, a good oblique shot from the right wing.

The second half of the game proved disappointing and somewhat scrappy; although we were playing downhill, and attacking nearly all the time, the soft ground being cut up made the game difficult for our forwards, and we did not score again.

Wright and Henton-White at back, Iliff at centre half, and Owston at centre forward, were all playing well.

Team: H. L. Hodgkinson (goal); F. C. Henton-White, P. M. Wright (backs); V. C. Snell, A. D. Iliff, J. H. Hunt (halves); L. P. Jameson Evans, C. L. Hay-Shunker, A. J. Owston, L. Heasman, J. Symonds (forwards).

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

Result: Drawn, 3—3.

February 7th, at Sandhurst.

On a fine day, on an excellent ground, this proved to be one of our best games this season. We were fortunate in having J. A. Nunn in Davidson's place, and Gale, by chance at Sandhurst that afternoon. Nunn played instead of Owston, who had missed his train. From the bully-off we nearly scored, a fine run down the field by Nunn ending in a shot which the goal-keeper stopped above his head. In spite of several more rushes by our forwards, the R.M.C. were the first to score. The game was fast and the play even, but just before half-time Jameson-Evans made us level.

Early in the second half Jameson Evans scored once more, but they again drew level. After a long run down the wing, ten minutes before time, Symonds sent across the goal-mouth a high pass, from which Nunn scored, having jumped to stop the ball with his hand above his head. We were unable to keep the lead, even at this point in the game, as they yet again drew level just before the end. Smallhorn in goal saved some hard shots, and Gale, in an unusual place, at outside right, had several good runs down the wing.

Team: T. Smallhorn (goal); F. C. Henton-White, P. M. Wright (backs); V. C. Snell, A. D. Iliff, J. W. Hunt (halves); D. Gale, L. P. Jameson Evans, J. A. Nunn, L. Heasman, J. Symonds (forwards).

## UNITED HOSPITALS HARE AND HOUNDS.

UNITED HOSPITALS HARE AND HOUNDS v. ORION H.

Held over the Hospitals' course at Richmond, on Wednesday, January 28th.

The course was in good condition, and the weather favoured fast times. The Orion turned out a small, though strong team, while the Hospitals were without several of their best men. At the start Ries and Elgie (O.H.) took the lead, with Strong (U.H.) hanging on. The first 3 miles were run at an extraordinarily fast pace. About here Elgie began to tire and had soon dropped back, while Ries began to draw away from Strong. For the next 2 miles there was little change, but then Ross, the Orion 10-mile champion, made one of his fine efforts, and passing Strong, set out after Ries, who by now had a 50 yards' lead. Ries, however, continued to run very strongly, and covered the 6-mile course in the record time of

35 min. 15 sec., Ross being 150 yards behind and Strong another 70 yards further back. Elgie (O.H.) was fourth, while Sandiford, who was just recovering from the effects of "District," ran in with Lee for fifth place.

Result: Orion H. (1, 2, 4, 7, 8), 22 pts.; U.H.H.H. (3, 5, 6, 10, 12), 36 pts.

#### UNITED HOSPITALS HARE AND HOUNDS v. BLACKHEATH H.

Held over the Hospitals' 6-mile course at Richmond on February 11th.

The afternoon was one of the worst of the season. There was a high wind and rain, and the course was in a relatively water-logged condition. With a slow start Smith and Newson (Blackheath) with Strong and Sandiford (U.H.), took the lead, with the rest of the field following close behind. At about 2 miles Newson dropped back and Smith took the lead. Sandiford and Strong, however, took up the challenge with such effect that Smith was forced to drop back. From 4 miles onwards the two Hospitals men ran together unchallenged and eventually won in the good time of 36 min. 16 sec., Smith running in third, about 100 yards behind. It had been hoped to establish a new course record, which is now held by a visitor, but the weather must be blamed for the failure. G. Dally (U.H.) ran a splendid race, and by coming in sixth helped to secure a victory for the Hospitals in a match which would otherwise have resulted in a draw.

Result: U.H.H.H. (1, 2, 6, 8), 17 pts.; Blackheath H. (3, 4, 5, 7), 19 pts.

## CORRESPONDENCE.

### ST. BARTHOLOMEW'S SIXTY-THREE YEARS AGO.

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

DEAR SIR,—In the October, 1930, number you had reminiscences of fifty-seven years ago, and you mention in your Editorial the Introductory Address in 1867, when the Treasurer was so badly treated.

It was my first year at Bart.'s and I was present on that occasion. Besides the pea-shooter, any amount of nuts were thrown on to his bald pate, he was jeered at, and there was an awful row. Having just joined I knew nothing about his unpopularity and didn't join in the throwing. What surprised me was that he sat quietly in his seat and never even turned his head. How differently Tom Smith, who gave the address in 1868, would have behaved! He would have jumped up like a shot and have slanged anyone who dared make a row or throw anything; and if Savory had been making the address he would simply have got up, turned round and sneered, and there would have been dead silence.

In my first year the Fontaine blew up part of the wall of Clerkenwell Prison and part of some houses on the other side of the street, and the injured were brought to Bart.'s.

A friend, a fellow student, and I were in the out-patient room when they were brought in and helped with the dressings, and when we had finished we went to see the scene of the explosion. We couldn't get anywhere near. Thousands of people had assembled. I said "Come along," and went to the nearest "Bobby," as we then termed a policeman, and told him that we had just attended to the injured and wished to tell Sir Richard Mayne, then Chief of Police, about them if he was there. He said, "Yes, he is right in front," and took us there after a good deal of pushing. I told Sir Richard about the number and nature of some of the injuries, and then we had a good look round. Besides the Prison wall the whole of the front walls of many houses were blown away, and the fireplaces, bedsteads and other furniture exposed. They were workmen's cottages, very thin walls.

I am afraid I have trespassed too much already on your space, but if you would care to have more reminiscences I could relate all about the last hanging in public of the man who caused the above, which we saw, and also reminiscences of the great surgeons and physicians of those days, for, besides out-patient work, I dressed for Savory and clerked for three physicians.

G. T. LANGRIDGE,  
Lt.-Col. R.A.M.C. (ret.).

February, 1931.

### "PAGET'S 'QUIET NECROSIS.'"

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

DEAR SIR,—

"And she named the child I-chabod, saying, 'The glory is departed from Israel.'"

We cannot all be historians. The shrill voice of priority ever leads the frail among us astray, and their historical voyages end in the tragedy of shipwreck. As long as there are men to practise the art of medicine, so long will they speak with the tongue of piety and reverence of those who, to their own undying glory, have erected noble monuments in many a clinical entity which has become the common property of science. Like myself and many others, my friend J. M. Jackson has had his historical temper aroused by that strange challenge in the new edition of *Bowly and Andrews*, which boldly associates the term "quiet necrosis" with Morratt Baker's name. When men are sufficiently provoked, they produce good work. But when I read the innocent statement, "It remained for Sir James Paget to apply the name of 'quiet necrosis,'" my pride as a Bart.'s man is grievously wounded. If no single discovery is ever due to one individual worker, may I protest that the credit should go to the man who, believing in its importance, succeeds in converting the world to his creed? Paget's name is inseparably linked with "quiet necrosis," not because he was the first to baptize or even to describe it, but because, even though unable to explain its nature, he was always anxious to impress upon the profession to bear its possibility in mind in any obscure bony swelling.

I am, Sir,

Yours faithfully,

W. R. BETT.

SHADWELL, F. J.

February 1st, 1931.

## REVIEWS.

AN INTRODUCTION TO MEDICAL HISTORY AND CASE-TAKING. By GEOFFREY BOURNE, M.D., F.R.C.P. (Edinburgh: E. & S. Livingstone, 1931.) Pp. xii + 195. Price 6s.

The size of this book is no indication of its value, for it is small enough not to frighten the laziest student and yet large enough to carry much clinical wisdom. It is intended as a first guide in the approach to the patient, and is not meant to replace books of reference to clinical methods. It is broadly conceived and attractively written. We liked particularly the well-balanced chapter on the necessity for making a diagnosis and how to set about it. The specimen case, showing the procedure for formulating a diagnosis, is most helpful. There are one or two minor points which we would like to add, e.g. cyanosis without dyspnoea may occur from a pulmonary cause, as in emphysema (p. 106). But, considering the book as a whole, we are of the opinion that any medical student will be the better for having studied it. In the preface, we should like to add, is a practical tribute to the teaching of Dr. J. H. Drysdale, to whom the book is inscribed.

SENSATION AND THE SENSORY PATHWAY. By JOHN S. B. STOFFORD, M.D., F.R.S. (London: Longmans Green & Co., 1930.) Illustrated. Pp. xii + 148. Price 7s. 6d.

To clinicians sensation is a physiological function perplexing to understand and difficult to estimate. They therefore welcome any clear and concise account of the anatomical pathways associated with sensation and a lucid interpretation of the physiological considerations of such pathways. The author is to be congratulated on the merits of this work. Wisely the clinician's interest is early engaged by a discussion as to the sensory disturbances associated with regenerating nerves; he is then led on to an able treatise regarding the peripheral and central sensory pathways. Finally the author discusses the two systems in both cutaneous and deep sensibility, and offers an explanation of the two-stage recovery met with following nerve suture. It is in the later chapters that controversial subjects are dealt with, and though all may not agree with the author's explanations, all must admit that he has offered a welcome and useful hypothesis. All interested in sensation, be it subjective or objective, are recommended to a study of this book.

TEXTBOOK FOR NURSES. By E. W. HEY GROVES, M.D., F.R.C.S., and the late J. M. FORTESCUE-BRICKDALE, M.D., M.R.C.P. Fourth edition. (Oxford Medical Publications, 1930.) Pp. xxx + 647, 229 illustrations. Price 20s.

This well-known text-book deals with anatomy, physiology, surgery and medicine in such detail as will enable the nurse to understand the principles underlying medical and surgical treatment. The book is sufficiently comprehensive to be used for reference and the General Nursing Council syllabus is adequately covered. Nursing technique is not included. The anatomical section is clear and concise, and is beautifully illustrated. The physiology part is accurate and up-to-date. The section dealing with medicine has been revised by Prof. J. A. Nixon, and includes much recent work, especially on specific infections. The subject of dietetics is perhaps rather inadequately dealt with; a clearer exposition of the principles of diet in alimentary, renal and metabolic diseases would be a great advantage. The chapter on war surgery has been omitted, and the contents of it have been distributed through the book. A few skiagrams of fractures and of various conditions of the alimentary canal would be an interesting and helpful addition.

The authors are to be congratulated upon the accuracy and simplicity of this book, and the publishers upon its attractive appearance and reasonable price.

SURGICAL EMERGENCIES IN PRACTICE. By W. H. C. ROMANIS, F.R.C.S., F.R.S. (Edin.), and P. H. MITCHNER, M.S., F.R.C.S. (London: J. & A. Churchill, 1931.) Pp. viii + 608. 158 illustrations. Price 48s.

This book is designed for practitioners who have no time to waste through the paragraphs dealing with pathology and alternative methods of treatment in the larger text-books. Clinical features, differential diagnosis and the best line of treatment are dealt with more or less briefly. It is indicated where expert advice should be obtained. Technique of emergency operations is merely outlined. The chapters on fractures are extremely good, full details of treatment being given and many illustrations provided. The recent method of using local anaesthesia in reducing fractures deserves full description, since it is likely to be very useful to the country doctor. It is, however, only briefly alluded to by the authors. Antiquated splints have been omitted; it appears, indeed, that metal and of applying plaster splints is fully described. The authors insist on frequent skiagrams to ensure that the fragments are maintained in good position. A useful section deals with improvisation of necessities for an abdominal operation.

Infections of the hand are fully dealt with, as their importance merits. A diagram of the surgical anatomy of the hand, showing the tissue spaces, tendon sheaths, vessels and nerves with the various incisions would be a useful addition.

The book is attractively got up, well illustrated and reasonably priced. It contains many of the features which have made the authors' *Principles and Practice of Surgery* so deservedly popular, but there is practically nothing in it which is not given in fuller detail in the larger work, and we consider that it is unlikely to replace it on the bookshelf of the practitioner, however pressed for time.

MINOR SURGERY AND BANDAGING. By GWYNNE WILLIAMS, M.S., F.R.C.S. Twentieth edition. (London: J. & A. Churchill, 1930.) Pp. viii + 445. 202 illustrations. Price 10s. 6d.

That this little book has reached its twentieth edition is sufficient evidence of its usefulness. It has been brought up to date, and can be confidently recommended to the dresser as a most valuable investment, since it contains many details and helpful hints not found in the large text-books. The injection treatment of varicose veins is briefly described, and the chapters on fractures have been considerably extended and more fully illustrated. Not the least useful is the chapter on bandaging, which is by way of becoming a lost art.

HANDBOOK OF DISEASES OF INFANTS AND CHILDREN. By F. M. B. ALLEN, M.D., M.R.C.P. (London: Baillière, Tindall & Cox, 1930.) Pp. vii + 595. Price 15s.

The object of this volume, as stated by the author in the preface, is to present the subjects in a concise and complete form in order to be of service to medical students preparing for the final examinations, as well as to general practitioners who wish to acquaint themselves with modern views on the subject of diseases of children, and particularly the problem of infant feeding. In this aim he succeeds to

a large extent, mainly as a result of copious quotations from the various standard authorities on diseases of children, but in the outcome the book has lost all trace of individuality, and has become to a large extent a compendium of the views of many paediatricians, of greater or lesser reliability, on the various aspects of disease in childhood. It is difficult to discover, however, any advantage in this text-book as compared with the numerous other standard works on the subject, nor does it seem probable that it will replace them, either as a text-book for the use of the student or as a standard of reference for the general practitioner.

ANTE-NATAL CARE. By W. F. T. HAULTAIN, O.B.E., F.R.C.S. (Edin.), and E. CHALMERS FARMY, F.R.C.S. (Edin.). Second edition. (Edinburgh: E. & S. Livingstone, 1931.) Pp. 127. Price 5s.

That this book has reached its second edition in so short a time is sufficient indication of its worth. This is the only book which deals exclusively with the all-important subject of ante-natal care. This subject has been attracting an increasing amount of attention, and this handbook adequately fills the gap in the present-day literature.

In the second edition a chapter on maternity and National Health benefits has been added for the benefit of the Paediatric practitioner, and somewhat paradoxically a chapter on post-natal care has been included. This is, however, a valuable addition. While the book contains little that is not included in the standard text-books of midwifery, the subject-matter is set out so attractively that it is a pleasure to read. It is a book which can be recommended alike to the student, the post-graduate and the general practitioner.

DISEASES OF THE TONGUE. (Being the third edition of Butlin and Spencer's *Diseases of the Tongue*.) By W. G. SPENCER, M.S., F.R.C.S., and STANFORD CADE, F.R.C.S. (London: H. K. Lewis & Co., 1931.) Pp. xvi + 561. 20 coloured plates and 123 illustrations. Price 35s.

Thirty years ago Butlin's book on Diseases of the Tongue stood alone amongst works on this subject. Although the last edition was published in 1906, nevertheless Spencer and Cade, as the preface to the present book tells us, considered that "no better foundation for the work could be found than the work of Henry Butlin."

The detail of the anatomy and physiology of the tongue and its connections which is given in this book is quite unusual, and the completeness with which descriptions of all including the most rare lesions of the tongue are presented is remarkable. As is only to be expected, a very large part of the book is devoted to cancer of the tongue, nevertheless over half of it is concerned with conditions other than malignant. A description of diseases of the salivary glands and thyro-glossal duct is included.

There is an excellent chapter on results of radium treatment. It is based on the results of 253 cases of oral cancer treated by the authors or their colleagues. Radium needles are preferred to seeds. Re-needling of the tongue at the end of seven days in extensive lesions is preferred to the use of larger doses left in for seven days only. The screenage advocated is 0.6 mm. of platinum. The best treatment for cervical glands is very clearly indicated under the three headings of (1) unpalpable glands, (2) palpable glands, (3) inoperable glands.

The bibliographies which are given at the end of each chapter throughout the book should stand as models in length and clearness for all authors on scientific subjects.

We feel that the treatment of many of the conditions other than carcinoma described in this book might very profitably have been given in more detail, and the descriptions of some of the individual cases is less detail.

This book should be read by every surgeon who wishes to keep abreast with the most modern views on all diseases of the tongue and neighbouring organs.

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

ANDREWS, C. H., M.D. "The Immunological Relationships of Fowl Tumours with Different Histological Structure." *Journal of Pathology and Bacteriology*, January, 1931.

ARMSTRONG, R. R., M.D., M.R.C.P. "A Simple Method for Deciding Pneumococcal 'Type.'" *British Medical Journal*, February 7th, 1931.



- BARNES, E. BROUGHTON, F.R.C.S.(Edin.). "Congenital Deformity and Deafness." *Proceedings of the Royal Society of Medicine*, January, 1931.
- CROOK, ERIC A., M.Ch., F.R.C.S. "Branchial Cyst." *Proceedings of the Royal Society of Medicine*, January, 1931.
- CUMBERBATCH, EYFEN D., M.A., B.M., B.Ch., D.M.R.E.(Camb.), M.R.C.P. "Old-standing Lupus Vulgaris: Results of Treatment by Fulgurization." *Proceedings of the Royal Society of Medicine*, January, 1931.
- "Uses of Diathermy in Medicine and Surgery." *Lancet*, February 7th, 1931.
- ELLIOT, R. H., D.Sc., M.D., F.R.C.S. "Cataract Operation in Extreme Old Age." *British Medical Journal*, January 24th, 1931.
- HAMILL, J. M., O.B.E., M.D., D.Sc. "Food as a Preventive of Disease." *Proceedings of the Royal Society of Medicine*, January, 1931.
- HANNAN, JOHN H., M.A., M.D., B.Ch. "Further Observations on Ovarian Transplantation." *British Medical Journal*, January 24th, 1931.
- HAYNES, F., M.A. "Experimental Dust Inhalation in Guinea-pigs." *Journal of Hygiene*, January 1st, 1931.
- HEALD, C. B., C.B.E., M.D., M.R.C.P. "Double Rudimentary Cervical Rib." *Proceedings of the Royal Society of Medicine*, January, 1931.
- HEKMAN-JOHNSON, F., M.D.(Aberd.), D.M.R.E.(Camb.). "The Place of X-Rays in the Treatment of Malignant Disease: With Especial Reference to Cancer of the Breast." *Practitioner*, February, 1931.
- LEVITT, W. M., M.B., D.M.R.E. *Deep X-Ray Therapy in Malignant Disease: A Report of an Investigation carried out from 1924-1929, under the Direction of the St. Bartholomew's Hospital Cancer Research Committee.* London: John Murray, 1930.
- PYBUS, F. C., M.S., F.R.C.S. (and FAWNS, H. I.). "The Effect of Variations in the Media on the Growth of Normal and Malignant Tissues *in vitro*." *Journal of Pathology and Bacteriology*, January, 1931.
- RIDOUT, C. A. S., M.S., F.R.C.S. "Papillomatous Condition of Vocal Cord: Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, January, 1931.
- ROBINSON, C. A., B.A., M.D., D.M.R.E. "Cerviculus Ireated by Diathermy." *Proceedings of the Royal Society of Medicine*, January, 1931.
- SAXBY-WILLIS, F. E., M.D. "Aortic Aneurysm and Syphilis of the Lung." *Proceedings of the Royal Society of Medicine*, January, 1931.
- SOUTHAM, A. H., M.D., M.Ch.(Oxon.), F.R.C.S. "The Incision for Appendicectomy." *British Medical Journal*, February 14th, 1931.
- SPENCER, W. G., M.S., F.R.C.S. (and CADE, STANFORD, F.R.C.S.). *Diseases of the Tongue (Being the Third Edition of Butlin and Spencer's Diseases of the Tongue).* London: H. K. Lewis & Co., 1931.
- TWEEDIE, A. R., F.R.C.S. "The Eustachian Tube." *Proceedings of the Royal Society of Medicine*, January, 1931.
- WALKER, KENNETH M., O.B.E., F.R.C.S. "The Relief of Retention." *Practitioner*, February, 1931.

### EXAMINATIONS, ETC.

#### University of Cambridge.

The following degrees have been conferred:  
 M.D.—Sturton, S. D.  
 M.B., B.Chir.—Oakley, W. G., Taylor, H., Ward, F. H.

#### Royal College of Physicians.

The following have been admitted Members:  
 Gaafar, M. M., Hancock, P. E. T., Hardwick, S. W., Mitchell, W. E. M.

#### Royal Colleges of Physicians and Surgeons.

The following Diploma has been conferred:  
 D.P.M.—Ashby, W. R.

### Conjoint Examination Board.

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

Adams, F. P., Andreas, A. T., Baxter, W. S., Churchill, M. H., Climer, A. L., Cohen, P., Cusack, M. K., Dean, D. M., George, W. F. T., Graham-Campbell, R. W., Great Rex, J. B., Hargreaves, W. H., Hobday, F. T. J., Ishmael, D. T., Knight, B. W., McGladdery, W. F., Marshall, S. F., Patrick, F. L. L., Pierre, J. H., Renbom, E. T., Rodgers, H. W., Scott, J. D., Sherman, I., Trueman, R. S.

### CHANGES OF ADDRESS.

ACTON, T., 3, Elmgate Gardens, Edgware, Middlesex.  
 DISOLEY, A. R., 111, Hatley Street, W. 1. (Tel. Welbeck 2507.)  
 LEITCH, J. N., Tarkwa, *via* Takoradi, Gold Coast, W. Africa.  
 PEARSE, R., 711, Medical Arts Buildings, Toronto 5, Canada.  
 SHORE, T. H. G., 18, The Crescent, Plymouth. (Tel. Plymouth 3224.)

### APPOINTMENTS.

MILES, A. A., M.R.C.P., appointed University Demonstrator in Pathology, Cambridge.  
 SPOONER, F. T. C., M.R.C.S., L.R.C.P., appointed University Demonstrator in Pathology, Cambridge.

### BIRTHS.

JEAFFERSON.—On February 20th, 1931, at a nursing home, Northampton, to Jessica, wife of Dr. Dudley Jeafferson, Blisworth—a son.  
 MOORE.—On February 20th, 1931, at 3, Wilbraham Place, S.W., to Mary, wife of Sir Alan Moore, Bt—a son.  
 SHERRARD.—On February 16th, 1931, at Fairseat, London Road, Beccles, wife of Noel Sherrard, M.R.C.S., L.R.C.P.—a son.

### MARRIAGE.

CROOKS—HEATH.—On February 6th, 1931, at the Savoy Chapel, James Crooks, F.R.C.S., to Irene Heath. No guests.

### SILVER WEDDING.

HADFIELD—MACDOUGALL.—On St. Valentine's Day, 1906, at St. Bartholomew-the-Great, West Smithfield, by the Rev. Sir Borradale Savory, Bart., Charles F. Hadfield, M.A., M.D., youngest son of Geo. H. Hadfield, J.P., of Moraston, Ross, Herefordshire, to Wine-Field Elizabeth, youngest daughter of A. W. MacDougall, Barrister-at-Law, of Oakhurst, Westcombe Park. Present address: 47, Queen Anne Street, W. 1.

### DEATHS.

FOULERTON.—On February 2nd, 1931, at his residence, 1A, Morpeth Terrace, S.W. 1, Alexander Grant Russell Foulerton, O.B.E., F.R.C.S., L.R.C.P., D.P.H., son of the late Captain Alexander Foulerton, aged 67.  
 HORNER.—On February 14th, 1931, suddenly, Charles Julian Horner, M.D., of 11, Orford Road, Walthamstow, aged 67.  
 RUSSELL.—On February 11th, 1931, at The Oaks, Yateley, James Russell, M.D., M.R.C.S., son of the late John Russell, of Dunlewy House, Croydon, aged 79.  
 SEGUNDO.—On January 31st, 1931, at 39, Howitt Road, N.W. 3, Charles Sempill de Segundo, O.B.E., M.B., B.S.(Lond.).  
 DE SILVA.—On February 23rd, 1931, in London, Wilton Lionel de Silva, M.D., M.R.C.S., L.R.C.P., B.Ch., of Colombo, Ceylon.

### 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.

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All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: National 4444.