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### St. Bartholomew's Hospital Journal,

OCTOBER 14th, 1897.

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

### Some Chapters on Pneumothorax.

By SAMUEL WEST, M.D., F.R.C.P.

#### II. ONSET, SYMPTOMS, AND PHYSICAL SIGNS.

(Continued from Vol. IV, p. 183.)

**A**S already stated, percussion yields the same tympanic note over the whole affected side, the only possible exceptions being over those parts where the lung may happen to be adherent or collapsed, or where fluid is present in the pleura.

If the lung be adherent at the apex the percussion note may be impaired, but it becomes rather "boxy" than absolutely dull, for the resonance from the pleural cavity below is transmitted through the solid lung or along the

chest walls, and there may be even considerable adhesion or consolidation at the apex without any impairment of the note at all. In the interscapular space behind also the note, theoretically, might be impaired if the lung were collapsed, round its root, as it commonly is; but in this case also any dullness that might be produced is usually masked by the surrounding hyper-resonance.

Even when fluid is present in the pleura it may be in considerable amount, and yet yield no dullness. The reason of this in most cases is that when the patient is in the semi-recumbent position, or sitting up for the purpose of examination, the diaphragm takes the shape of a saucer, so that a good deal of fluid may lie in it, deep and out of reach, and thus not affect the percussion note. Hence it is that succussion may often be obtained easily when percussion gives no evidence of fluid.

When the amount of fluid is large enough to give dullness, the level is found to change readily with position, and with very much greater rapidity than is the case in simple pleural effusion.

The percussion note is said to change its pitch according as the mouth is open or shut. I have often tried, but have not succeeded in satisfying myself that this statement is correct.

It is also stated that when the intra-pleural tension is high, the percussion-note may lose its tympanic character, and become impaired, or even dull. I have never seen anything at the bedside to justify this statement, and the experimental observations that I have made go far to disprove it, and have led me to reject it.

*Auscultation.*—The voice- and breath-sounds are usually absent, just as they are in an effusion of fluid, except, it may be, in places where the lung is still in contact with the chest wall. Thus, the breathing may be bronchial or amphoric in the interscapular space behind where the lung lies collapsed near the spine. At the apex also, when the lung is adherent, the breath-sounds may be exaggerated. This, however, is not nearly as frequent as might be anticipated, the explanation being, I suppose, that the lung here is so completely collapsed that even the air-tubes

contain but little air, so that the breath- and voice-sounds are not transmitted.

Although, as stated, it is the rule for the voice- and breath-sounds to be absent over a pneumothorax, still there are cases in which they are greatly exaggerated, the voice-sounds being distinctly heard, and the breathing being bronchial or amphoric in character.

Of this, two explanations are usually offered.

(1) The first assumes that in such cases there is a wide opening into the lungs, allowing the air to pass freely in and out of the pleura, so that the voice- and breath-sounds are transmitted directly to the air in the pleura. Pneumothorax then offers practically the same conditions as a large pulmonary cavity, and may yield similar auscultatory sounds.

This explanation, however, can at best only be partly true, for even when the pulmonary opening is free, amphoric breathing is not always heard, indeed no breath-sounds at all may be audible; while, on the other hand, amphoric breathing may be present when it was obvious during life that the opening was closed, and the fact be proved by post-mortem examination.

Thus, I remember a man with pneumothorax in whom amphoric breathing was at first absent, but developed subsequently, and that at a time when it was evident from the contraction of the side and the return of the organs to their normal places that the air was being rapidly absorbed from the pleura, and that therefore no free opening could exist through the lung. As the air continued to be absorbed the amphoric breathing ultimately became fainter and fainter, and finally disappeared, its place being taken by the normal respiratory murmur.

(2) The other explanation is that the amphoric breathing is the effect of consonance, the sounds—produced in the collapsed lung, and which are often heard behind even when there are no respiratory sounds to be heard elsewhere—being taken up and reinforced by the air contained in the pleura.

This explanation also seems unsatisfactory, for if it is adequate to explain the less common cases in which amphoric breathing occurs, it does not explain why it is more frequently absent. Consonance certainly cannot explain the bronchial or amphoric breathing which we get in some instances of fluid effusion, and I think it must be admitted that there is at present no really satisfactory explanation of the phenomenon which will fit all cases.

The heart-sounds are sometimes heard loudly over a wide area in pneumothorax, and may have a somewhat amphoric character. This is also explained as the result of consonance, but it is far more often absent than present.

Whatever the explanation given, it must be recognised clinically that in respect of physical signs, there are two groups of pneumothorax, the first (the common form) that in which both the voice- and the breath-sounds are absent,

the physical signs being like those of pleuritic effusion, except that the side is resonant instead of dull; the second (the rarer form) that in which both voice- and breath-sounds are audible and usually exaggerated, so that they have a bronchial, or it may be an amphoric character.

Two phenomena which auscultation yield are very characteristic, viz. the *bell-sound* and *succussion*, to which may be added perhaps a third, viz. the *metallic tinkle* or *echo*. Though very suggestive of pneumothorax, they are not absolutely pathognomonic, for they may be heard in a large pulmonary cavity, and the two former also in a dilated stomach.

*The bell-sound*.—If a coin be placed flat upon the walls of the thorax in front and tapped with another, while the chest is auscultated in the axilla or behind, under ordinary circumstances nothing is heard except a dull, metallic tap, like that produced by striking the two coins together upon the hand; but in pneumothorax the sound acquires a clear, ringing character, much like that obtained on striking a metal bell or porcelain bowl. This is called the "bell sound." Though known to Laennec, it was especially studied and described by Trousseau under the name of "bruit d'airain" (brass).

The bell-sound, though very suggestive of pneumothorax, is not quite pathognomonic, for it may be heard over a dilated stomach, and occasionally over a large cavity in the lung.

The conditions upon which the phenomenon depend are not clear; but the cavity must be of considerable dimensions, and I think it must have smooth walls. The tension of the air within the cavity cannot have much to do with it, for it may be heard in pneumothorax, where the intra-pleural tension is high, e.g. several inches of water, as well as in cases where the tension is not above that of the atmosphere. It has been heard in the corpse when it was absent during life, and it was this fact that led Traube to suggest the view that it was the result of diminished tension. That the matter is not as simple as it may at first sight seem is clear from the fact that, though generally present in pneumothorax, it is sometimes absent, and that it is not heard everywhere over the side, but only in certain places. Trousseau maintained that, in order to elicit it, the part auscultated should be directly opposite to that on which the coins were placed. This, however, is not the case, and it is not possible before trying to say in what position the bell-sound will be best obtained. In places where the lung is adherent to the chest walls, the bell-sound will not be heard, but it may be absent in parts where there are no adhesions to explain it. On the other hand, especially in partial pneumothorax, or where the lung has in great part expanded after an ordinary pneumothorax, it is possible sometimes, by means of the bell-sound, to mark out fairly definitely the limits of the air-containing cavity.

*Succussion*.—This phenomenon, familiar to Hippocrates, is the splashing sound produced by suddenly shaking fluid contained in an air-containing cavity. There are three conditions essential to its production, viz. (1) that the cavity should be of fairly large size; (2) that it should contain both air and fluid; and (3) that the fluid should be splashable, i.e. should not be so viscid that it could not be made to splash by any shaking to which the patient could be fairly subjected.

Succussion can be produced in the stomach of anyone after drinking largely and hastily of fluid, and in some cases of dilated stomach it may not be easy at first to decide whether the succussion has been produced in the stomach or in the left pleural cavity.

In the same way it is possible for succussion to be produced in a large pulmonary cavity, and I have more than once seen such cavities diagnosed on this account as pneumothorax.

However, succussion in a pulmonary cavity is rare, and chiefly for this reason, if for no other, that the fluid contained in such cavities is too viscid and tenacious to splash easily.

A cavity which contains air only cannot produce succussion, and therefore it will not be obtained in a case of simple pneumothorax. When succussion, therefore, is obtained, it is a proof that the cavity contains both air and fluid, and that in the case of the pleura we have not a simple pneumothorax to deal with, but a hydro- or pyo-pneumothorax, as the case may be. Hence it follows that succussion is not obtained in the early stages of pneumothorax, but only at a later period, when effusion has formed; nor is it necessarily obtained even then, if the fluid be in small amount or be very viscid or thick. Consequently, succussion is easily elicited in hydro-pneumothorax, or where the effusion is sero-purulent; but in pyo-pneumothorax it may be absent, and that even when the amount of fluid is considerable.

Thus, putting aside the rare cases in which a large cavity in the lung or a dilated stomach might cause some difficulty in diagnosis, succussion is practically pathognomonic of pneumothorax with effusion; but the converse is not true—the absence of succussion shows the absence of fluid.

In most cases the succussion splash has a ringing, metallic character, due, no doubt, in this instance to consonance. It is sometimes so loud as to be easily heard at a distance, just as succussion in the stomach often is. Patients frequently hear it themselves, and describe it accurately, and sometimes even complain of it.

*Metallic tinkling*.—Closely allied to succussion and the bell-sound, and like them, no doubt, a phenomenon produced by consonance, is the metallic tinkle, a peculiar, musical, ringing sound, like that produced by the falling of a drop of water in a grotto ("gutta cadens"). This is, indeed, the explanation usually given of its production, viz. that a

drop falls from the walls of a large cavity into the fluid contained in it, and makes a splashing sound, which, reverberating from the walls of the cavity, obtains its metallic, ringing character. Similar sounds produced, not in the pleura, but in parts near the pleura, may also in like manner acquire similar characters, e.g. the gurgle of fluid swallowed as it passes down the oesophagus, or crepitation produced in a cavity in the lung.

*Bruit de fistule*.—Under this name Riegel describes a sound not often heard in pneumothorax, viz. a bubbling noise, audible on inspiration only, such as would be produced by the bubbles of air passing slowly through fluid and breaking on its surface—the explanation which Riegel has given of the phenomenon. The condition under which such sounds could be produced is that in which the opening into the lung is still patent, and the mouth of the fistula below the level of the fluid, so that on inspiration bubbles of air are sucked into the pleura. It is obvious that for this sound to continue the fluid must be pressed out of the pleura on expiration, being displaced by the air which has entered on inspiration. If the communication with the bronchus were so free as is obviously necessary, a kind of fluid valve would form, which would be sufficient to prevent the entrance of air, and consequently the occurrence of this phenomenon. In fact, the "bruit de fistule" is an accidental and altogether rare phenomenon, and is really more likely to be met with in an empyema discharging through the lung than in pneumothorax.

### Pathological Findings.

By A. A. KANTHACK, M.A., M.D., F.R.C.P.

#### VI. THE PROCESS OF ACUTE INFLAMMATION.

**I**F we observe the process of acute inflammation in the frog's mesentery, we find that the first dilatation of the small arteries (*inflammatory congestion*). Thus more blood flows into the part, and the veins as yet not participating in the dilatation, the velocity of the blood-flow is increased. Gradually, but more slowly, the veins and capillaries also dilate, so that arteries, capillaries, and veins now become turgid, and the increased velocity gives way to retardation of the blood-flow. During this retardation the leucocytes arrange themselves along the inner wall of the veins, in the marginal zone, preparatory to their emigration. In the capillaries analogous changes are observed; in some the blood still travels onwards, in others there is barely a flow of plasma-like fluid, while in many the current has ceased altogether: there is stasis, the capillary being filled with red corpuscles, or sometimes with plugs of white corpuscles (white stasis). Emigration of leucocytes follows on the marginal distribution in the veins. This emigration is an active

process on the part of the white corpuscles; they may be watched sending out pseudopodia through the vessel wall, and gradually following the extruded part. The emigration or diapedesis of the leucocytes is generally accompanied by a diapedesis of the red corpuscles, at times but slight, at other times very marked, but always present. At this stage then we find amongst and between the capillaries numbers of white and red corpuscles, scattered about or collected together. At the same time that all those changes occur there is also a transudation of fluid, of plasma, sometimes so considerable in amount that the part becomes œdematous (*inflammatory œdema*).

Exactly similar phenomena are seen if we examine the inflammatory process in the mesentery of warm-blooded animals, or if we study the irritated cornea; the vessels at the corneal margin become dilated, and there is copious diapedesis and transudation of fluid. We have, therefore, the following conditions:

1. Dilatation of the arterial vessels (inflammatory congestion and increased velocity).
2. Dilatation of the capillaries and veins (retardation).
3. Retardation, and marginal arrangement of the leucocytes.
4. In the capillaries there may be complete stasis.
5. Diapedesis of white and red corpuscles.
6. Transudation of fluid (inflammatory œdema).

Although the process of emigration must be regarded as an active one on the part of the white corpuscles, there are a few factors which assist, and which must not be lost sight of. (1) Changes in blood-current: the quickened stream by centrifugal action forces the corpuscles which normally travel peripherally against the vessel wall, where they are inclined to adhere during the retardation on account of their natural tactile stickiness. When there is stasis the marginal distribution of the leucocytes is entirely absent. (2) Increased capillary and venous pressure to some extent must assist diapedesis, especially when (3) the permeability of the delicate vessel wall is at the same time increased. That the vessel wall becomes more porous can hardly be questioned, as we shall see when we come to discuss the process of transudation. (4) Lastly, the vessel wall must be in a suitable condition to allow the leucocytes to adhere. Certain chemical substances, without affecting the leucocytes, will prevent diapedesis, presumably by producing some alteration of the vessel wall. Before emigration can occur it appears, therefore, certain conditions must exist: (a) changes in the blood-current to allow of a marginal distribution of the leucocytes; (b) a suitable state of the vessel wall, without which adhesion cannot take place; (c) amœboid activity of the white corpuscles. It is by means of their own movements that the leucocytes pass out, and in this sense emigration is an active process, and anyone who has directly observed the diapedesis of leucocytes is firmly convinced of their

vitality and activity. Substances which paralyse the amœboid movements of the white corpuscles completely stop diapedesis.

If we observe amœboid leucocytes outside the animal body, we find that whenever they come in contact with the surface of a foreign body they attach themselves and become flattened out; and if the foreign body be porous, we find that having attached themselves they send out pseudopodia into the pores. It is important to remember that this tactile sensibility of the amœboid leucocyte is a natural property. When once the corpuscle has been allowed to come in quiet and undisturbed contact with the vessel wall it will flatten out and attach itself, send a pseudopodium through a pore in the vessel wall, and creep into the surrounding connective tissue. If the irritant which causes the inflammation is such that it will not paralyse the protoplasm of the leucocyte nor prevent the vessel wall from responding to its tactile sensibility or adhesiveness, emigration must take place, for nature must assert itself.

After the leucocytes have passed out of the vessel they begin to wander, so that emigration is succeeded by migration. They migrate to the seat of irritation; and this migration is also mainly a pseudopodial act, although it is no doubt favoured by concomitant conditions, such as the exudation currents and the diminished resistance of the tissues. It is now generally believed that the migration to the seat of irritation is due chiefly to an attraction of the leucocytes by the chemical products of bacterial activity or tissue destruction, *i.e.* chemiotaxis. Experiments have shown that certain substances will attract leucocytes, and amongst such substances we find the albuminoid bodies contained in the bacteria (proteins) and the earlier products of decomposition or necrosis. That chemiotaxis, or rather the chemiotactic irritability of the leucocytes, is an important factor in their migration cannot be questioned, but it does not explain altogether why the cells collect in the inflamed area. In pneumonia, for instance, a whole consolidated lobe may show all the alveoli full of leucocytes, and it is difficult to explain an extensive aggregation of leucocytes on the simple principle of chemiotaxis. We can understand a local and circumscribed attraction, but matters are different when a whole organ is invaded by leucocytes. Moreover if the collection of leucocytes in the inflamed lung were due to chemiotaxis, we would expect the blood in the peripheral circulation to be impoverished in white corpuscles. The contrary, however, is the case; in most cases of pneumonia which run a favourable course there is an almost extraordinary leucocytosis. Chemiotaxis does not, therefore, satisfactorily explain the migration of leucocytes, nevertheless it is a matter which cannot be neglected, and the importance of which must be recognised; but we must not go too far, and say that this migration to the seat of irritation is entirely due to chemiotaxis.

A point of considerable interest is that the various forms

of leucocytes do not show the same tendency towards diapedesis or migration. In circulating blood the following general types of white corpuscles may be found, viz. (1) the lymphocytes; (2) the "multinuclear" or finely granular eosinophile; (3) the large uninuclear, and (4) the coarsely granular eosinophile cells. The lymphocytes are small cells possessing scanty protoplasm and a round nucleus, and are indistinguishable from the small cells of lymphoid tissue. They may form up to 30 per cent. of the leucocytes present in human blood. The large uninuclear cells have a round or kidney-shaped nucleus and abundant protoplasm, and are rare in the blood (2 per cent.). The "multinuclear" cells have a lobed or multipartite nucleus, and their protoplasm is beset with small granules staining pink with eosin. They are abundant in the blood (up to 70 per cent.), and are actively amœboid and phagocytic. The true and genuine coarsely granular cell shows large and numerous granules staining deeply with eosin; they are rare in human blood (up to 5 per cent.), are amœboid, but not phagocytic. During the earlier stages of inflammation, when chemiotaxis is said to be most active, the "multinuclear" (neutrophile) cells leave the vessels in greatest number, and migrate to the irritated area; hence most pus corpuscles belong to this class of leucocytes. Sometimes the coarsely granular eosinophile cells also appear in great quantity. This fact of "selective attraction" proves that we must not take the process of chemiotaxis too literally. The cells which migrate to the inflammatory focus are the most amœboid among the leucocytes, and this demonstrates the close relation which must exist between so-called chemiotaxis, tactile sensibility, and motility. There are certain advantages in this aggregation of leucocytes; they form a cordon around the inflammatory zone, and prevent the invasion of the bacteria and the absorption of the toxic material; the cells being phagocytic destroy the mechanical irritant, and further they assist in clearing away the tissue debris, and prepare the ground for the proliferating connective tissue, and being possessed of chemical activity they also act upon the irritants in solution. At times, however, they collect in such enormous numbers that when an inflammation is very acute and severe, suppuration appears with ulceration and all the dangers of suppuration; emigration and migration may be and generally is scant then, so that in a broad way chemiotaxis must be regarded as a good sign.

Besides leucocytes a fluid transudation leaves the vessels. This is undoubtedly derived from blood-plasma, and in its composition it often differs but little from ordinary plasma. Normally a fluid leaves the capillaries in the form of lymph, but this normal process is exaggerated during inflammation. The amount of transudation varies with the laxity of the tissues, the nature of the irritant, and inversely as the resistance of the tissues and the animal. The transudation is often of great advantage in that it flushes out the part,

removing the poisonous irritant, or at any rate diluting it. By doing so it may reverse the chemiotaxis; for it has been shown by experiments that a strong solution may paralyse the tactile sensibility and the motility of the amœboid leucocytes, while when diluted the same solution may become an attraction of these corpuscles. Also the transuded fluid may act as a germicide, impairing or destroying bacterial life. Further, this serum may supply the proliferating tissues with nourishment. Equally often, however, the exudation may prove harmful by impairing nutrition, the tissues becoming water-logged, by pressing on vital organs and thus favouring necrosis and gangrene.

Without entering into a lengthy discussion, it may be said that the appearance of the transudation is due to three chief factors, viz. (1) the increased permeability of the capillary wall, (2) an increased lymph secretion, and (3) a diminished lymph absorption. But it must be stated that some observers deny that there is a true lymph secretion, but regard the process as a mechanical one, *i.e.* a filtration under pressure; and, according to them, instead of increased lymph secretion we must put increased filtration due to raised intra-capillary pressure.

The inflammatory exudation consists of plasma or a plasmatic fluid, various enzymes, derived from the bacteria, tissues, or leucocytes, fibrin and its precursors, albumoses and peptones, mucin, bacterial toxins in solution, and also certain germicidal substances. The exudation may or may not coagulate. The coagulation is, of course, due to fibrin formation. When coagulation is well marked we have a fibrinous inflammation, and when it is absent a serous inflammation, while intermediate between these two is the sero-fibrinous inflammation. Again, if many leucocytes appear, we have either a purulent or fibrino-purulent or a sero-purulent form of inflammation.

*Fibrinous inflammation.*—Under physiological conditions outside the body, plasma will coagulate on the addition of fibrin ferment or leucocytes, and therefore we should expect that in inflammation, wherever there are leucocytes present, fibrin is formed. The absence of coagulation in the case of serous effusion, therefore, requires explanation. It is undoubtedly due to certain inhibitory influences, amongst which may be mentioned (a) integrity of the endothelial or epithelial surface; (b) absence of fibrin ferment and leucocytes; (c) increased alkalinity; and (d) the presence of certain toxic or chemical substances, which in small quantities are capable of preventing coagulation. Thus extremely minute quantities of cobra poison will successfully keep coagulation in abeyance, and we may justly believe that certain bacterial substances or tissue products are possessed of similar inhibitory powers. Fibrin generally appears on free surfaces or in enclosed spaces (tonsils, pleura, and pericardium), especially when there is continued superficial friction (heart and lungs), or it may appear as the result of the action of certain, perhaps un-

known, chemical substances; as, *e. g.*, in some bacterial inflammations (diphtheria and pneumonia). It may be formed either immediately or after a delay, the exudation being to begin with serous, and then becoming fibrinous; it may either form a true membrane lying on the free surface, as in fibrinous pericarditis, or it may form an interstitial deposit, as in diphtheria, where the fibrin appears in part between and among the epithelial cells, which undergo a so called coagulation necrosis.

**Serous inflammation.**—If the inflammatory plasma does not coagulate, then we have a serous inflammation. The amount of fluid which is poured out varies considerably, and, generally speaking, it is most copious when it exudes from a free surface. The free surface may be lined by epithelium, which is either columnar, as in the nose, larynx, intestine, or uterus, or it may be lined by squamous epithelium, as with the conjunctiva and vagina. A serous inflammation in connection with free epithelial surfaces is generally called a catarrh; the exudation generally contains much mucus. On the other hand, the effusion may exude from an endothelial surface, such as the pleura or peritoneum. It is possible that coagulation does not occur because the epithelium or endothelium is intact, or because there are inhibitory influences which contract and prevent coagulation.

Instead of trickling from a free surface the exudation may collect in the tissue substance, *i. e.* we have an interstitial serous infiltration. This may occur either in the connective tissue (inflammatory oedema) or between the layers of the epithelium (vesiculation). An inflammatory oedema is often observed when there is extensive fibrin formation,—as, for instance, in croupous pneumonia; on cutting into the consolidated lung, fluid generally exudes copiously. Again, the serous effusion may subsequently coagulate, either completely or in part, producing a so-called sero-fibrinous inflammation. In cellulitis and acute septic inflammations the oedematous infiltration is as a rule well marked; and, broadly speaking, the weaker the local or general resistance of the individual the more marked the inflammatory oedema. The fluid which is poured out may be completely absorbed, or it may stagnate and then lead to a chronic or persistent effusion, or to necrosis and gangrene of the part by impairing the nutrition of the tissues, which become softened and water-logged.

A good example of a serous inflammation, which is usually not recognised as such, is acute parenchymatous or tubal nephritis. Here, as elsewhere, the inflammation affects the connective tissue supporting the renal tubules; the vessels dilate till eventually retardation or stasis occurs; a fluid exudes, passing in part into the interstitial tissue, which becomes thereby oedematous in part, or being discharged directly into the glomerular capsules or uriniferous tubules to be drained away with the urine, producing the characteristic albuminuria. Blood-cells are also frequently

discharged in numbers, and they also collect in part in the connective tissue and in part appear in the urine, the red corpuscles causing the hæmaturia of acute nephritis, and

Fluid constituent of inflammatory exudation	
Coagulation = fibrinous inflammation	Absence of coagulation = serous inflammation
(a) Interstitial = diphtheria	(a) Interstitial = inflammatory oedema, vesicles
(b) Free endothelial surfaces = fibrinous pleurisy	(b) Free endothelial surfaces = serous effusion
(c) Free epithelial surfaces = membranous tonsillitis croupous pneumonia	(c) Free epithelial surfaces = catarrh.
Result { Destruction and removal = resolution Organisation = induration	Result { Discharge = catarrh (restitution) Absorption = resolution Stagnation = chronic effusion Coagulation = fibrinous or sero-fibrinous inflammation (q. v.)

white corpuscles may always be observed in acute albuminuria. The epithelium of the glomerular capsule and the tubules suffers, because there is an acute inflammation of the connective tissue, whereby their nutrition is greatly impaired. The term parenchymatous inflammation is unjustifiable, because the inflammation is essentially interstitial, as all other inflammations are; there is no such thing as an inflammation of the epithelium.

**Purulent inflammation.**—If the emigration and aggregation of leucocytes is excessive, coagulation being at the same time absent, the exudation becomes converted into pus. Macroscopically, pus in its usual form is a thick, creamy, viscid, light yellow or yellowish fluid, with a faintly sweetish sickly odour; such is the so-called laudable pus of older writers. On allowing it to stand it separates into two portions, a serous element, the liquor puris, and a whitish sediment, the pus corpuscles. Although pus consists of inflammatory plasma and leucocytes, it is a characteristic of it that it does not coagulate, so that there must have been influences or substances which, during the process of pus formation, inhibited coagulation completely. Microscopically, the most important constituents of pus are the pus corpuscles. These are round cells, which are mostly of leucocytic origin. In fibrinous inflammation, *e. g.* in pneumonia, the number of white corpuscles present may be as great as that which we find in pus, but the fact that coagulation has taken place is a distinctive character, and therefore the pneumatic process cannot be compared to a suppuration, as has been done by some observers. The leucocytes which constitute the pus corpuscles are mostly and generally of the so-called multinuclear or neutrophile (finely granular eosinophile) variety. Sometimes, however, the number of coarsely granular eosinophile cells

present is striking; anyhow it is the actively amœboid corpuscles which mainly occur in pus. But besides the typical leucocytes young connective-tissue cells are often found, and these are generally included in the term pus corpuscles. It is frequently stated that pus corpuscles are degenerated or dead leucocytes and connective-tissue cells. This, however, is erroneous; many of the cells are no doubt degenerated or dead, but, on the other hand, many are still amœboid, well preserved, and phagocytic, as may be seen on placing fresh pus on the warm stage of a microscope.

Before studying the chemical nature of pus a few words must be said concerning the pathogenesis of suppuration. In most cases micro-organisms are present, so that we must conclude that pus is generally of bacterial origin. It may, however, also appear independently of micro-organisms. Thus it is possible by means of nitrate of silver, turpentine, castor oil, perchloride of mercury, and other chemical substances to produce a suppuration without micro-organisms appearing (sterile suppuration). Similarly, continued irritation—as, for instance, the presence of metal in the anterior chamber of the eye, and the products of necrosis—may call forth a suppurative process. Chemical irritation, therefore, is a cause of suppuration; we must believe that a continued irritant produces a necrosis, and that the products of necrosis act as a chemical poison. Buchner has shown that the latter act positively chemiotactic, *i. e.* attract leucocytes; and he has further shown that croton oil causes a necrosis of the tissues, and that it is the products of necrosis which call forth suppuration.

In most cases, however, micro-organisms are found, so that pus is generally of bacterial origin, a point of fact which the surgeon especially should remember. There are some bacteria which are so constantly found in pus that they are regarded as pus-producing or pyogenic organisms. These mostly belong to the group of micrococci, and the commonest forms are the following. I. Staphylococci: (a) *Staphylococcus pyogenes aureus*; (b) *Staphylococcus pyogenes albus*; (c) *Staphylococcus pyogenes citreus*. II. Streptococci: (a) *Streptococcus pyogenes*; (b) *Streptococcus erysipelatis*; and (c) *Pneumococcus*. Most authorities are inclined to believe that the *Streptococcus pyogenes* and *erysipelatis* are one and the same organism. These are the pyogenic organisms, or pyococci; each variety may occur by itself, or any combination of them may be found—mixed infections in pus are extremely common. Other microbes may, however, produce a suppuration,—as, for instance, the bacillus of typhoid fever, the gonococcus and the bacillus of tuberculosis; yet they are so markedly specific in their action that they are not included among the pyogenic organisms. How do these germs produce suppuration? Buchner has clearly shown that they do this by chemical irritation, for the dead bodies of the protoplasmic substances (proteins) of the bacteria will produce suppuration as effectively as or

even better than the living organisms. Therefore the true cause of suppuration is chemical irritation. The chemical irritant is extremely chemiotactic, and stimulates the leucocytes to emigrate and to wander to the seat of lesion. We have, therefore, two necessary conditions without which there can be no pus: (1) chemiotaxis and aggregation of leucocytes, and (2) inhibition of coagulation. There is, however, a third factor, *viz.* histolysis or tissue destruction. Under the influence of pus formation the tissues are dissolved and disintegrated, and according to the law of repair the tissues must react against this dissolution, and they do so by proliferation and an attempt at forming new cells. This new formation of tissue may be observed at the margins of any suppurating focus, and it is on this account that connective-tissue cells are so frequently found in pus.

The fluid constituent of pus consists of serum devoid of fibrinogen, of albumoses, and peptones, toxins of bacterial origin, and the products of degeneration. The albumoses and peptones are in part due to the digestive or proteolytic action of the micro-organisms concerned, and partly to a similar action on the part of the pus corpuscles themselves, and it is probable that the histolysis depends on this proteolytic property of pus. Although pus is generally produced by bacterial irritation, it is a curious point that it forms a bad soil for the growth of bacteria, and is distinctly germicidal; and we find, therefore, that pus which has been long pent up in the body is sterile, the pyococci having been gradually destroyed. The chief physiological properties of pus, therefore, are the following: it is (1) bactericidal, (2) histolytic, (3) contains phagocytic elements, and (4) is a strong solvent; for Leber has shown that it is capable of dissolving such metals as platinum and copper, which require strong acids for their solution. There can be no doubt, then, that suppuration must be frequently a useful issue of the inflammatory process, assisting in the destruction of the irritant and in stimulating the tissues to react by proliferation. On the other hand, suppuration is often a source of great danger by destroying the tissues, and especially by laying open the vessels, and thus offering serious chances for complications, such as septicæmia and pyæmia.

### Specialism in General Practice.

A Paper read before the Abernethian Society on February 25th, 1897.

By E. H. EDWARDS STACK, M.B., F.R.C.S.



WISH this evening very shortly to mention a subject which seems to me to be of great importance to those of us who are going into what is called "general practice;" that is, to join a class of men for whom I have a profound respect, who are overworked, underpaid, and amongst the most sympathetic and kind-hearted in the kingdom. We are all apt while still in the hospital to run them down a little, and I think I can partly show you the reason why.

Adam and Eve had to do everything for themselves, they had no

servants, and required no doctors; owing to the scarcity of the population there was no competition, and so they managed very well. Specialism had not yet begun. It was not long, however, before the natural results followed, that for the better working of the community specialism started, and has ever since increased, not only among individuals, but in departments, and in most cases this is best.

If a man happens to have wonderful muscular development beyond other men, what is more natural than that he should not only gain his own livelihood, but amuse thousands by tossing "fifty six pounders" about like cricket balls, or by allowing a couple of elephants to play at see-saw across his back? or what could be finer than to see a surgeon of a great hospital like this cut down and remove a vesical calculus in thirteen seconds?

But with general practitioners the case is different; to the public he is a specialist for every kind of ailment. They have a disease and wish it cured; no matter where it is situated, he is supposed to know all about it. Alas! very often he doesn't, and either thinks he does or has to pretend to.

And so this sort of thing often happens. Say a patient is deaf; after a course of medicine, or perhaps syringing for some time, he sends him (or still more likely the patient goes himself) to an "ear doctor," who discovers adenoids, and recommends him to consult a throat specialist, who in turn says he ought to be operated on, but as east winds are prevalent he had better wait a few months, and so he returns home. He does not thank his own doctor for the round he has made or the guineas expended, whereas the adenoids, both easy to diagnose and cure, might have been removed at home long before, and the general practitioner rendered famous in that house at least.

Now if we learn—and this is the pith of my remarks—something of each branch, and it need not be very much, we shall know in the first place whether we can undertake to cure a case or not, or in the second whom to send a patient to, and when to send him. That is, we use the pure specialist to confirm our opinions or to treat a case too difficult for us, and not for diagnosis.

Some may have realised what a worry it is to a conscientious doctor to know what to do when he is not quite sure of his diagnosis, and in a case the is not serious enough to need a consultant.

A "G. P.," as we call him—and one could often question his right to such a name—deals mainly with "ordinary medical cases." He may or may not have some particular subject he is interested in, and if he has, so much the better, both for him and the patients; but of most he is ignorant, either from never having acquired them, or having forgotten what he knew. Well, these medical cases are all important, and rightly do we spend most of our time here in acquiring their knowledge; but if a few months were spent, especially after qualification, in getting an intelligent hold of the other branches we should find it of incalculable service.

I feel quite convinced, and I wish to lay particular emphasis on this, that there is nothing which will gain us so much credit, and therefore so many patients, as the treatment of these cases; and often when a man has got past the worry of a whole practice he can fall back on some branch he has made a reputation in. "Any one can tie a pile."

Supposing two men covering the same ground and about equally capable—a fairly common circumstance,—surely the one who can feed a baby, dilate a stricture, or fit a truss is the one who will forge ahead; and remember when one patient in a house is acquired, the rest follow as a matter of course. To illustrate what I have been saying by a few cases, I know of one which had been treated for three months' metrorrhagia, supposed to be due to cancer, but which had never been examined *per vaginam*; a friend of mine taking a *locum* there put in a speculum, and removed a mucous polypus,—she was quite cured of her cancer in five minutes.

I saw a boy lately who had had headaches ever since he went to school two years before, and had been taking medicine on and off during that time; a pair of convex glasses completely cured him, and yet that was a very simple eye case.

I saw a girl the other day in the country with a pain in her foot; I thought it was early tubercular disease, and recommended plaster of Paris. I knew nothing of orthopaedics at the time, but I feel sure now that it was a case of incipient flat-foot, and plaster the worst thing for it.

A case apparently convalescent from typhoid fever (diagnosed on an irregularly raised temperature, pain in the abdomen, and diarrhoea) had lasted six weeks, and no further physical signs developed; no vaginal examination had been made, because she was not married. One day she suddenly collapsed with symptoms of peritonitis. A Bart.'s man who happened to be there examined her, and found a suppurating ovarian tumour which had ruptured; but it was too late—she died.

A lady I was treating for something else told me she was deaf in one ear, and had been for two years. Her doctor said it was chronic; in that, at any rate, he was not far wrong. The removal of some wax quite restored her hearing.

Every eye department at a hospital occasionally has cases of glaucoma, due to the "hope it will do good," treatment of putting in atropine on chance; and if a mistake like this gets known it is very damaging. That patient keeps his eye on the doctor for many a year. A set of false teeth will often convert a chronic dyspeptic into a new woman. I have removed adenoids in the country several times, but the *adversus* was not for me, but for the local man who discovered what was wanted.

Men sometimes say you can't examine patients in private as you can in a hospital; I can only say I have never known a woman refuse even a vaginal examination if it was said to be necessary. The more careful the doctor is, the more they think of him; and if he thinks fit to examine with a series of "scopes" one after the other, even if he finds nothing, yet that is a useful negative, and the patient is impressed, and rightly so. To acquire patients legitimately is our prime object, and then to cure them; and it is quite impossible to avoid overlooking something belonging to one of the special branches unless we have at one time been familiar with it.

I feel sure even in my own case that I have made much more impression by being able to remove a nasal polypus, which would not have killed the patient, than by diagnosing a difficult case of typhoid fever. Yet the latter might be called our bounden duty, and the backbone of our practice; and the former a lucrative trifle, but the one which gains the patients. Any one can place a stethoscope on a chest and look serious, and the patients have no estimate of the knowledge gained, but they can say who removed a tooth well or ruptured a perineum.

Just one word about diseases of women; many will let their own doctor examine them, and no one else,—I mean they would go to no one else. If he finds an ovarian tumour, he can perhaps save their life by persuading them to have it removed; the same remark applies to an early case of cancer, or to quote that great man, Dr. Matthews Duncan, "What a grand thing it is to be able to say, 'You've not got cancer!'"

Dr. Gee says, "No matter where you are, half your practice will be children; and yet perhaps no complaint is so common amongst young practitioners as 'I wish I had done some work at a children's hospital!'"

Another subject very little attention is paid to in hospital is prognosis, and there is no need to emphasise its importance, not so much with a view of benefiting the patient as to insure our own position.

We may think we are fully equipped when we have been round the departments in a hospital like this, but unless we think, as we are learning each subject, "How would I manage this in private?" we shall find ourselves one day at a loss. A leg has to be massaged, and we should like to instruct the patient's mother; but we are compelled to read it up, and that is never the same as having had a few practical lessons.

Now you may say, "How can we get time to do it all?" In the first place we remember this when doing our ordinary appointments, and never lose an opportunity of putting a mirror down a throat or a finger up a rectum, then we will find that a very few months after qualification spent in the departments not yet attended will not only be interesting and useful to ourselves, but may save many a patient's life.

In fine, though I would not go so far as a pamphlet published in Paris called 'Every Man his own Lithotritist,' yet I would like to uphold this maxim, "Every general practitioner his own specialist."

### A Case of Spinal Injury followed by Recovery.

By E. G. SIMMONDS, M.R.C.S., L.R.C.P.

**THE** following is a brief account of a case of spinal injury which occurred on board the ship "Hesperus," during a voyage to Australia.

S. M.—, at. 26, able seaman, met with an accident on November 9th, 1896.

November 9th (10.45 a.m.).—Patient fell from a height of four feet on the deck of the ship, alighting on the back of his neck, so that

his head was "doubled under him." Immediately after the accident pain was in a state of collapse. Face pale, breathing shallow, pulse small, intermittent and slow. Did not lose consciousness. He immediately lost all power in his arms and legs, and complained of numbness and tingling in the right arm and leg. He was immediately placed on an improvised stretcher, and removed to his berth; he then vomited twice.

About half an hour after the accident his condition was as follows:—Loss of power in the arm and leg on both sides, but more especially on the right side. Severe pain in the right shoulder and the cervico-dorsal region of the spine. Hyperæsthesia in both arms and legs. Knee-jerks increased on both sides. Pupils reacted normally, and of equal size. No headache, or anything pointing to head injury.

At 6 p.m. (seven hours after the injury) patient had regained the use of both legs, and sensation in them was normal. The right arm was still quite motionless and hyperæsthetic. Left arm: patient could raise his left hand to his mouth, but had a very feeble grasp; sensation not materially altered. There was also a hyperæsthetic area over the right pectoralis major muscle, but apparently not elsewhere on the chest. Knee-jerks now appeared to be diminished.

10th.—Patient passed a very restless night, and had only an hour's sleep. Has complained of a good deal of pain in the back of the neck and right shoulder. There was no evident deformity of the spine, and no signs of injury, dislocation or otherwise, about the right shoulder. Temperature this morning 100° F. Pulse 84, regular, good volume. Respirations 20. Patient has not passed water for the last twenty-four hours. Has great discomfort; he feels the desire to micturate, but is unable to do so. Every available catheter was tried, but none would pass into the bladder. The passage of the catheter caused great pain, though done as gently as possible; it seemed to be arrested at the membranous portion of the urethra. Patient denied having ever suffered from gonorrhœa, and had never had an instrument passed before.

A full dose of tincture of opium was given, and hot sponges applied continuously to the perineum for an hour, with the idea of removing any urethral spasm which might be present; this did no good as far as passing a catheter was concerned. There had been no incontinence of urine from overflow, the bladder was evidently full, and presented a central swelling in the abdomen, with percussion dullness as high as the umbilicus. As his symptoms of retention were becoming urgent, it was decided to try the effect of a hot bath. A bath having been placed by his bedside, the water being as hot as could be comfortably borne by the hand, patient was lifted, blanket and all, into the bath and suspended as if in a hammock, special care being taken to support the head, so that no displacement of fragments might occur, should there be a fracture of the spine present. After remaining suspended in the bath for ten minutes, patient began to pass his water voluntarily, though he had much difficulty in commencing the act. The urine passed was acid and quite clear, and in a good stream, so that a stricture, if present, must have been a very slight one. While patient was passing his water in the bath I tried to pass a catheter, but with the same want of success, owing to the pain it caused and probably the spasm it gave rise to. Patient was then removed from the bath, thoroughly dried, and carefully placed between dry blankets, when a cup of hot beef tea and brandy ʒss were given to him.

11th.—Another restless night; obtained some sleep after several small doses of tinct. opii. Passed water voluntarily in the night, but bladder is very distended this morning and causing much discomfort. Had to resort twice to-day to the hot bath, to get patient to empty his bladder. The urine remained clear and acid. Every precaution was taken in moving the patient, as in yesterday's note. Patient's bowels have not been opened since the injury, though calomel (gr. ʒ) was given at once. Temperature normal.

There is scarcely any change noticeable in the condition of the right arm since the accident; there is absolutely no movement, and well-marked hyperæsthesia, so that even a fly crawling on the arm gives pain. The left arm has certainly improved, and can be raised more easily by the patient, while the grasp of left hand is stronger. The legs have quite regained their power. Respiration almost entirely abdominal.

12th.—In much the same condition; the use of the hot bath still necessary. Bowels not open.

13th.—Bowels opened after calomel gr. ʒ; hot bath as usual; left arm still further improved; right arm still powerless, but less hyperæsthetic.

14th.—Some difficulty in breathing, but no physical signs in chest.

15th.—Hot bath still necessary and effectual. Urine quite clear and acid. Can now raise his right arm from his side, but chief loss

of power is in the forearm. No grasp in right hand. Still complains of pain in the right shoulder. Left grasp still further improved. Has a good deal of respiratory trouble to-day, and is using his muscles of extraordinary respiration. The chest appears to be moving very little, while the abdominal walls appear to be working more than naturally in respiration. The percussion note is dull at both bases behind, and moist sounds are numerous at the bases, with rhonchi all over the chest.

18th.—Much improved. Breathing easier, fewer moist sounds. Left arm practically recovered. Right arm continues to improve; sensation normal. No signs of bedsores.

22nd.—Right arm still further improved; the upper arm has very fair movement, but there is only slight power in the forearm and hand. Patient can now pass his water naturally. He is still troubled with slight bronchitis, which is being treated by Vin. Ipecac. and ammonia internally, with mustard poultices externally.

December 4th.—Patient still suffers from attacks of dyspnoea, with moist sounds at the bases of both lungs; these attacks are worse some days than others. As to the paralysis, the left arm has completely recovered, while in the right arm the extensors are the muscles chiefly affected. Thus the patient cannot extend the elbow-joint when it has been fully flexed. There is some wrist-drop, while the fingers of the right hand cannot be extended fully.

24th.—The right triceps is still very weak, but there is no wrist-drop. Patient is unable to extend the little and ring fingers of the right hand; he can extend the other fingers, and has a fair grasp. Patient has been on his back for six weeks, and is now allowed to get up for a short time every day.

January 3rd.—Patient has much improved, and is doing light work on deck; attending twice a week at one of the Melbourne hospitals for galvanism. What is most noticeable now is the dropping of the little and ring fingers of the right hand. The muscles of the right arm feel more flabby than those of the left, but there is no very obvious wasting.

February 17th.—Patient says he is now as well as ever he was. Power in right arm almost totally restored. He has a strong grasp in the right hand. Percussion over the lower two cervical vertebrae causes some pain. There is no obvious angular curvature of the spine. Patient is doing his ordinary work on board, and can now go up aloft.

Since last note patient has left the ship, according to his own account "as well as ever he was."

Among the points which the above case serves to illustrate may be mentioned the fact that, after an injury in the lower cervical region of the spine due to indirect violence (such as falling on the back of the neck and doubling the head under the body as in this case), though there may be at first total loss of power below the seat of injury, yet this loss of power may partially be regained in a few hours after the injury according to the amount of damage to the spinal cord at the seat of injury. In this case power was regained in both legs and partially in the left arm seven hours after the injury, though the right arm remained paralysed, and did not completely recover for three months.

Another point which presented itself was: "What to do in a case of spinal injury, when there is retention of urine, with urgent symptoms, and a catheter cannot be passed into the bladder." It was obviously necessary to empty the bladder at once, and by the simplest means possible. The easiest means of doing this—the catheter—had failed. A hot bath was the next thing that suggested itself, but it was a very serious question as to whether it would be justifiable to move a patient as to the nature of whose spinal injury there was necessarily some doubt; for although there was only partial loss of power, yet movement of the patient, should there be a fracture-dislocation of his spine, might bring about displacement of the fragments and further injury to the spinal cord. However, all things being considered, among others the urgency of the symptoms of retention of urine, a hot bath was decided on and given with the precautions mentioned in the note, so as to reduce to a minimum the danger of displacing fragments of the injured vertebrae. Seven men (three on either side, and one to support the head) were required to suspend the patient in the bath as in a hammock. The result was quite satisfactory, both immediately and ultimately. Three months after the injury patient was at his work again, and expressed himself as being "as well as ever he was."

### Contributions towards a History of the Surgical Teaching at St. Bartholomew's Hospital during the Nineteenth Century.

By D'ARCV POWER, F.R.C.S., F.S.A., Demonstrator of Practical and Operative Surgery.

#### III. THE DEMONSTRATORS.

**I**N former articles we have spoken of two out of the three great Lecturers on Surgery at St Bartholomew's Hospital. Of the third it would ill become us to speak for the present. His loss is still a personal one, the mark of his individuality is still upon the School, and the echoes of his magnificent periods have hardly yet died away from the larger lecture theatre, to which his oratory attracted some of the best speakers in the profession.

We turn, then, from the lecturers to the demonstrators. Then, as now, the demonstrators were a most important factor in the School, and the names of Stanley "the little butlerman," of "Tommy" Wormald, and of Skey still linger in the memories of the older students, who ever think of them as demonstrators, forgetting that each in due season served the high office of President of the Royal College of Surgeons of England.

Of the three demonstrators who succeeded each other in linear succession, Stanley first, then Skey, afterwards Wormald, Stanley was by far the most able scientific man. His "Illustrations of the Effects of Diseases and Injury of the Bones" was conceived and executed in the true Hunterian spirit, and the specimens which he collected to illustrate it are still some of the best and most interesting in the museum.

Born July 3rd, 1793, his mother being a sister of Thomas Blizard, Surgeon to the London Hospital, Stanley was educated at the Merchant Taylors' School. He was apprenticed to Thomas Ramsden, a surgeon at St. Bartholomew's Hospital, and when his master died in 1810, Stanley was "turned over" to John Abernethy to serve the remainder of his term. Even during his apprenticeship his love of morbid anatomy was so great that, with Abernethy's assistance and approval, he enlarged the museum to such an extent that he practically created it. Ill-fortune, however, condemned him to the dull routine of the dissecting room and the anatomical lectureship, so that a good pathologist was driven to become little more than a schoolmaster. All inclination for original work seems to have been crushed out of him, until he became what Sir James Paget remembered him: "Mr. Stanley lectured on anatomy and physiology every day except Saturday at half-past two. The physiology was, even for that time, feeble, dull, and barren, and the anatomy was very elementary; but he lectured so carefully and clearly, he was so deliberate and simple, so grave and earnest, he repeated all the "tips" so frequently and so variously, yet without changing one important word,

that I believe there was not one in London who taught a larger proportion of his class than he did. Besides, his appearance and his manner were very strange, easily remembered and imitated; and with them his words were well remembered too. It was believed that a pupil, who afterwards became a distinguished writer in *Punch*, passed the College in anatomy solely by means of the bits of lectures with which he used to make fun by imitating Stanley." Stanley acted as foil to Lawrence almost throughout his life. "Lawrence," says Paget, "was inimitable, and he never seemed in difficulty; Stanley made all see the value of dull hard work, the need of learning the very commonest facts. His plodding day's work was a daily lesson, and the story of his life was full of teaching; for after striving against many difficulties, he became constantly more esteemed, more gladly worked with by those who knew him well, and these became constantly more numerous. He was a true and truth-loving man, keenly conscious of his duty, and resolute in doing it." But Mr. Willett has already told the story of Stanley's life and work in this Journal (vol. i, p. 146), so that there is no need to dwell upon it here. Suffice it to say that I cross-examined Mr. Mark Morris one day, just before he died, as to the exact place of Stanley's death, for, as is well known, he died of cerebral hæmorrhage after an hour's illness on Saturday, May 24th, 1862. He had just examined a patient with a diseased knee in the front ward of Henry when he staggered against a bed and sank on to the floor. The dressers of Sir William Lawrence, whose ward it was, raised him and put him on the "state" bed, then unnumbered, now No. 6, in the front ward of Henry, where he soon breathed his last.

Fredric Carpenter Skey (1798—1872), Abernethy's last demonstrator of anatomy, had also been apprenticed to him. It is said that his master was so impressed with the tact and clinical ability of his pupil, that he employed him during the later years of his servitude to attend upon his private patients. By Abernethy's interest Skey was appointed Demonstrator of Anatomy in 1824, an office he resigned in 1828 in consequence of a dispute with Lawrence.

The direct outcome of Skey's separation from the teaching staff of St. Bartholomew's Hospital was the revival of the Aldersgate Street School of Medicine, where Skey taught surgery for the next ten years, though he had been elected an assistant surgeon at St. Bartholomew's Hospital, August 29th, 1827, becoming full surgeon in 1854. He lectured upon anatomy for the long period of twenty-two years, from 1843 to 1865.

Skey's prolonged experience in the out-patient room sharpened his natural aptitude for clinical surgery, until he became skilful to ingenuity in diagnosis. He put an end to the bleeding, cupping, and purgatives which formed so marked a feature in the treatment of disease fifty years ago, and his principles still linger in the out-patient room of the Hospital, for he was the first to advocate the "tonic" treatment. We owe to his teaching the enormous quantities of

Hst. Q. cum.F. which are still ordered daily for the anæmic surgical patients who apply for relief; whilst in the operating theatre he exercised an influence for good by his energetic protests against the use of the knife except as a last resource in the surgical treatment of disease.

Thomas Wormald (1802—1873) was the last of Abernethy's apprentices, the Benjamin of his old age, and so consummate a mechanic that Abernethy employed him as prosector, to teach the junior students, and to assist Stanley in putting up preparations for the museum long before he was out of his articles. Familiar with Abernethy as his resident pupil, and naturally outspoken, Wormald treated his master with scant reverence. It is told of him that one very wet evening Abernethy came from Bedford Row to lecture on surgery. He was sitting by the fire in the old museum, and complained that his feet were wet. Wormald said, "Didn't you come in your carriage?" "No," says Abernethy,—"Old Johnny," as he was called, "Mrs. Abernethy wanted it to take the children to the theatre." "Well," says Tommy, "you had a shilling in your pocket, why didn't you take a hackney coach?" "I didn't think of that." "Then I don't pity you," says Wormald, "it serves you right." To which Abernethy replied with a smile, "You are a pretty impudent fellow, Tommy."

In 1824, when Abernethy contemplated retiring from the lectureship of anatomy, he made arrangements that Stanley should succeed him as lecturer, and that Wormald should act as demonstrator at a salary of £150 a year, so long as he could keep the class together. Wormald, overjoyed, promptly proposed to a lady, who accepted him; but when the time came for making the appointment, Skey claimed it and was elected. Wormald was therefore nominated house surgeon to Lawrence in October, 1824, and it was not until 1826 that he was appointed, conjointly with Skey, to act as demonstrator of anatomy. Skey left the hospital in 1828, and Wormald then continued to act as sole demonstrator. For fifteen years Wormald ruled his class with a rod of iron. Beer and tobacco he banished from the dissecting rooms. As to smoking, he positively disliked it. Seeing a man once dissecting with a cigar in his mouth, Wormald told him with a threat to take it out. Next day four-fifths of the men were smoking. Wormald came, walked through the rooms, and left without a word. The day after not a cigar was to be seen in the rooms, nor has the habit ever been resumed there since. Sir James Paget says of him, "The more influential teacher was Mr Wormald. . . . Among the majority of the students he was the most popular of all the lecturers; a shrewd, hard-headed man, without any science, but with abundant common sense, directness, and good mechanic skill. He gave the demonstrations, that is the daily morning lectures on anatomy. For then and during several years later there were really two courses of lectures on anatomy. In Stanley's, anatomy (both general and descriptive) and physiology were combined. The arrange-

ment was according to structures—bones, muscles, arteries, and so on, and these were called the lectures.

"In Wormald's, anatomy alone was taught, and in the order of the parts dissected—arm, leg, neck, and so on, and these were called demonstrations. They were completely practical and often very instructive. He omitted what he did not like or did not know, but what he did teach he taught well, in plain English and with good illustrations. It was not then generally thought amiss that he told many stories, some of which were obscene, some nasty;" but Wormald was brought up in the early years of the century, and if the manners of the Regency were coarse, the speech of the time was coarser. As a teacher of surgical anatomy Wormald has seldom been surpassed, whilst his surgical teaching was strictly clinical. His plan of instruction was to single out a student, give him a case to examine, and then test his knowledge by questions. Himself no great reader, he rarely referred his pupils to books, but taught them to rely chiefly on the observation of nature. Hard-working students were attracted to him by his kind and familiar manner, but idle ones he repelled by his known power of sarcasm.

#### Notes.

FOR THE FIRST TIME in the history of the University of Cambridge has a medical graduate been raised to the dignity of its Vice-Chancellor. We congratulate Dr. Alex. Hill upon his election to this high office, at the early age of forty-one. He was, as we all know, a distinguished student of Bart.'s twenty years ago. He was a contemporary of Dr. Tooth, Dr. Herringham, Mr. Bowly, and Mr. Lockwood, and in his student days was a prominent debater at the meetings of the Abernethian Society. Dr. Hill was elected Master of Downing College in 1888; and before this the last Medical Master of a college at Cambridge was Dr. John Caius, founder of the college bearing his name. The great Harvey is said to have been Vice-Chancellor of Oxford University, but this, we believe, is an error. He certainly was Warden of Merton College in 1644, and this office he held for only a few months.

THE OPENING ADDRESSES at the Medical Schools this year seem to us to have been only moderate performances. They lack originality, and are mostly very dry reading, and feeble in the extreme. We are glad that the authorities in our School are wise enough to look with disfavour on opening addresses. It is, we believe, many years since one was given at Bart.'s. Perhaps other schools need more advertisement.

WE beg to offer our newly elected Entrance Scholar in Science, Mr. W. Morley Fletcher, our congratulations on his election to a Fellowship at Trinity College, Cambridge. It is a recognition not only of the interesting researches which he has undertaken, but also of the claims of physiology upon the older universities.

MR. GILBERT SMITH has taken the degree of M.B. in the University of Durham.



DR. DUNDAS GRANT, who for some time was conductor of the Hospital Musical Society, has been elected President of the British Laryngological Association.

OWING to the death of candidates for the Army Medical Service, a new regulation regarding the Examination will shortly come into effect. Candidates for the Indian and Army services will not in future be required to state which service they are competing for, and those who pass the Examination may choose their service afterwards in order of merit. The regulation virtually allows the unsuccessful candidates (who obtain the requisite minimum of marks) for the Indian Service to accept a commission in the Army.

THE SCARCITY of candidates for the Army Service seems to us to offer unusually good prospects to well-qualified men seeking employment, for with the present depleted state of the service promotion must be rapid, and the conditions of service, after all, are not so bad as they are made out to be.

WE HEAR with much regret of the death of Dr. C. S. Roy, Professor of Pathology at Cambridge. He had been unable to discharge his duties for over a year, and, as is well known, Dr. Kanthack had accepted the office of his Deputy. Professor Roy married a daughter of Sir George Paget, late Regius Professor of Medicine, but there were no children. The funeral took place on October 8th, and was largely attended by his friends and colleagues.

MR HOWARD MARSH will read a paper at the East London District of the Metropolitan Counties Branch of the British Medical Association on October 21st. The subject is "Operative Surgery of the present day in its application to Affections of the Joints."

WE HEAR that Dr. West is about to commence the usual class in the wards, in Commentaries for the London M.D. It will begin on the first Wednesday in November at 4 o'clock, and will be taken once a week.

MR. A. N. WEIR won the Ladies' Cup in the Golf Competition on October 16th at Stanmore, finishing one down to Bogey.

DURING the summer a Golf Handicap was organised, and there were twenty-eight entries. The Staff were represented by Sir Thomas Smith, Mr. Howard Marsh, Mr. Bowlby, Dr. Griffith, Dr. Herringham, and Mr. Edgar Willett. There were many exciting matches, and the handicapping worked out on the whole with excellent results. In the semi-final round Mr. Lance (10) beat Mr. Harmer (4), 5 and 4, and Mr. Furnivall (7) beat Mr. Laming Evans (7), 4 and 3. In the final round Mr. Furnivall beat Mr. Lance, 6 and 5, thus winning the handicap. This is the first Golf Handicap that has been played in the Hospital, and its success, in a large measure due to the energy of Mr. W. D. Harmer, the organiser, leads us to hope that a Golf Handicap may now be looked upon as an annual event.

THE continued popularity of the Bacteriology course provided here is evinced by the number of men from other hospitals who are attending it. At the present rate of extension of the work done by the pathological department, the question of accommodation for its various activities will soon become a serious one.

DR. MAIDLOW asks us to make the following corrections in his paper published last month. (1) The word "monosyllable" in the note on page 186 is a slip of the pen; "single expression" is the correct phrase. (2) The quotation on page 190 contains the word "vent," which is of course a misprint for "veut." (3) The accent on the word *ἄληθη* is obviously wrong.

WITH this number a new editor takes office, Dr. H. B. Meakin having resigned the position which he has filled so long and ably. He leaves the JOURNAL in every way a more flourishing institution than he found it, and only those who have been closely associated with the work can realise how much of its success is due to the late editor.

AT THE MOMENT of going to press we learn that the entry for the year 1897-8 is 188, divided as follows:

Full entries	97
Special entries to lectures or Hospital practice	69
Preliminary scientific class	22
	188

These figures compare favourably with last year both in regard to full entries and entries to special courses, for the figures then were—

Full	Special	Preliminary Science Class	Total
84	59	22	165

THE ENTRIES to the full course show considerable variation during the past six years, whilst special entries appear to be increasing, thus:

Year	Special, including Preliminary Science Class			Total
	Full	Preliminary	Science Class	
1892	112	38	150	
1893	95	61	156	
1894	119	74	193	
1895	105	82	187	
1896	84	81	165	
1897	97	91	188	

Amalgamated Clubs.

J. W. Malins.	S. E. Crawford.	W. H. Scott.
L. R. Fosswill.	F. Whitaker.	E. Leverton-Spry.
T. Gillespie.	G. C. Hodgson.	F. M. Boulton.
T. Bates.	G. M. Levick.	N. Maclaren.
L. B. Scott.	F. Harvey.	F. F. Shout.
G. H. Hunt.	H. L. P. Hulbert.	S. W. Milner.
T. P. Baldwin.	C. E. West.	T. R. Coudrey.
R. M. Im Thurn.	C. Murdoch.	C. V. Nicoll.
L. L. Winterbotham.	J. G. Cooke.	J. D. Barris.
P. M. Rivaz.	A. R. Wade.	A. Hamilton.
M. O. Boyd.	J. A. Nixon.	D. M. Johnston.
G. F. Travers.	T. B. Davies.	H. M. H. Melhuish.
H. Gordon-Smith.	W. C. Hurst.	C. O'Brien.
C. S. Kingston.	H. E. L. Purcell.	A. F. Forster.
W. A. Murray.	A. Hallows.	A. H. Bloxsome.

HOCKEY.

The following fixtures have been arranged:

Oct. 9th	Blackheath Preparatory School	Blackheath.
„ 30th	Southgate 2nd XI	Southgate.
Nov. 13th	Epping	„
Dec. 4th	Ealing 2nd XI	Acton.
Feb. 12th	Epsom College	Epsom.
„ 19th	Blackheath Preparatory School	„

As the Club has been elected on the Hockey Association, a full list of fixtures may be expected shortly. It is hoped that some energetic men will become regular players, as a table of wins and losses is published weekly in the Sportsman, and it will not look well to see Bart.'s at the bottom.

MATCH.

Blackheath Preparatory School. Played on October 9th at Blackheath. We only took down 10 men (one of those chosen not turning up). The School, who were in very good training, had much the best of the first half, and scored four goals. In the second half we had more of the game; the ball was several times near their goal, but we failed to score. Blackheath got two more goals through good forward combination, a thing which was entirely absent on our side, though some of the individual efforts were good. Team.—Backs, G. B. Nicholson, D. Jeaffreson; halves, G. Harris, C. T. Price, S. H. Pollock; forwards, H. Huggins, F. Bull, A. Ware, T. Johnson, P. B. Grenfell.

CRICKET CLUB.

ST. BART.'S HOSPITAL 2ND XI v. WINCHMORE HILL.  
Played at Winchmore Hill on July 21st. Scores:

WINCHMORE HILL.		ST. BART.'S.	
G. T. Vint, c Nunn, b Marrett	19	H. W. Pank, b Sale	21
A. Adams, b Marrett	5	F. H. Maturin, b Sale	12
J. C. Sale, b Pank	0	A. Farrington, b Scoones	4
H. Whitwell, c Farrington, b Boyle	2	C. G. Watson, 1-b-w, b Sale	5
H. E. Scoones, b Boyle	9	H. J. Pickering, b Sale	0
R. A. Maude, b Turner	2	J. M. Collins, not out	16
T. C. Barry, b Boyle	3	H. G. Boyle, b Moore	13
L. Favis, b Boyle	0	C. H. Turner, b Sale	14
E. P. Suggen, not out	7	H. N. Marrett	0
W. Moore, c Turner, b Pank	3	C. M. Pennefather	0
F. Markham, b Boyle	0		
Extras	12	Extras	13
Total	81	Total	156

ST. BART.'S HOSPITAL 2ND XI v. BLACKHEATH SCHOOL.  
Played at Blackheath on July 24th. Scores:

BLACKHEATH SCHOOL.		ST. BART.'S.	
H. M. Norris, c and b Turner	9	C. G. Watson, 1-b-w, b Morris	24
F. R. Hodgson, b Turner	7	W. H. Randolph, b Hodgson	25
F. C. Whately, b Turner	4	R. H. Smith, b Morris	17
F. C. Kendall, b Turner	3	J. M. Collins, c Horne, b Morris	0
J. W. Horne, not out	22	G. Weld, b Horne	28
H. M. Kendall, b Collins	4	C. H. Turner, not out	104
H. Tehrani, b Turner	0	A. S. Woodward, b J. Horne	0
H. Morris, b Turner	0	C. T. Price, b Morris	0
E. V. Sargent, b Turner	0	Friday, b Morris	9
W. Smith, b Turner	0	Foucar, b Whately	0
H. B. Horne, b Turner	0	A. N. Other, absent	0
Extras	5	Extras	23
Total	54	Total	230

Turner accomplished a good performance in taking 9 wickets for 12 runs, and scoring 104 (not out) of 230.

RUGBY UNION FOOTBALL CLUB.

President.—A. A. Bowlby, Esq., F.R.C.S.  
Vice-Presidents.—A. N. Weir, Esq., F.R.C.S., J. S. Sloane, Esq., F.R.C.S., H. Bond, H. M. Cuddas.  
Captain 1st XV.—W. F. Bennett.  
Vice-Captain.—S. Mason.  
Hon. Secretary.—C. H. D. Robbs.  
Assistant Hon. Secretary.—E. R. Risien.  
Captain 2nd XV.—A. Ll. Vaughan.  
Committee.—J. K. S. Fleming, A. M. Amsler, A. J. W. Wells, T. A. Mayo, J. M. Body, M. B. Scott, H. C. Adams.

FIXTURES—1897.

First XV.	Club.	Ground.
October 9th	Civil Service	Richmond.
16th	Upper Clapton	Clapton.
23rd	Kensington	Wood Lane.
27th	R.N.C.	Greenwich.
30th	Wickham Park	Catford.
November 3rd	East Sheen	Richmond.
6th	R.I.E.C.	Cooper's Hill.
13th	R.N.C.	Sandhurst.
20th	Marlborough Nomads	Stamford Bridge.
27th	Croydon	Croydon.
December 4th	Old Leysians	Stamford Bridge.
11th	Old Merchant Tailors	Richmond.
18th	Upper Clapton	Winchmore Hill.

ASSOCIATION FOOTBALL CLUB.

President.—W. H. H. Jessop, Esq., F.R.C.S.  
Captains.—L. E. Whitaker, 1st XI, C. G. Watson, 2nd XI.  
Vice-Captain.—J. A. Willett.  
Hon. Secretaries.—A. H. Bostock and A. R. Tweedie.  
Committee.—R. P. Brown, H. N. Marrett, H. J. Pickering, C. H. Turner, G. W. Stone, L. Orton.

FIXTURES—1897.

Wed. Oct. 6th	Practice Match	Winchmore Hill
Sat. „ 9th	Cheshunt	Cheshunt.
Wed. „ 13th	Ealing	Ealing.
Sat. „ 16th	R.M.A.	Woolwich.
Wed. „ 20th	Eastbourne	Eastbourne.
Sat. „ 23rd	Reigate Priory	Reigate.
Wed. „ 27th	West Herts	Watford.
Sat. „ 30th	Crouch End Vampires	Wood Green.
Wed. Nov. 3rd	Clapham Rovers	Winchmore Hill.
Sat. „ 6th	Hampstead	Away.
Wed. „ 10th	Hasting and St. Leonards	Hastings.
Sat. „ 13th	Beckenham	Beckenham.
Wed. „ 17th	„	„
Sat. „ 20th	Civil Service	Chiswick Park.
Wed. „ 24th	Casuals	Winchmore Hill.
Sat. „ 27th	Marlow	Marlow.
Wed. Dec. 1st	„	„
Sat. „ 4th	Tunbridge Wells	Tunbridge Wells.
Wed. „ 8th	Sittingbourne	Sittingbourne.
Sat. „ 11th	Newbury	Newbury.
Sat. „ 18th	Pemberton	Winchmore Hill.

The Rahere Lodge, No. 2546.

MEETING of the Rahere Lodge, No. 2546, was held by dispensation at Frascati's on Tuesday, October 12th, Bro. W. J. Walsham, the W.M., being in the chair. Bros. Ralfour Neill and Perram were raised to the third degree in Freemasonry; Bros. J. W. Haines, Sargent, Matthews, Miles, and Shewell were passed to the second degree; and Messrs. Henry Ellis, Auden, and Surgeon Folliot, R.N., were initiated. Bros. C. O'B. Harding, of Eastbourne, and Bro. Dr. Stubbs, of Wynberg, Cape Town, were elected joining members. Two of the ceremonies were performed by the W.M., the third by Bro. Swinford Edwards.

Bro. J. Keogh Murphy proposed in very appropriate terms a vote of condolence with Mrs. Forman on the death of her son, Bro. G. H. Forman, wrecked in the "Aden." The vote was seconded by Bro. Valérie, and was carried unanimously and in silence. It ran, "The members of the Rahere Lodge beg respectfully to convey to Mrs. Forman their deep sympathy with her in the great loss she has

recently sustained. The Lodge feels that by the death of Bro. G. H. Forman it has lost one of the best and brightest of its members, and is assured that his end was, like his life, one of brave self-sacrifice and thought for others."

A vote of one guinea was made from the Lodge funds to the Home for the Dying.

The members and their guests, to the number of fifty-one, afterwards dined together, the evening being enlivened with music by Bros. West, Burns, and Grant.

### Ibernetian Society.

#### OFFICERS FOR THE SESSION.

*Presidents*:—W. Langdon Brown, J. Hussey.  
*Vice-Presidents*:—T. J. Horder, A. L. Ormerod.  
*Treasurer*:—A. Willett, F.R.C.S.  
*Hon. Secretaries*:—Earnshaw Hewer, H. Thursfield.  
*Additional Committeemen*:—E. Talbot, J. S. Williamson.

#### LIST OF PAPERS TO BE READ BEFORE THE SOCIETY.

1897.	Author's Name.	Subject of Paper.
July 8.	Norman Moore, M.D., F.R.C.P.	The Deaths of the Kings of England.
Oct. 7.	John Langton, F.R.C.S.	Some of those after whom the Wards are named.
" 14.	J. J. Grace, M.B., F.R.C.S.	Empyemata of the Sinuses of the Nose.
" 21.		Discussions, Clinical and Pathological.*
" 28.	J. D. Rawlings, M.B.	Some Diseases often overlooked.
Nov. 4.	T. P. Legg, M.D., F.R.C.S.	Appendicitis.
" 11.	R. de S. Stawell, M.D.	Perforating Gastric Ulcer.
" 18.	J. Morrison, M.D.	Albuminuria in Pregnancy.
" 25.	E. G. D. Drury, M.B.	Shortness of Breath.
Dec. 2.		Discussions, Clinical and Pathological.*
" 9.	F. C. Wallis, M.B., F.R.C.S.	
1898.		
Jan. 13.	Lovell Drage, M.D.	The Coroner's Court.
" 20.	J. Milne Bramwell, M.B.	Hypnotism.
" 27.	W. H. Rivers, M.D.	Fatigue.
Feb. 3.	Gladstone Clark, M.B., F.R.C.S.	Extra-uterine Gestation.
" 10.		Discussions, Clinical and Pathological.*
" 17.	A. R. J. Douglas, M.B., B.S.	Lymphadenoma.
" 24.	W. J. E. Enery, M.B., B.Sc.	The Action of Tobacco.
Mar. 3.	G. H. D. Robinson, M.D.	Some Points of Interest concerning Gonorrhoea in Women.
" 10.	J. P. Maxwell, M.R.C.S.	Pyuria.
" 17.		Annual General Meeting.

\* At these meetings short communications will be made, with illustrative cases and specimens. At all meetings members are invited to show cases of interest.

#### INAUGURAL ADDRESS.

On Thursday, October 7th, at 8 p.m., the Inaugural Address was delivered in the Medical Theatre by Mr. Langton; Mr. Hussey, President, in the chair. His subject, "Some of those after whom the Wards are named," could not fail to be of interest to all who have any thought of those who in time past have helped to make our Hospital the great institution that it now is.

He commenced by saying that most students looked upon the names of the wards in merely an abstract sort of way, and did not connect them with any definite individual, concerning whom in the majority of cases a great many interesting facts could be ascertained.

The names of Lazarus and Magdalene wards, he then went on to say, it was just as well had dropped, as they were altogether inapplicable, pointing out at the same time that the transference of Faith and Hope to the medical side was, he considered, most

appropriate, as these formed a considerable part of medical therapeutics. He then gave the history of most of those whom the wards are named after, commencing with Rahere. Coburn, we are sorry to say, was not touched upon. Mr. Langton terminated his address by alluding shortly to those who are still amongst us.

Dr. Meakin then proposed a vote of thanks, expressing the indebtedness of the Society for the trouble and interest that the Staff took in it. This was seconded by Mr. Drury. The meeting then adjourned to the library, where tea and coffee were provided. There were present about 230, including the matron and nursing staff.

On Thursday, October 14th, an ordinary meeting was held. Mr. Langdon Brown in the chair. Mr. Lance showed a case which was considered to be hæmorrhage into the lesser sac of the peritoneum after a severe strain.

Mr. J. J. Grace then read a paper on "Empyemata of the Sinuses of the Nose." Mr. Grace's paper thoroughly went into the question of diagnosis, and an abstract of his communication will appear in our next issue. In the discussion which followed, some thought that the methods that had been suggested were rather severe for diagnosis, but it was also pointed out how essential it was in some cases that the diagnosis should be correct, and how frequently the disease was mistaken.

### Old Students' Dinner.

THE dinner of Old Students was held as usual on October 1st in the Great Hall of the Hospital. There was a very large attendance of old Bart.'s men and guests. Sir Thomas Smith, Bart., was in the chair, and was supported by Sir William MacCormac, Bart. (President of the

Royal College of Surgeons), Surgeon-General Jameson (Director-General Army Medical Department), Sir Trevor Lawrence, Bart. (Treasurer of the Hospital), Dr. Alex. Hill (Vice-Chancellor of the University of Cambridge), Dr. Collins (Chairman of the County Council), Sir Richard Thorne Thorne, Dr. Church, Mr. Willett, Sir Dyce Duckworth, and most of the Staff of the Hospital and Medical School. After an excellent repast, Sir Thomas Smith gave the loyal toast of "The Queen and the rest of the members of the Royal Family." This was duly honoured. Sir William MacCormac then proposed "The Army, Navy, and the Reserve Forces," speaking of the deeds of valour which British soldiers and sailors had performed in the past, and of their great devotion to duty. He spoke also of the Medical Department of the Army, and coupled the toast with the name of Surgeon-General Jameson. The Director-General replied, and spoke of the great self-sacrifice in time of need of the members of the Army Medical Staff.

Sir Thomas Smith then proposed the toast of the evening, "The Hospital and Medical School." He first spoke of the regret of several old Bart.'s men that they were not able to be present, notably Sir James Paget and Sir Robert Claver of Hull, who was qualified so far back as 1847. He congratulated the authorities of the Hospital on its position of independence of outside financial support, which he said was due to the munificence of past benefactors, and to the good management of past and present Treasurers and Almoners. In regard to the School, the earliest record of students attending is 1662; and although probably there were students here much earlier than this, to-day we begin our 225th session. When he entered in 1830 there were about 60 new students; last year the number was 165. Forty-seven years ago there were nominally only 12 or 14 teachers, and some of these "would not teach;" now there are 65, all actively engaged. During the forty-seven years the history of the School had not always been one of prosperity—there was a period of depression. For the ten years 1851 to 1860 the average yearly entry was 85 all told; from 1861 to 1870 the average was only 74; from 1871 to 1880 the average entry had risen to 128; from 1881 to 1890 the average was 150, and for the past six years the average has been 166 all told. He expressed the hope that some day the Medical School may form part of a teaching University in London, and spoke of the necessity for extended provision for research and for an endowment of the Medical School. Sir Trevor Lawrence in his reply hoped that, although his retirement from the Staff would shortly take place, Sir Thomas would live for many years to come. In retiring he would carry with him a record for good work and kind charity. Having congratulated Sir Thomas Smith and Sir Richard Thorne on their Jubilee honours, he spoke of recent improvements in the Hospital, e.g. the re-flooring and re-furnishing of the East Wing, and said that St. Bartholomew's ought to

set the example of what a hospital should be. Next year, he said, it would be fifty years since he entered the School, and a hundred years since his father entered. St. Bartholomew's had no rival in the number of distinguished men amongst its former students. He contrasted the School of fifty years ago with that of to-day, and referred to the Hospital's income, which is now roughly £70,000 a year.

Mr. Butlin then proposed the health of "The Visitors," and remarked that even our visitors and guests were mostly old Bart.'s men; and spoke of Dr. Griffith, Master of the Society of Apothecaries; Dr. Job Collins, Chairman of the County Council; and Dr. Hill, Vice-Chancellor at Cambridge, to show the distinguished positions that Bart.'s men attain to. The toast was coupled with the name of Dr. Hill. The Vice-Chancellor replied in appropriate terms.

Sir Henry Oakley then proposed, in neat and well-chosen words, "The Chairman and the rest of the members of the Hospital Staff," and the Chairman and Sir Richard Thorne replied, Sir Richard speaking of the pride he felt in being a member of so distinguished a Staff as ours.

Dr. Collins next proposed the health of Mr. Bruce Clarke, the Secretary, who had organised the dinner. He referred to his own entrance as a Bart.'s man twenty-one years ago, and to the training in the sort of public duties he was now performing received in the debates of and as Chairman to the Abernethian Society. Energy and taste, he said, were required to organise a successful dinner, and these Mr. Bruce Clarke possessed. Mr. Bruce Clarke responded appropriately, and said that this was the largest Old Students' dinner on record. There were, he said, 173 present, and the largest previous number was 170, when Sir James Paget presided some years ago.

At ten o'clock the company adjourned to the Library for coffee, and ultimately separated at half-past eleven, after what was voted by every one to have been a most successful gathering.

### Junior Staff Appointments.

The following appointments have been made, dating from October 1st.

HOUSE PHYSICIAN TO—		JUNIOR.	
<i>Dr. Church</i> .....	A. L. Ormerod, M.A., M.B. B.Ch. (Oxon), M.R.C.S., L.R.C.P.	A. Heath, M.B. (Lond.), M.R.C.S., L.R.C.P.	
<i>Dr. Gee</i> .....	T. J. Horder, B.Sc. (Lond.), M.R.C.S., L.R.C.P.	W. Langdon Brown, M.A., M.B., B.C. (Cantab.).	
<i>Sir D. Duckworth</i> .....	J. Hussey, M.B. (Lond.), M.R.C.S., L.R.C.P.	C. F. Lillie, M.A., M.B., B.C., D.P.H. (Cantab.), M.R.C.S., L.R.C.P.	
<i>Dr. Hensley</i> .....	F. H. Maturin, B.A. (Cantab.), M.R.C.S., L.R.C.P.	H. F. Cowin, M.R.C.S., L.R.C.P.	
<i>Dr. Brunton</i> .....	E. G. D. Drury, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P.	S. F. Smith, M.B. (Lond.), M.R.C.S., L.R.C.P.	
HOUSE SURGEON TO—		GILBERT SMITH, M.B. (Dunelm.), M.R.C.S., L.R.C.P.	
<i>Sir T. Smith</i> .....	H. W. Lance, B.A., M.B., B.C. (Cantab.).	A. B. Tucker, M.B. (Lond.), M.R.C.S., L.R.C.P.	
<i>Mr. Willett</i> .....	J. A. O. Briggs, M.B. (Lond.), M.R.C.S., L.R.C.P.	R. de S. Stawell, B.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P.	
<i>Mr. Langton</i> .....	E. Laming Evans, M.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P.	M. W. Coleman, M.B. (Lond.), M.R.C.S., L.R.C.P.	
<i>Mr. Marsh</i> .....	J. J. Grace, M.B., B.S. (Dunelm.), F.R.C.S.	A. R. J. Douglas, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P.	
<i>Mr. Butlin</i> .....	H. Williamson, B.A. (Cantab.), M.R.C.S., L.R.C.P.	H. Thursfield, M.A., M.B., B.Ch. (Oxon.), M.R.C.S., L.R.C.P.	
OPHTHALMIC HOUSE SURGEON.—		J. H. Thursfield, M.A., M.B., B.Ch. (Oxon.), M.R.C.S., L.R.C.P.	
INTERN MIDWIFERY ASSISTANT.—		J. W. Haines, M.B., B.S. (Lond.), F.R.C.S.	

EXTERN MIDWIFERY ASSISTANT.—J. L. Maxwell, M.B. (Lond.), M.R.C.S., L.R.C.P.

RESIDENT ASSISTANT ANÆSTHETISTS.—  
H. J. Paterson, M.A., M.B., B.C. (Cantab.), F.R.C.S.  
F. H. Lewis, B.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P.

### Award of Scholarships for the Year 1896-7.

THE Scholarships and Prizes in the Medical School for the past year were awarded as follows:

<i>Lawrence Scholarship and Gold Medal</i> .—	{ G. A. Auden } Æq. { J. Hussey }
<i>Brackenbury Medical Scholarship</i> .—	T. J. Horder.
<i>Brackenbury Surgical Scholarship</i> .—	L. B. Rawling.
<i>Matthews Duncan Medal and Prize</i> .—	{ 1. Not awarded. 2. E. C. Morland. }
<i>Senior Scholarship in Anatomy, Physiology, and Chemistry</i> .—	S. R. Scott; <i>prox. acc.</i> , F. C. Borrow.
<i>Open Scholarships in Science, Chemistry, and Physics</i> .—	H. F. Parker E. H. Scholefield. } Æq.
<i>Biology and Physiology</i> .—	C. J. Thomas.
<i>Junior</i> .—	R. C. Elmlie.
<i>Preliminary Scientific Exhibition</i> .—	R. A. S. Sunderland.
<i>Jefferson Exhibition</i> .—	S. G. Mostyn.
<i>Kirkes' Scholarship and Gold Medal</i> .—	H. Thursfield; <i>prox. acc.</i> , T. J. Horder.
<i>Bentley Prize (Medical)</i> .—	C. C. I. Turnbull.
<i>Hichens Prize</i> .—	A. G. Ede.
<i>Wix Prize</i> .—	J. S. Williamson.
<i>Harvey Prize</i> .—	J. S. Williamson. 2. A. E. Lidout. 3. C. A. S. Ristout.
<i>Sir George Burrows' Prize</i> .—	J. L. Maxwell.
<i>Skyner Prize</i> .—	J. L. Maxwell.
<i>Practical Anatomy, Junior</i> .	
<i>Treasurer's Prize</i> .—	R. C. Elmlie.
2. W. R. Read.	
3. H. Love.	
4. F. Gröne.	
5. H. H. Raw.	
6. H. J. Slade.	
7. F. N. White.	
8. R. T. Worthington.	
9. E. W. J. Ladell.	
10. A. E. Thomas.	
<i>Practical Anatomy, Senior</i> .	
<i>Foster Prize</i> .—	A. T. Compton.
2. J. S. Williamson.	
3. A. E. Lidout.	
4. M. G. Winder.	
5. C. A. S. Ridout.	
6. A. T. Pridham.	
7. A. R. Tweedie.	
8. R. H. R. Whitaker.	
9. J. C. Newman.	
10. G. M. Seagrove.	
<i>Shuter Scholarship</i> .—	{ F. A. Bainbridge } Æq. { B. Truman }
<i>Junior Scholarships</i> .—	{ R. C. Elmlie. 2. F. Gröne. }
<i>Junior Scholarships in Chemistry (1896)</i> .—	{ 1. J. S. Williamson. 2. E. C. Smith. }

### Award of Entrance Scholarships.

THE Entrance Scholarships and Exhibitions which were competed for on September 27th, 28th, 29th, and 30th have been awarded as follows:

SCHOLARSHIP OF £75 IN BIOLOGY AND PHYSIOLOGY TO	W. Morley Fletcher, B.A., Trinity College, Cambridge.
SCHOLARSHIP OF £75 IN CHEMISTRY AND PHYSICS TO	C. Ernest West, B.A., Balliol College, Oxford.
SCHOLARSHIP OF £150 IN BIOLOGY, CHEMISTRY, AND PHYSICS, TO	Æq. { H. R. Kidner (Int. B. Sc., London). E. C. Williams (Præf. Sci. London). }
PRELIMINARY SCIENTIFIC EXHIBITION OF £50 IN BIOLOGY, CHEMISTRY, AND PHYSICS, TO	E. G. Pringle (Præf. Sci. London).

JEAFFERSON EXHIBITION OF £20 IN CLASSICS AND MATHEMATICS, to

L. R. TOSWILL, of Marlborough College.  
We offer to these freshmen our best congratulations on their success, and we further congratulate them not only on their choice of a profession, but also on their good fortune in becoming "Bart's men." We give them, as well as all those who have recently entered our School, a most hearty welcome, and hope that the five years they will spend here will be as happy as they were to the thousands who have preceded them as *alumni* of our ancient Hospital. "Bart's" looks to them, and to all their fellow-students, each one to do his best to maintain and hand on untarnished the high prestige and traditions of his *alma mater*.

Mr. W. MORLEY FLETCHER comes to us with a good reputation from Cambridge, having already distinguished himself not only in Natural Science, but also in the athletic field. He has also done, we are told, some first-rate original work in Physiology at Cambridge. He is a brother of Dr. Morley Fletcher, one of our Demonstrators of Medicine, whom we all know.

Mr. C. ERNEST WEST has taken a very high degree in Chemistry at Oxford, having gained a First in that subject in the Natural Science Schools. He has also, we understand, acted as a Demonstrator of Chemistry in the Balliol Laboratory.

Mr. H. R. KIDNER has passed the Intermediate Bachelor of Science Examination of the University of London, and is now studying for a degree in Science as well as in Medicine.

Mr. E. C. WILLIAMS is not quite a stranger, having been a student in the Preliminary Scientific Class during the past year. He passed the Preliminary Scientific in July last, taking Honours in Chemistry.

Mr. E. G. PRINGLE also was in the Preliminary Scientific Class last year, and passed Biology at the Preliminary Scientific Examination in July last.

Mr. L. R. TOSWILL is the son of an old Bart's man. He was a Scholar and Prizeman at Marlborough, and has passed the Matriculation Examination. We hear he is a good "footer" man, and hope he will prove a useful addition to our Rugby team.

### Clinical Lectures for the Session.

*Medical*.—Fridays at 1 p.m., in the Medical Theatre.

October 8th.—Dr. Church.

" 15th.—Dr. Gee.

" 22nd.—Sir D. Duckworth.

" 29th.—Dr. Hensley.

November 5th.—Dr. Brunton.

" 12th.—Dr. Church.

" 19th.—Dr. Gee.

" 26th.—Sir D. Duckworth.

December 3rd.—Dr. Hensley.

" 10th.—Dr. Brunton.

*Surgical*.—Wednesdays at 2.45, in the Medical Theatre.

October 13th.—Sir Thomas Smith.

" 20th.—Sir Thomas Smith.

" 27th.—Mr. Willett.

November 3rd.—Mr. Willett.

" 10th.—Mr. Willett.

" 17th.—Mr. Langton.

" 24th.—Mr. Langton.

December 1st.—Mr. Langton.

" 8th.—Mr. Butlin.

" 15th.—Mr. Butlin.

*Gynaecological*.—Thursdays at 9 in the Medical Theatre.

Dr. Champneys.

### Appointments.

BREMIDGE, R. H., B.A. (Oxon.), B.Sc. (Lond.), M.R.C.S., L.R.C.P., has been appointed Assistant House Physician to the Metropolitan Hospital.

HAMPTON, T., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Royal Hospital for Diseases of the Chest, City Road.

HAYNES, G. S., M.R.C.S., L.R.C.P., appointed House Physician to the Metropolitan Hospital.

WAGGETT, ERNEST, M.B. (Cantab.), appointed Assistant Surgeon to the London Throat Hospital.

WOODWARD, A., M.R.C.S., L.R.C.P., appointed House Surgeon to the Metropolitan Hospital.

### Examinations.

L.S.A.—*Biology*.—H. M. Huggins; *Materia Medica*.—H. F. Stilwell and R. Storrs. *Physiology*.—N. C. Beaumont.

FIRST CONJOINT.—*Biology*.—C. R. Keed.

### Correspondence.

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

NEWSPAPERS FOR THE PATIENTS.

DEAR SIR,—I have the pleasure to suggest, for the consideration of your committee, that a box should be placed in some conspicuous and convenient position for the reception of newspapers for the use of patients.

There are a number of men who bring up morning papers with them, who would be very glad to hand them over to the patients; and, as you well know, the patients are only too glad to see the news of the day.

I shall be very glad to contribute five shillings for the purchase of such a box.—Yours truly,

LANCE ALLEN.

Harrow; September 28th, 1897.

### Births.

BATEMAN.—On October 5th, at Devonshire Street, W., the wife of A. G. Bateman, M.B., C.M., of a daughter.

KENNEDY.—On the 18th inst., at Burke House, Beaconsfield, Bucks, the wife of William Willoughby Kennedy, M.A., M.B.(Lond.), M.R.C.S., L.R.C.P., D.P.H.(Camb.), of a daughter.

POWELL.—On September 22nd, at Glenariff House, Upper Clapton, N.E., the wife of Herbert E. Powell, M.R.C.S., of a son.

REICHARDT.—On October 5th, at Dorset House, Ewell, Surrey, the wife of E. Noel Reichardt, M.B., of a daughter.

### Marriages.

EDWARDS—McCALLUM.—On September 15th, at Holy Trinity Church, John Hammerton Edwards, M.A., M.D.(Cantab.), of Aadneven, Bedford, to Grace Alice McCallum, widow of James Braddon McCallum, M.A., C.E., of Blackburn.

OXLEY—MALCOLM.—On August 17th, at Christ Church, Streatham Hill, by the Rev. J. Nicholl, William Henry Francis Oxley, M.R.C.S., L.R.C.P., of Barking, Essex, to Lily, daughter of the late William Malcolm, Esq., of Glen Moray, Argyleshire.

PERRAM—MACLAINE.—On September 13th, at St. Mark's Church, Dundela, Belfast, Edward Arthur Perram, M.D., third son of Rev. George J. Perram, M.A., Holmwood Lodge, Highgate, London, to Violet Frances, younger daughter of George Langtry MacLaine, Wandsworth House, Strandtown, Belfast.

### Death.

BROGDEN.—At Lagos, West Coast of Africa, on August 9th, Marie Victoria Brogden.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette*, *London Hospital Gazette*, *St. Thomas's Hospital Gazette*, *Middlesex Hospital Journal*, *The Nursing Record*, *The Student*.

# St. Bartholomew's Hospital



## JOURNAL.

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### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C., BEFORE THE 1ST OF EVERY MONTH.

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

All communications, financial or otherwise, relative to Advertisements ONLY, should be addressed to J. H. BOOTY, Advertisement Canvaser and Collector, 29, Wood Lane, Uxbridge Road, W.

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD AND SON, Bartholomew Close. MESSRS. ADLARD have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 6d., or carriage paid 2s. 3d.—cover included.

### St. Bartholomew's Hospital Journal,

NOVEMBER 14th, 1897.

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

### Contributions towards a History of the Surgical Teaching at St. Bartholomew's Hospital during the Nineteenth Century.

By D'ARCY POWER, F.R.C.S., F.S.A., Demonstrator of Practical and Operative Surgery.

#### IV. THE METHODS OF TEACHING.

HERE have been remarkable variations in the methods of teaching adopted during the present century. Not only has the manner of instruction varied with each individual, as must always be the case, but the very system itself has altered greatly from time to time.

The original method of teaching surgery was purely clinical. The pupil followed his master to the bedside and watched the measures he adopted in curing his patient, asking such questions as might occur to him on the spur of the moment. There are traces of such a method in the interesting "Anatomical and Practical Observations in St. Thomas his Hospital, made by J. Molins, 1674 to 1677," the friend of Wiseman, which were lately published by Dr. Payne in the *St. Thomas's Hospital Reports*, and no doubt a similar plan was followed in our own Hospital.

The principles and the theory of surgery were taught at this time by a series of public lectures delivered at the College of Physicians and at the Barber-Surgeons' Hall in Monkwell Street. Percivall Pott with us, and Samuel Sharpe at Guy's Hospital, first gave individual lectures on surgery to small classes.—Pott privately to his own pupils who were students at the Hospital, Sharpe to a class of navy surgeons who were anxious to improve themselves. Both courses became very celebrated. Pott's lectures were attended by most of the celebrated surgeons in Europe, and were gratefully recognised by the Governors of St. Bartholomew's Hospital, who built him a theatre to accommodate his audience. Sharpe's lectures were continued by William Hunter, and thus became the origin of the Hunterian or Great Windmill Street School of Medicine, the foundation of modern medical teaching.

The success of the Hunterian School was due to the fact that its pupils were thoroughly grounded in anatomy, and that they were taught systematically the great principles underlying the practice of their profession. The backbone of the school was its anatomy, for the students dissected from early morn till late at night, their work being superintended by such men as John Hunter, Hewson, Sheldon, Cruikshank, Wilson, and Matthew Baillie, who acted successively as demonstrators to William Hunter. The importance of this training will be understood when it is remembered that until William Hunter opened his school (after the formation of the Surgeons' Company in 1745) the dissection of a dead body, except at the College of Physicians or at the Barbers' Hall, led to the fine or even to the im-

prisonment of the enterprising anatomist. Not more than five or six men in London, therefore, had ever had a scalpel in their hands, and the average knowledge of anatomy was only such as could be gained by seeing a dead body cut up in from three to five days.

Botany was soon added to anatomy as an important item in the curriculum of the medical student, for, like anatomy, it bore some affinity to an exact science. The reawakening of the Apothecaries' Society after the passing of the Apothecaries Act in 1815 was marked by a very thorough teaching of botany to every medical student who took his L.S.A.

Thomas Wheeler (1754—1847), Apothecary to the Hospital, was also Custos of the Society's gardens at Chelsea, and Demonstrator of Botany. His herborising expeditions soon became a remarkable feature in the life of the London medical student. Many good stories are told of Mr. Wheeler, a most simple, unassuming man, who lived to be ninety-four. The following is perhaps one with the strongest local flavour. He was very peculiar in his style of dress, carrying simplicity in this respect almost to the verge of eccentricity. It is said that he was one evening sitting at the back of the "shop," as the dispensary is still called in the Hospital, with a number of students who were bantering him and each other, and he was descanting on the folly of superfluity in dress, when Lawrence said, with his usual assumed air of gravity, "Well, Mr. Wheeler, how can you support such a doctrine while you wear such a superfluity as this?" lifting up a small queue or pigtail which Wheeler wore. Thus taken aback, the old man confessed that it was superfluous. "Yes, my dear sir, you are right; we are too prone to preach one thing and to practise another. I never thought of it; cut it off, sir, pray cut it off;" and Lawrence forthwith performed the amputation requested.

The plan of instruction in botany was for the demonstrator to discourse in the open air at certain fixed periods during the summer months to the members of the Society and their apprentices. The medical plants were arranged in systematic order in a certain part of the garden, and the demonstrator showed them to his pupils, explaining as he went from bed to bed their botanical characters, their place in the Linnaean classification, and their uses in medicine.

As early as 1633, however, the Society of Apothecaries organised a system of herborisings, which continued for the long period of two hundred years. Originally there was but one gathering in the year, but the number was gradually increased to six, of which five were attended by the apprentices of the Apothecaries' Society under the superintendence of the demonstrator, and one of them, called the General Herborising, was confined to the members only. The custom was for the apprentices to assemble punctually at six o'clock in the morning at St. Bartholomew's Hospital, while Mr. Wheeler held the post of Apothecary at that institution

(1806—1820). An official of the Apothecaries' Society carried a large metal box for the collection of the specimens, and each student carried a similar though smaller box, slung round his shoulder for the same purpose. None carried umbrellas or great-coats, and if the rain came down the clothes were allowed to dry when the sun shone again.

Different routes were pursued on different occasions. Sometimes the excursion was to the north-west, passing through Islington, where it was still possible to find the deadly nightshade (*Atropa belladonna*) growing wild in a ditch in Goswell Road; then through Copenhagen Fields and Kentish Town, to Hampstead Heath, where a halt was called at "Jack Straw's Castle." There the company breakfasted on tea, rolls, and butter, after which they scattered themselves about the heath, gathering ferns and heath plants. The ramble was conducted to Finchley, Hendon, or Caen Wood, the party returning to the inn for dinner, which consisted of substantial joints of meat and pudding, with a moderate allowance of table ale. "Formerly," says Dr. Sempie, from whose edition of 'Field's Memoirs' of the Botanic Garden at Chelsea this account is taken, "the apprentices were once a year at least indulged in wine," for at a committee held at Chelsea Garden in the year 1823 it was ordered that "the pupils at private herborisings should be allowed a bottle of wine among four, and a bottle of cider between two, but that no porter or other malt liquor should be allowed except table beer." Immediately after dinner the large metal box carried by the attendant was opened, and the plants collected during the excursion were produced and exhibited to the students, who were seated on each side of a long table. The name of each plant was given, together with the peculiarities of form or structure by which it was distinguished; and if it possessed any medicinal qualities, it would receive special attention as to its therapeutical uses. The students were then free to go home as they liked. Another route lay along the Old Kent Road to Blackheath, where breakfast was taken at the "Green Man," and another from Blackfriars into Battersea Fields, the present Battersea Park. Breakfast in this case was ordered at the "Star and Garter," Putney.

The success of the Hunterian School, and the increasing requirements of the College of Surgeons and the Society of Apothecaries, led to the establishment of a series of private schools in London. Some of these, like the Aldersgate Street School, of which mention has been made in a previous article, gave a complete course of instruction, others taught single subjects, but all agreed in giving a most thorough grounding in anatomy. Of some of the methods adopted in these schools we have already spoken, but the plans of imparting knowledge adopted by the private teachers were sometimes very curious. Thus J. C. Carpué, who was known as "the chalk lecturer," from the facility with which he extemporised blackboard diagrams when subjects were scarce, made his pupils learn their bones by rote. He first

described the different parts of a bone, and he then called upon a student by name to demonstrate the bone to others in the same words as he had used. This done, it was given to a third student, and so on until the process had been repeated fourteen or fifteen times in succession. It is recorded that he had a temporal bone with its styloid process broken off, and that after repeating the other parts he would say, "the styloid process broken off." One of his pupils, on presenting himself at the College of Surgeons, was asked to describe the temporal bone; which he did after the manner of Carpué, much to the amusement of the Court of Examiners. "The styloid process broken off!" said old Sir William Blizard in astonishment, for it was about two inches long. And when the student explained, the veteran surgeon laughed heartily at the joke. Dermott, another of the great private teachers in anatomy and surgery, taught in a different manner. He was very unpunctual in the time of beginning his lectures. His afternoon discourse usually occupied two hours, and if he observed symptoms of weariness in his audience he would say, "Gentlemen, you are fatigued with your labours; let us have a little interlude to revive you." He would leave off his teaching for a few minutes, and deliver himself of the soliloquy of Hamlet, or the death scene in Richard III, amidst the enthusiastic applause of his audience.

In our school teaching at the present time there are remnants, as if atavistic, of both methods of teaching, unvaried, alas! by the histrionic talents of a Dermott. There are the dull and formal demonstrations of the dark winter afternoons, in which the demonstrator of surgery does all the talking; and there are the much more useful tutorial classes conducted on strictly Socratic lines.

The private teachers were practically starved to death by an ordinance of the Royal College of Surgeons, which enacted that the teaching of anatomy should be carried out during the winter session, and that summer classes would not be recognised after 1824. The private schools which gave more than a course of anatomy and surgery lingered for some time longer, almost the last being the Grosvenor Place School, which was very ably conducted by Samuel Lane.

The passing of the Medical Act in 1858 gave a great impetus to all systematic teaching. At first lectures counted for everything, but little by little it yielded to the present method of many demonstrations and comparatively few lectures. In our own school this system was inaugurated by the appointment of Mr. Willett as the first Demonstrator of Surgery in the summer of 1871. Before this time every student had to attend two courses of Lectures on Surgery, but in this year the Royal College of Surgeons of England required that candidates for the final examination should attend one course of lectures and one course of demonstrations. Mr. Willett secured the office of Demonstrator of Surgery for five years, and his place was taken in due

course by Mr. Marsh; Mr. Butlin and Mr. Walsham replaced Mr. Marsh, and were in turn succeeded by Mr. Bowly and myself.

The destruction of the private schools, coupled with the advent of a stricter system of examinations, gave rise to a new genus of teacher—the "grinder." He is now as extinct as the dodo, but his methods are crystallised in Albert Smith's skit, "The Physiology of the London Medical Student." Of these unfortunate people he says, "Not only is the medical grinder intimately acquainted with the different branches required to be studied, but he is also master of all their minutiae.

"In accordance with the taste of the examiners, he learns and imparts to his class at what degree of heat water boils in a balloon; how the article of commerce, *Prussian blue*, is more easily and correctly defined as *ferrosoquicyanuret of the cyanide of potassium*; why nitrous oxide, or laughing gas, induces people to make such asses of themselves; what you would do if you were called to see a tipsy barber who had cut his throat with a razor, or divided his carotid artery with his scissors, and especially all sorts of individual inquiries." As an instance of his methods Albert Smith gives the following dialogue:

"Now, Mr. Muff," says the gentleman, handing him a bottle of something which appears like specimens of a chestnut colt's coat after he has been clipped, "what's that, sir?" "That's cowitch, sir," replies Mr. Muff. "Cow what? that won't do, sir. You must call it at the Hall by its botanical name, *Dolichos pruriens*. What is it used for?" "To strew in people's beds that you owe a grudge to," replies Mr. Muff, whereat all the class laugh except the last comer, who takes it all for granted, and makes a note of the circumstance in his interleaved manual; but it is right to say that after attending the grinding class two or three times he runs his pencil through this note as valueless. "That answer would floor you," continues the grinder. "The *Dolichos* is used to destroy worms.—How does it act, Mr. Jones?" going on to the next pupil. "It tickles them to death, sir," answers Mr. Jones. "You would say it acts mechanically," observes the grinder. "The fine points stick into the worms and kill them. They say, 'Is this a dagger which I see before me?'" and then die. Recollect the dagger, Mr. Jones, when you go up. I have known three men saved of an evening by remembering the dagger, Mr. Jones."

The professional grinders of this type spent their lives at the work, and aspired to nothing higher. We, though more timely happy, find that eight or ten years of similar drudgery too often crushes out of us all originality, and leaves us without the inclination or the ability to further the scientific progress of our profession.

THE Title-page and Index to Volume IV are unavoidably held over till next month.

## Diseases often Overlooked.

A paper read before the Abernethian Society on  
October 28th, 1897.

By J. D. RAWLINGS, M.B.(Lond.).



Y object this evening is not to discuss elaborate methods of diagnosis or to raise questions of deep theoretical interest, but rather to point out a few conditions which are in most cases easy to diagnose, but are often overlooked merely because they are not looked for or thought of, and which thus form a series of pitfalls for any man, however well read, until he has either suffered by them himself or witnessed the discomfiture of a confrère.

Of all chronic diseases that which is most commonly overlooked is *chronic interstitial nephritis*. From the clinical point of view this is practically the same disease as arterio-sclerosis or arterio-capillary fibrosis; the only difference between them is that in granular kidney the change occurs first in the kidneys and affects secondarily the cardio-vascular system, whereas in arterio-sclerosis the primary change is in the cardio-vascular system and spreads to the kidneys. The two diseases present the same clinical picture, and often cannot be distinguished with the naked eye after death. Granular kidney is a far more common disease than most people think; it is not so exclusively confined to middle and old age as the text-books lead us to suppose; its onset is insidious in the extreme; it may progress for many years without causing any symptoms at all, and the symptoms when they do occur are often very indefinite, and not in any way calculated to direct one's attention to the kidneys. (Edema, for instance, does not usually occur, and the albumen and casts may either be absent from the urine altogether or may occur in such small quantities as to be easily missed. Consequently, anyone who is not constantly on the look-out for this disease is sure to overlook a large proportion of the cases that come to him. On the other hand, no disease is easier to recognise when looked for; the hypertrophied left ventricle, the hard tortuous arteries, the low specific gravity of urine may be recognised with certainty by any man who has done his auscultation and percussion classes. The albumen often has to be looked for very carefully; by far the best way to find a minute trace of albumen is to boil the top inch or so of the urine in a test-tube, add a drop of acetic acid, see that the outside of the tube is quite clean, and then hold it up to the light with a dark background formed by a black coat sleeve. In this way minute traces of albumen may be recognised which I defy anybody to be certain of by the nitric acid test. The specimen chosen should be one passed after food or after exercise; I have often found that the urine passed by a patient immediately after admission to the hospital has contained a minute trace of albumen which has been absent from all subsequent specimens while he is in the ward. I had the good fortune to be Dr. West's house physician at the Royal Free before I came on at this Hospital, and to Dr. West I am indebted for impressing these facts upon me. As a result of his teaching I looked for the signs of granular kidney in every middle-aged or elderly man who came to the surgery with indefinite but persistent symptoms of any kind, and I was astonished at the number of such cases in which they were present. The following are some of the symptoms which have brought my granular kidney patients to the hospital.

Indigestion, general debility and lassitude with inability to work, headache, occasional attacks of giddiness, symptoms of anæmia, rheumatic pains in the shoulders or back, muscular cramps, neuralgia of the face and elsewhere, spitting up blood, eczema, palpitation, cough and shortness of breath, epistaxis, loss of sight. Deafness and tinnitus are said to occur.

I can only recall one case in which the increased quantity of urine brought the patient to the hospital, and in that case, curiously enough, the patient was referred by the casualty officer not to the physician but to the gynaecologist. She was a woman of sixty who gave the history that three months ago she had had some marital troubles, and that she had since been troubled with frequent micturition. No local cause was found by the gynaecologist, and she was accordingly sent to the medical out-patient department, and was there found to have well-marked cardio-vascular signs of granular kidney. And, moreover, the symptom she complained of was not merely frequent micturition but true polyuria.

General debility and lassitude are perhaps the commonest symptoms of the disease; they almost always occur whether there are other symptoms or not. A tradesman once brought one of his

employés to the hospital complaining that he had been doing his work so badly for some time past that he had been obliged to discharge him; and the man had excused himself on the ground of health. The man was in a pitiable condition, for he knew that he was working badly and felt that ruin was staring him in the face, but could not pull himself together. These people, by the way, always take the most gloomy possible view of their prospects. This man had granular kidney with emphysema and an unusually large quantity of albumen in the urine—about a quarter.

Headache and giddiness are very constant symptoms. The headache may be secondary to dyspepsia, or it may be uræmic, or due to high blood-pressure in the cerebral circulation, or to atheroma of the cerebral arteries cutting off the blood-supply from parts of the brain. The vertigo is partly due to atheromatous vessels, partly to increased blood-pressure in the brain; it also occurs in syphilitic endarteritis. When a middle-aged fallow-faced man complains of persistent headache with occasional attacks of giddiness, by far the most probable cause is granular kidney. I should say that in middle-aged people granular kidney is a more frequent cause of dyspepsia than phthisis is in young people. The vomiting of granular kidney may be either gastric or central, and this disease is one of the causes of morning sickness, simply because a person with atheromatous cerebral arteries is liable to vertigo on any sudden change of position, and suffers, therefore, on rising in the morning. The same applies also to cases of cerebral tumour. In a small percentage of cases loss of sight is the first thing complained of. I have seen one or two such cases, and Dr. West has published some. Osler says,

"It is remarkable in how many cases of interstitial nephritis the condition is diagnosed first by the ophthalmic surgeon." A woman of about fifty-five came to Moorfields in the early part of this year complaining of loss of sight; she had not been treated elsewhere for any other symptoms. On examination with the ophthalmoscope she was found to have very extensive albuminuric retinitis; the cardio-vascular and urinary signs of granular kidney were then looked for and found. It must be borne in mind that albuminuric retinitis generally is very extensive before the patient complains of failing sight.

In one of Dr. West's cases the first thing noticed by the patient was that he could not see a wire fence when hunting. A fortnight later he had lost all vision except the perception of light. Dr. West then saw him, and found extreme albuminuric retinitis; a week later he died with pericarditis, i.e. three weeks from the time the first symptom was noticed.

The most striking early symptoms of granular kidney are the *hemorrhagic ones*. A universal degeneration of arteries and capillaries is an essential part of the disease, and hemorrhages may occur in any part where there are blood-vessels. I saw a boy of seventeen and a half in the Casualty Department here who came because his nose bled frequently. He was also subject to headaches, but did not mention that until the question was asked. The apex-beat was in the sixth space one and a half inches outside the nipple line, and there were no signs of valvular disease. The first sound was reduplicated. The radial arteries were thickened. The urine contained a trace of albumen. He was a printer by trade. Dr. West saw the case subsequently, and confirmed the diagnosis.

A middle-aged man came to the surgery because he had just been vomiting blood; he was a drinker, and the first things one thought of were cirrhosis of the liver and gastric ulcer. There were, however, no other signs of portal obstruction nor of gastric ulcer. On the other hand, there was a hypertrophied left ventricle, emphysema, hard arteries, and typical granular kidney urine; and I see no reason to doubt that the gastric hemorrhage was due to arterio-capillary degeneration in the mucous membrane of the stomach.

I was called down to the surgery one night to see a patient who was spitting up blood. I found a man between twenty and twenty-five, very anæmic and thin, who had spat up a small quantity of bright frothy blood. He had never done so before. On examination I found, to my surprise, that there was not a single sign of phthisis, but that there was a very hypertrophied left ventricle, hard arteries, and typical granular kidney urine. He worked in tin. Unfortunately I have never seen the patient again, and the notes that I took were on the paper I gave him. Hemoptysis is an extremely rare complication of granular kidney; Dr. West tells me he has never seen a case, nor has Osler; but as far as one can be certain of any diagnosis from a single examination of a patient I feel certain of this one.

Hemorrhage may occur from the kidney in chronic interstitial nephritis, and is comparable to the other hemorrhages. I have noticed in more than one case that puerperal women who have the cardio-vascular signs of granular kidney without any of the symptoms may pass smoky or pink urine for a day or two after delivery. It is

also an interesting fact that the symptoms of granular kidney may in a latent case be precipitated by any constitutional upset; thus a man may have the cardio-vascular signs for years, but all that time he may enjoy good health and pass normal urine, until one day he gets influenza, or has some great business worry, and from that time has headaches, giddiness, dyspepsia, polyuria, and so on. I have no doubt that the case I have mentioned of the woman of sixty who complained of polyuria was of this kind. She must have had granular kidney for years before she came to the hospital, but the symptoms were precipitated by mental excitement. And, conversely, in many of the cases in which the debility following a fever appears to be unduly prolonged, it will be found that the patient has the signs of granular kidney.

Hemorrhages into the retina and the brain are of course extremely common in this disease. Hemorrhage into the skin is rare, but it does occur, and Dr. West has published a case in which it was accompanied by another very rare complication, viz. detached retina.

As an example of the disease being easily recognisable before the patient has noticed any symptoms, the following is perhaps interesting. Last May I was left in charge, as *locum tenens*, of a lady who had cirrhosis hepatis, and various other alcoholic disorders. Considering the amount of organic disease that she had, her general condition was very good. After my first visit to her, however, she suddenly became moribund. Her brother pressed me to tell him what was the original cause of her troubles, and when I told him that the case was undoubtedly alcoholic he was very much shocked, partly because it was news to him that his sister sipped, and partly because it occurred to him that he might be going the same way. He suggested that I should overhaul him, and see that he was all right at present.

When he came to see me after dinner he remarked with a cheerful smile that he did not seriously think there was anything the matter with him, for he felt in such perfectly good health, and, moreover, he insured himself a year ago, and was then accepted as a first class life. When I came to examine him I found his left ventricle hypertrophied, his lungs emphysematous, his liver down to his umbilicus; the radial artery was easily felt, although he was only thirty-six; the urine was *torio* with a trace of albumen. Although he considered himself in such perfect health, he admitted, on being asked, that he passed two or three liquid motions every day, and I noticed that when he walked a mile with me at a fairly brisk pace his breathing became very laboured, and on arriving at our destination he at once showed other signs of his condition.

When I say that granular kidney is an easy disease to diagnose, I do not of course mean that it is always easy to say in an advanced case whether we have to do with granular kidney or with some other serious disease. It may be a very difficult thing to say whether a dilated heart with anasarca is due to valvular or renal disease, and renal disease may closely simulate cerebral affections. I well remember a case in which I diagnosed mitral regurgitation with heart failure; one of my senior colleagues said it was a renal case primarily. Post mortem it was tubercular meningitis.

In another case a diagnosis was made of malignant disease in the region of the descending colon. Post mortem the lumps we had felt proved to be a cystic kidney about the size of two fists. The patient had died of uræmia. There is nothing like the post-mortem room for teaching us humility.

Now a word about the treatment of granular kidney. It is a favourite maxim of Sir Dyce Duckworth's that experienced physicians treat patients, not diseases; it is only homeopaths, he says, who treat diseases. There is no class of patient about which this is truer than the victims of granular kidney. No line of treatment will make a contracted kidney do all the work it was intended to do; no therapeutic measure will render an atheromatous tortuous artery firm and supple again. All we can do is to relieve the patient of some of the results of the organic disease, and induce him to abandon such modes of life as would encourage the progress of the morbid changes. By the time some serious complication has occurred, such as acute nephritis, uræmia, or cerebral hemorrhage, the treatment of the case is pretty obvious, being simply that necessitated by the complication. But in the earlier cases—those that are so often overlooked—the choice of treatment requires careful judgment. Let me describe two patients suffering from this disease, each of whom is typical in his own way, and can be seen any morning in the surgery, but who present very different appearances and require equally different treatment. No. 1 is a big, heavy, obese brute, who denies stoutly that he drinks to excess, but admits that he is a brewer's drayman. He is thirty-five to forty years of age, of florid countenance and fishy eyes. He complains of loss of appetite, and flatulence and discomfort after meals. He has frequent headaches, and his bowels are irregular; they may be either loose or constipated. His breath has

the odour, not of the man who has just had a whisky and soda, but of the chronic smoker, which is very different. His tongue is coated with brown fur; his lungs are emphysematous, the area of cardiac dullness is diminished; the apex-beat is impalpable; the heart-sounds are muffled, but the aortic second sound is distinctly louder than the pulmonary. The pulse is of high tension, and the radial artery, though not extremely thick, is easily felt. He passed water just before he came in, but thinks perhaps he can make a little more.

He at once supplies half a pint of pale urine, of sp. gr. 1010, which contains a minute trace of albumen. Looking man, whose face is not only anæmic but sallow, his expression is serious and his spirits depressed, his skin generally is dry and inelastic, he is obviously wasted. He is forty years of age, but has already a well-marked *arcus senilis*. He has worked in lead. He says he drinks very little, and his appearance bears out the statement. He complains chiefly of lassitude and loss of appetite. His tongue is flabby and only slightly furred. His heart is found to be thumping away in the sixth space an inch outside the nipple line. The first sound is loud and reduplicated; the second sound is reduplicated and accentuated over the aortic cartilage. The radial artery is very thick and tortuous, but the pulse is of low tension. A low tension pulse with accentuated aortic second sound is quite a common combination in granular kidney.

These two men require very different treatment. No. 1 should be cut off his drink absolutely, and his butcher's meat should be limited or forbidden altogether. If he is constipated he should be purged freely, partly to eliminate the poison, partly to reduce the blood-pressure, and in any case his bowels should be kept open at least once a day. He should be given iodide of potassium, which will have some effect in lowering the blood-pressure and is said to improve the condition of atheromatous arteries. He should also be given nitro-glycerine, the quantity of which must be regulated according to the effect it has on the blood-pressure.

No. 2 must be dealt with much more cautiously. He is already depressed mentally and debilitated physically. If one limits his diet to just those things which he cares least about, cuts him off his little drop of stimulant, purges him vigorously, and adds to his depression by giving him iodide of potassium, one will probably do him far more harm than good. I would rather give such a man a diet like the following. For breakfast, at 8 a.m., one egg with as many rashers of fat bacon as he cares for; *café au lait* to drink; this to be preceded when his appetite improves by a plate of porridge with cream or butter. *Lunch* at 11: a tumblerful of milk and an oatmeal biscuit. *Dinner* at 1.30: a chop with cauliflower or other fresh vegetables, one glass of Burgundy with as much soda-water as he cares for, bread and butter or milk pudding *ad lib.* *Afternoon tea* at the usual time. *Supper* at 8 p.m.: white fish, porridge with cream, bread and butter, milk pudding, one glass of Burgundy. After each of his three meals he should have a mixture containing tinct. ferri perchlor.  $\text{m} \times$ , tinct. nucis vom.  $\text{m} \times$ , out of hst. acid. nitro-hydrochloric. His bowels should be regulated if necessary with gentle laxatives. A few weeks of treatment on these lines will probably be found to make a considerable improvement in the general health, and then the question of reducing the alcohol and meat may be reconsidered.

There is, of course, far more to say about the treatment of patients with granular kidney, but I mention these two cases merely as examples of the fact that it must be treated very differently in different cases according to the indications presented by individual patients. Not long since, a late student of St. George's told me that he had heard Dr. Dickinson say that it was a very fortunate thing that granular kidney was so seldom diagnosed, for in those cases in which it was recognised, the patient was almost invariably starved and his life shortened. I believe that this is no injustice to those practitioners whose knowledge of medicine is derived mainly from text-books.

*Scarlet fever* is generally an easy disease to recognise, but we occasionally let it slip through our fingers simply because we do not think of it. Thus the febrile stage may be so mild as to be called a cold, and neglected by the patient or his parents; then in the second or third week scarlatinal nephritis occurs, and one is called to see a child with general dropsy. Now acute nephritis without any chronic renal disease is almost always caused by a specific fever, generally scarlatina; therefore this disease should always be thought of when a child has acute nephritis.

W. G.—, a boy of 6, was admitted August 28th, 1895, suffering from occasional drowsiness. The boy had the appearance of being in good health, and the symptoms complained of were quite indefinite, and not in any way suggestive of renal disease. He was only admitted because he was the son of one of the employés of the

hospital, and it was intended to send him out in a few days. In the course of the routine examination it was found that his urine contained one quarter albumen and casts, but there were no other physical signs anywhere. There was no oedema, and the skin was not desquamating anywhere. The following statements were now elicited from the mother. Two months ago the child went to stay with friends in the country, where he attended a school. Six weeks ago patient's neck began to swell on both sides about the angles of the jaw, and about the same time he had a "bilious attack." In other words, he had presumably sore throat and vomiting six weeks ago. Five weeks ago his school was closed on account of an epidemic of scarlet fever. The mother does not know that his face or feet have ever swelled, but thinks she remembers hearing something about his boots being too small for him while he was in the country. The boy developed no fresh symptoms while in the hospital, and was kept in bed until the albumen had entirely disappeared from the urine, five weeks after admission.

I was once expressing the opinion to a friend that acute nephritis in a previously healthy man was very rarely due to cold. My friend deprecated the opinion, saying that it certainly occurred sometimes, for his own father had had nephritis through sleeping on the floor. When I expressed surprise at this conduct on the part of a staid elderly gentleman, my friend said, "Oh, we were all being turned out of our rooms at that time, because the house was being disinfected after a case of scarlet fever."

When a sick child is brought to one with a sore throat, and one finds well-marked false membrane on the fauces and soft palate, one may perhaps be excused for notifying it as diphtheria without further examination; but such a case ought to be examined for a scarlet fever rash, for exudation sometimes occurs in the throat of scarlet fever without any diphtheritic infection, and in that case is generally due to streptococci. I have seen one case of membranous laryngitis where there was no scarlet fever, diphtheria, or syphilis, in which the *Bacillus pyocyaneus* was demonstrated.

A few days after I had written this I was called to see a girl of seventeen who was complaining of a sore throat. The history was as follows:—She suffered frequently from sore throat. On Thursday she felt ill all day; on Friday morning she still felt ill, but she was working hard for the London Matriculation, which was to begin on Monday, and she went to school as usual; at school she found she could not work, and had to come home in the middle of the day. There had been no rigors or vomiting. I saw her at 5 p.m. She looked ill, and was anæmic; complexion rather muddy; the temperature was 101°. There was considerable glandular enlargement at the angles of the jaw, especially the left. The pulse was 124—that is, the frequency was considerably more than could be accounted for by the temperature, which by itself would have raised the pulse-rate to about 100 only. The tongue was furred; the fauces were slightly reddened, and the tonsils were not enlarged; behind the left tonsil, but *not on it*, was a small yellowish-white patch. The insidious onset, the rapid pulse, the patch in the throat, and the glandular enlargement, out of all proportion to the condition of the throat, led me to make a provisional diagnosis of diphtheria. At 10 p.m. there was a slight blush on the chest, and the face was distinctly more flushed than at my first visit. The patient had vomited copiously in the interval. The urine contained only a trace of albumen; and when the patch in the throat was rubbed with a sterilised swab for bacteriological purposes it came right off, leaving a surface which did not bleed. Next morning there was a typical scarlet fever rash, and Dr. Andrews reported that no cultures had been obtained from the swab.

Again, the throat in scarlet fever may resemble a follicular tonsillitis, therefore it is necessary to exclude scarlet fever before a diagnosis of follicular tonsillitis is made in any case. The affection of the joints in scarlet fever may easily lead to the diagnosis of acute rheumatism, of which this case is an example.

E. W., æt. 13, was first seen by me on July 29th, complaining of a rash on his legs. The rash was a discrete, slightly raised, purpuric eruption, which was scattered over the trunk and limbs but was most marked on the lower part of the legs; it was fading. The hands and feet were desquamating in large flakes. The temperature was normal. The pulse was 132. There was a trace of albumen in the urine. The boy was slightly anæmic, but there were no other physical signs whatever. The boy was not over-intelligent; but the following is the history I got from him and his mother. He has never had scarlet fever nor any other illness. He was quite well till three weeks ago (*i. e.* about July 8th), when he "came out red all over except his face;" there was no shivering, vomiting, or headache, but his throat was slightly sore. He was ill enough to be put to bed for about one day. The rash lasted two or three days. Four days after he was taken ill his ankles became swollen and painful; they

remained so for about five days, and then his wrists swelled and became painful. He now went to a doctor, and was told that he had rheumatism and was given salicylate of soda. On July 25th he noticed that his hands were peeling, and on the 26th the purpuric rash appeared on his legs. The case as I saw it was fairly straightforward; there was a history of rash and sore throat, followed during the first week by painful joint swellings, there was desquamation such as rarely occurs apart from scarlet fever, and there was still a little albuminuria. I had but little hesitation in notifying the case, and the medical superintendent of the hospital to which the boy was sent agreed with the diagnosis. But now let us look at the case from the point of view of the man who saw it when the joints had been painful for nine days. He saw an anæmic boy with rheumatic joints; there was no rash to be seen and no desquamation, and no history of an acute onset. Although he overlooked a case of scarlet fever, I think few of us would like to cast the first stone at him. And even now, if he were to rise up and say that the original rash was no doubt a rheumatic erythema, and that any erythema may cause peeling; that sore throat is almost as common in rheumatism as in scarlatina; that the late purpuric rash was peliosis rheumatica; that the rapid pulse was perhaps due to an active endocarditis; and that though the patient had lived for three weeks in overcrowded rooms with several other children none of them became infected, I think his case would appear fairly plausible.

Finally, it is well known that a second attack of scarlet fever often presents itself as a mere catarrhal sore throat without any other signs or symptoms whatever. Thus, then, acute nephritis in a child, any kind of acute sore throat or rheumatic joints, should make us think of scarlet fever as a possible cause. Dr. Andrews published in the JOURNAL about a year ago an interesting paper on hospital sore throat, in which he showed that a sore throat of any degree from a mild catarrhal form to follicular tonsillitis or sloughing tonsils might prove on bacteriological examination to be diphtheritic. The practical outcome of these facts is that any acute sore throat should be regarded as possibly infectious. It is by no means impossible to mistake measles for diphtheria. Diphtheria is so much the commonest cause of laryngeal stridor in children that when one meets with this condition in a child who is ill and has no rash and no membrane on the fauces, one is very likely to call the case laryngeal diphtheria, and in at least nine cases out of ten the diagnosis will be right; but it must be borne in mind that among the early catarrhal symptoms of measles is laryngitis, and this may be severe enough to cause stridor before there are any other symptoms.

P. C., æt. 13 months, was admitted for laryngeal obstruction. She was quite well till a week before, when she developed a cough which continued till the day of admission, when the cough became croupy and the breathing noisy. The day before there was a little discharge from the nose and redness of the eyes. No history of exposure to infection of diphtheria. Two children in the house where patient lives had measles a fortnight ago. Patient has never had measles or any other illness. On admission the child was not very ill; the breathing was stridorous, but the laryngeal obstruction was not very great,—indeed tracheotomy never became necessary. There was no rash. Temp. 102.8°, resp. 40, pulse 160. General dry bronchitis existed, but no signs of pneumonia. There was nothing abnormal in the fauces, and little or no enlargement of glands at the angles of the jaw. There was a thick cloud of albumen in the urine. There was very slight injection of the conjunctivæ. Here, then, we had all the symptoms of laryngeal diphtheria, but an obvious possibility of measles. The diagnosis was discussed with some warmth, but I finally admitted the child to Radcliffe. Next morning, before I was up, I received two messages—one from Radcliffe to the effect that the child had developed a measles rash, and would I remove her as soon as possible; the other from the pathological laboratory, saying that the cultures of diphtheria bacilli had grown. When the child died, as these mixed cases almost always do, flakes of membrane were found in the larynx and trachea, and there was extensive double broncho-pneumonia.

I find that Oser says nothing about the diagnosis between measles and diphtheria in the early stage.

There are several conditions associated with broncho-pneumonia in children which are very easy to overlook, but which are very important. A child is brought to the surgery with a temperature of 104°, pulse 120, resp. 60 or 80, and signs of broncho-pneumonia are found in the chest. It looks a straightforward case enough, and one's first impulse is to send it as quickly as possible to the ward, and yet that innocent-looking child may cause an epidemic in the ward of measles, whooping-cough, or diphtheria, and make one more wary of broncho-pneumonias in the future. As a complication of whooping-

cough, broncho-pneumonia is particularly deceptive, for when a child with whooping-cough develops broncho-pneumonia, the whooping often ceases, to return again when the pneumonia has cleared up; but the child of course remains infectious all the time. There is one little symptom which is characteristic of whooping-cough, and may help in the diagnosis of these cases; a child with whooping-cough often coughs till he is sick, *even though he does not actually whoop*, and this does not often happen to other coughs. Before we are justified, then, in treating a broncho-pneumonia as non-infectious, we must exclude measles, diphtheria, and whooping-cough; these cases are not, mind also, that broncho-pneumonia may be the only obvious manifestation of an acute general septicæmia or pyæmia; these cases are often extremely difficult to recognise even when one thinks of the possibility, but the difference in prognosis is of course enormous. The following is an abstract of the post-mortem notes on a child aged eighteen months, who was in the hospital for eight days and was thought to be suffering from simple broncho-pneumonia. "Right lung covered with purulent pleurisy; much collapsed, with patches of broncho-pneumonia. Left apex solid with broncho-pneumonia. Acute purulent pericarditis. Both middle ears full of pus." This was obviously a case of septicæmia, of which the broncho-pneumonia was merely one among many manifestations. The case also serves as an example of the ease with which pericardial effusion may be overlooked.

There is a class of case occurring more often in children than adults which is very embarrassing. I mean patients who have a high temperature with no physical signs to correspond with it. These cases are very trying unless one has some system of examining them and sticks to it; and there is no better plan than to count the pulse and respiration, and then examine the various physiological systems in order, as in Dr. West's scheme. Look all over the skin for rashes; examine the heart and lungs; examine all the long bones and joints for swellings and tenderness, and the ears for discharge or offensive odour. Next, under the neuro-muscular system, examine the limbs for paralysis and rigidities; look for disorders of the cranial nerves and retraction of the head; examine with the ophthalmoscope. Under the digestive system examine the abdomen for tenderness, rigidity, distension, and enlargement of spleen; and last of all look at the inside of the mouth and throat, because this generally makes the child cry, and no further examination is possible. There is for some reason a great tendency to omit the throat from the examination of these cases; and it is a very important omission, because the cause of the fever is often found there, although the child may have given no indications that its throat is sore. Even adults who have follicular tonsillitis sometimes come complaining not of sore throat, but of pains in their limbs. It is generally hopeless to try to get a sick child to consent to have its throat examined; the thing must be done by force or fraud, and whatever way is the quickest is the best. I think the best plan is for the physician to sit facing the nurse with his knees nearly touching hers, and for the child to lie on its back with its hips on the nurse's knees and its head firmly fixed between the physician's knees.

The examination just described is quickly made, and if nothing abnormal is found, one can say that there are no physical signs of any of the ordinary pyrexial diseases. The question is then, what is it likely to be? It may be one of the infectious fevers—chicken-pox, scarlet fever, smallpox, measles,—and unless there is good reason for excluding each of these, the case should be treated for the time being as infectious. By the duration of illness, together with the absence of rash, and the fever is of several days' duration, the four things to be borne specially in mind are typhoid, meningitis, pneumonia, and influenza. In distinguishing between these without definite physical signs, the following small points are useful:—A pulse-rate which is slow in proportion to the temperature (for instance, temp. 103°, pulse 90), suggests typhoid or meningitis; irregularity of the pulse in addition to slowness suggests meningitis rather than typhoid; a respiration-rate which is rapid in proportion to the pulse-rate (*e. g.* resp. 40, pulse 100) suggests pneumonia. But, speaking generally, such a case should be treated at first as a typhoid, that being the commonest cause of prolonged pyrexia without physical signs.

In the case of children it must be remembered that "great events from little causes spring;" very insignificant ailments may cause very high temperatures. I have had a case of a child of three and a half with a temperature of 105° without physical signs, which came down in two days under the influence of aperients, and no signs of anything but constipation ever appeared. This fact, that a child may get high fever due only to constipation, always seems to me to have an interesting bearing on the causation of pyrexia in the puerperal

period. Many people tell us that such temperatures are practically always septic. I do not believe it. It is generally admitted that a woman's temperature rises more easily than a man's, and a child's more easily than a woman's, and a puerperal woman's more easily than that of a woman who is not lying-in. All lying-in women, practically without exception, are constipated; constipation in children may cause a temperature of 105°; why should not the occasional harmless temperature of 102° in the lying-in wards be due to constipation? The fact that such a temperature comes down at once when a purge is given does not seem to me to be against this theory, although our friends explain it by saying that the purge merely sweeps out poisons which have been absorbed from the general canal. I think the burden of proof rests with them.

On the other hand, a child may die with a high temperature before any physical signs or even any gross pathological changes occur.

A. W., æt. 1 year and 11 months, was admitted because she had a temperature of 104°. Patient was quite well until the evening before admission, when she had a fit. She was immediately brought to the hospital, and was found to lie with her eyes closed, paying no attention to her surroundings. From time to time there was a convulsive stretching of the arms and trunk, and a sudden shrill cry. There was no squint. The temperature was 102°. She was admitted to the surgery ward, where she had a slight fit which lasted a few seconds and was accompanied by squinting. She was sick a great deal in the night. There was no history of infection or blow on the head. The bowels were open four times in the night. She was so much better in the morning that the question of sending her out was considered. By 2 o'clock, however, the temperature had risen again to 104°, and she was admitted to Elizabeth. At 5 p.m. the pulse was 200, and the respiration 50. There were signs of general bronchitis. About midnight the child was very restless, the pulse uncountable, the respiration 76, and the temperature 104.2°. A hot mustard bath improved the general condition very considerably, but an hour later the temperature rose to 107.2° and the child died, having presented no physical signs of anything but slight general bronchitis. At the post-mortem nothing was found but a few patches of collapse in the lungs, due to the bronchitis. This may have been the onset of one of the infectious fevers, or it may have been influenza.

J. R., æt. 4 months, was admitted for pyrexia and collapse without physical signs. He was quite well in the morning of the day of admission, but at 3 p.m. his mother noticed that he was drowsy, seemed ill, and was blue about the face. He "came out hot and went cold again." The history reveals absolutely nothing else of any interest about the case. When seen the temperature was 102.2°, respiration 52, heart-rate about 200, but it was too rapid to count, and the radial pulse could not be felt. There was a double external squint which came and went. There was one vaccination scar on the left arm. At midnight there were a few purpuric spots on the face about the size of a split pea. Similar spots came out all over the body before the child died at 2 a.m. Post mortem the spleen was slightly enlarged, but nothing else was found. Dr. Kanthack examined the spleen bacteriologically, but with negative result. This may have been malignant smallpox.

Considering what a very unmistakable disease pneumonia is in its typical form, it is wonderful how it tricks us occasionally; sometimes by presenting no physical signs, at other times by causing no constitutional symptoms. When a patient is very ill with some other febrile disease it is quite possible for him to develop pneumonia without any fresh symptoms, so that one only discovers it on a routine examination of the chest, and not always then.

A pneumonia may be straightforward in every way, except that its physical signs may be very late in appearing, and this is very puzzling for the first few days. A boy of nine was admitted to the Royal Free Hospital acutely ill with high fever. He was seen on the sixth day of his illness by a house physician, who found no physical signs, and referred the case to the out-patient department. The assistant physician at about 4 p.m. found no physical signs, and suggested typhoid fever. At midnight there was absolute dulness and loud bronchial breathing all over one base; and the crisis occurred next day.

Among the less common causes of pyrexia without physical signs, perhaps acute military tuberculosis and infective endocarditis are the most important, and they certainly escape diagnosis as often as most things. The latter should always be thought of when a subject of chronic heart disease gets prolonged pyrexia without obvious cause. Acute tuberculosis should be suspected in any case which is believed to be typhoid but in which the diagnosis is not perfectly clear. The following case is interesting, if only from the number of diagnoses that were made. I first thought the temperature was emotional; when it persisted with a slow pulse I thought it was due to constipa-

tion, which the patient undoubtedly had; finally I found some signs in the chest and diagnosed *chronic phthisis*. The case next came into the hands of an outside practitioner, who notified it as *typhoid*; at the fever hospital a diagnosis of *meningitis* was made. Post mortem it was *acute general tuberculosis*.

Mrs. C—, a primipara *æt.* 21, was delivered of a seven months' baby while on her way to the General Lying-in Hospital, Lambeth. She was with her husband when the accident occurred, and he carried her the rest of the way to the hospital. When she arrived the placenta was found to be entire, and the *perineum* intact. The following morning the temperature was 103°, pulse 92, resp. 16, and apart from the temperature the patient seemed quite well. I thought the excitement of the previous evening was enough to account for the pyrexia. The temperature persisted, however, and I made a cursory examination of the apices of the lungs, and found nothing. As the pulse was slow and the lochia normal, and no vaginal examination had been made, I felt convinced the case was not septic. The patient suffered from chronic constipation, and every purge was followed by a large, hard, scybalous motion; the abdomen was slightly distended, but not tender, nor was there any local resistance. This state of things went on for a fortnight, the temperature ranging from 101° to 103°, but the patient being otherwise quite well. The bowels were open twenty times in thirteen days.

On the thirteenth day I examined the chest more thoroughly, and found signs of thickened pleura at the right base, but no signs of any active phthisis anywhere. She had never had any symptoms of phthisis. She was one of a family of five, of whom one had died of phthisis and the rest were healthy. I thought then that the temperature was due to tubercular disease of the lungs which was more active than the physical signs alone would lead one to suppose; and I accordingly discharged her from the lying-in hospital. In a few days she was so ill that a general practitioner in the neighbourhood was called in; he attended her till the thirtieth day, when he sent her to a fever hospital as typhoid fever. There she was found to have signs of meningitis, which taken with my previous opinion that the case was tubercular, made it easy to diagnose acute general tuberculosis. Although the diagnosis was not completed during life it was made before the body was opened. The meninges, lungs, pleura, peritoneum, liver, spleen, and kidneys were crammed with tubercles; and there was great thickening of the pleura at the right base, but no ulcerative phthisis.

I suppose pregnancy caused the general infection in a tuberculous subject, and the acute fever caused premature labour.

I will conclude with a case which, I think, not an unfair example of the difficulties that may be presented by *ulcerative endocarditis*. A youth of eighteen was quite well till January 5th, when he played football; he did not know that he received any injury during the game, but his father said that he did not look well that evening. On January 6th he still looked unwell, but did not complain, and went out. About 9 p.m. he complained of pain in the left groin. On January 7th he went to his work, though still in pain, and stayed at it all day. On his return from work he looked pale, could not eat his supper, and went to bed still complaining of pain in his left groin. On January 8th he only succeeded in getting downstairs, and had to return to bed at once. He was admitted the same day to the hospital, when the temperature was found to be 104°, and the pain in the groin persisted. The abdomen, external abdominal rings, and rectum were perfectly normal, with this exception, that in the left inguinal region there was great tenderness on palpation, the pain and tenderness corresponding closely in position with the course of the spermatic cord. Movement of the left thigh caused pain in the left groin. On January 10th patient seemed more ill; tenderness in groin diminished; expression much more that of a patient with abdominal disease than it had been. Towards night he got into a state of low delirium, with a running pulse of 140; he had hicough, and passed urine and feces under him. On January 11th the Hippocratic expression of face became more marked; he cried out with the pain, and drew his legs up. Towards night he became quite comatose, the lungs became clogged, and he died. Post mortem there was infective endocarditis with pyæmic foci in the liver and kidneys, and a pyæmic embolus in the left middle cerebral artery. Nothing was found to account for the pain in the groin.

Such, then, are the monkey tricks of which infective endocarditis is capable. Small wonder that it is often overlooked!

Gentlemen, it only remains for me to thank you—and I do so most heartily—for the patience with which you have allowed me to talk about things which are, I fear, more interesting to myself than to anyone else. If I am told that I have said nothing new, that the cases I have quoted are wayside examples of facts which are perfectly

familiar to every member of the Abernethian Society, I fully admit the justice of the criticism; but I would at the same time remind you that though many of the mistakes I have mentioned were merely my own, and therefore not surprising, some of them have been made by men of ability and experience, visiting physicians to hospitals, physicians to insurance companies, and so on; and this, I hope, is a sufficient excuse for my attempt to put a danger-board in front of them—

TO DOCTORS.  
THIS CASE IS DANGEROUS.

### A Case of Puerperal Eclampsia.

By G. E. DODSON, M.R.C.S., L.R.C.P.



HE notes of the following case, which occurred under my care as Extern Midwifery Assistant, are published by kind permission of Dr. Griffith.

The patient had had three previous full-term easy labours—all three children, girls, being alive and well. She had since had two miscarriages, both at fourth month, the last twelve months ago. There was no history of "fits." She had never before had a serious illness. Her feet did swell slightly during the later months of the three full-term pregnancies, but not so much as during the present one. For the last three years she has had to get up at night to pass water one or two times, whether pregnant or not; there were no further indications of pre-existing nephritis.

On August 9th, 1897, she was delivered at 3.12 a.m. of a male child, healthy, 7½ lbs. in weight. The occiput presented in the second position; the labour was easy, and lasted eight hours. The placenta was expelled half an hour after the child, some membranes (chorion and amnion) being retained. Very little blood was lost. Slight œdema of feet and legs was noticed.

At 8.30 a.m. she had a "fit" and when seen fifteen minutes later was quite sensible, but very restless. Pulse 120, small volume, high tension. No premonitory symptoms had been noticed.

At 9.15 a.m. a second fit occurred, which was severe; she suddenly lost consciousness, and her eyes turned upwards and to the right, remaining so during the toxic stage of fit; both hands were thrown up above her head, and her face grew increasingly cyanosed. No conjunctival reflex was present. This lasted about a minute, and then she began to struggle violently, being still unconscious, and continued to do so for about five minutes, after which she became quieter and conscious, although still restless. There had been no aura or cry. She had no headache, and was not sick; her pupils were of natural size, and her breathing was slightly hurried. Pulse and temperature normal.

At 9.45 a.m. chloroform was administered, and the retained membrane removed by hand; a catheter was then passed, and a pint of urine drawn off. The urine, which was clear, became solid on boiling, and contained epithelial tube-casts. On recovery from anaesthesia she was quiet and sensible. She was given Pot. Brom. gr. xx, chloral gr. xx, by mouth.

During the day, from 10.30 a.m. to 3.45 p.m., she took nearly two pints of milk by mouth. She was not sick or giddy, but complained of severe headache, and sweated profusely.

At 1.5 p.m. a third fit occurred, of similar character to the one described, and the dose of bromide and chloral was repeated.

At 3.30 p.m. a fourth fit occurred; after each entire consciousness returned.

At 3.45 p.m. a fifth fit occurred, after which she did not regain consciousness, and struggled violently; but for restraint she would have thrown herself off the bed and injured herself. Her pupils were now pin-point, reflexes were absent, and her face was rather cyanosed.

At 4 p.m. chloroform was administered, which soon quieted her. Under anaesthesia the condition of the pupil did not alter, and her breathing was stertorous when she was not struggling.

At 4.45 p.m. a subcutaneous injection of gr. ½ morphine acetate was given. Pulse 150, high tension; temp. 102.2°.

At 6.30 p.m. gr. ½ of morphine was injected.

At 8.5 p.m. croton oil ʒij was given on back of her tongue. This gave no result. Pulse 122, high tension; temp. 102.9°.

At 8.20 p.m. a catheter was passed, and half a pint of urine drawn off. Pulse 130.

At 8.30 p.m., the high pulse tension still continuing, Dr. Roberts advised bleeding, and a pint of blood was let from the right median basilic vein; this lessened the cyanosis, and lowered the pulse tension.

At 11.15 p.m. patient, still unconscious, was admitted to Martha Ward, under the care of Dr. Griffith. Until her admission, since 4 p.m. chloroform had been given intermittently about every quarter of an hour; it delayed for a longer interval she began to struggle violently. As the effect of the anaesthetic passed off, the slightest noise or jar in the room was sufficient to cause this. While quiet the breathing was stertorous, but each time, before struggling began, it grew more shallow and rapid, becoming less stertorous; a small quantity of chloroform sufficed each time, ʒxiiij being given in all. After admission to hospital no more chloroform was administered; her breathing grew less stertorous, no more fits occurred, and she struggled less violently, and at intervals only.

At 12 midnight she became purposive in movements. August 10th—3 a.m., she became rather collapsed; ʒss brandy given, and her condition improved.

At 4.45 a.m. she passed urine under her.

At 5 a.m. conjunctival reflex returned.

At 7 a.m. pulse 120; temp. 105°.

By 11 a.m. consciousness had sufficiently returned for patient just to answer questions, but no more; she was very restless and irritable. Her breathing was laboured, but the breath-sounds were well heard at the bases of the lungs.

The albumen in the urine amounted to one quarter on settling. At 3 p.m. patient took milk by the mouth, and ʒiv of brandy in the twenty-four hours.

*Subsequent progress.*—During August 11th she completely recovered consciousness. Her bowels were freely opened after medicine. Pulse and temperature gradually fell to normal next day, and the amount of albumen in the urine rapidly grew less; on the 17th only a cloud appeared after boiling. Some at least of the albumen present was paraloglobulin, as was shown by its precipitation on saturation with magnesium sulphate. She was kept in hospital twenty-five days, as her temperature subsequently rose on three occasions to 101°, possibly due to slight suppuration in the lower end of the venesection wound. During her stay in hospital the quantity of urine was diminished in the second week; the absolute quantity of urea was subnormal throughout. The albumen varied in quantity, never entirely disappearing, and casts were frequently present. After the fifteenth day she got up daily, and she steadily progressed towards recovery, an attack of bronchitis being the only complication. She left hospital on September 3rd. When seen on September 22nd she considered herself well but for some bronchitis still present. On getting about her legs became slightly œdematous. The urine was not diminished in quantity now. She was advised to come up to hospital for treatment, as there were signs of effusion at the base of the left lung.

### Notes.

THE APPOINTMENT of Dr. Kanthack to the Chair of Pathology at Cambridge can hardly be regarded as unexpected. Indeed, with such a candidate the result of the election on November 6th was a foregone conclusion. The electors were the Vice-Chancellor (Dr. Hill), Prof. Bradbury, Dr. Gaskell, Prof. Michael Foster, Dr. J. F. Payne, Prof. Clifford Allbutt, Sir James Paget, Dr. Donald MacAlister, and Dr. Latham; and their task must have been an easy one under the circumstances. No appointment could possibly be a more popular one, and we heartily congratulate Prof. Kanthack on achieving this distinction so early. Still more do we congratulate the University of Cambridge.

\* \* \*

THE EAST WING of the Hospital is now re-opened, and

we can judge of the many improvements introduced during the summer. The wards and landings have been re-floored with polished teak, and the walls painted a light red with a dado of a darker shade. The hypercritical aesthete may object that in the male wards (*i. e.* all except Paget) the red quilts on the beds afford neither a match nor a pleasing contrast. Hot-water pipes have been placed at the ends of the wards to reinforce the fires, and behind each stand of pipes is a ventilator which can be opened and shut after the manner of those in a railway compartment.

\* \* \*

The new beds are of a modified "Lawson Tait" pattern; the metal-work being coated with white paint. It is an apparent drawback that the bed ends are both raised and immovable, which at first sight adds to the difficulty of applying extension apparatus. In Mr. Butlin's wards, however, we notice that this is overcome by a most ingenious appliance fitted to the foot of the bed. It is readily applied, and very stable when in position; altogether it is a great improvement on the old apparatus, and we congratulate the inventor on the mechanical skill displayed therein. The increased height of the bed is of course a great advantage both in nursing and clinical work.

\* \* \*

The new lockers are elaborate and ingenious, and a great improvement on the old primitive style. The top part consists of two "pigeon-holes," one above the other, which may be closed at the side by a curtain; the roof is of glass, affording the means of ready inspection—a necessary routine after visiting days! This top piece supports a flap which is of the right height to be pulled over the bed, forming a convenient table for the patient. The foot of the locker contains quite a spacious cupboard. India-rubber pads protect the door of this cupboard and the table-flap from inflicting or receiving damage in their movements.

\* \* \*

WE OWE AN APOLOGY to Sir Robert Craven, from whom we publish a letter in another column, for stating that he was not present at the Old Students' Dinner on October 1st. As he qualified in 1846 he was the "Father of the House" on that occasion.

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IN ANSWER to numerous inquiries, we may state that Dr. Norman Moore finds himself unable to publish his Abernethian Address on "The Deaths of the Kings of England" earlier than Christmas.

\* \* \*

THIS SESSION the courses in Chemistry have been considerably remodelled by Dr. Chattaway and Dr. Orton. It has been necessary to extend the course for the Conjoint Examination over the whole year instead of merely in the summer session as previously. This enables the subjects to be treated much more fully, so that students have an opportunity of doing more of the practical work for themselves than is possible in any similar course given elsewhere.

A SPECIAL COURSE of twenty lectures in Organic Chemistry will be given in future during the summer session to meet the requirements of the Conjoint Board and of the new syllabus for the Preliminary Scientific Examination at London University, which now requires volumetric analysis. Further, the class for the Intermediate M.B. Examination in Organic Chemistry is being altered to meet the new regulations. Dr. Chattaway advises candidates for the London examinations to obtain a copy of the new schedule, which is widely different from the present one in force.

WE HAVE RECEIVED a number of communications reflecting unfavorably on the note in our last issue with reference to the Army Medical Service and the prospects thereof. Naturally the subject permits of different views, and the note in question was not an *ex-cathedra* utterance, but merely an individual expression of opinion.

MR. D'ARCY POWER has sent us a copy of his address at the Veterinary College, in which he makes an appeal for the appointment of veterinary inspectors to work in conjunction with medical officers of health. Considering the influence that diseases of animals frequently have on man, this plea seems rational, and we may add, from a perusal of the pamphlet, practicable.

IF THE MODERN NOVELIST must deal with medical matters, why cannot he or she submit the proof to a professional opinion? we should be spared many startling passages. We have only just recovered from the pranks of a probationer with a morphia syringe in *The Christian*, and now we find the following passage in *The Beth Book* by Sarah Grand, whose unhappy handling of some medical topics in *The Heavenly Twins* may perhaps be still remembered.

"Mrs. Caldwell said very little. She was suffering from a great swelling at the back of her neck—an anthrax the doctor called it—and was not fit to be about at all. . . . The doctor came every day to dress the abscess on Mrs. Caldwell's neck, and every day he said that if it had not burst of itself he should have been obliged to make a deep incision in it in the form of a cross." After this amazing display of knowledge we do not shrivel up at the contemptuous indictment of the medical profession placed in the mouth of the heroine. And why add to the already portentous length of her tale by repeating the stale libels of the Anti-vivisection Society?

THE following notice has been forwarded to us by the secretary of the Guild of St. Barnabas for Medical Students.

The above Guild is now entering on its fourth year of existence. It was started in 1894 with the purpose of uniting together medical students, and assisting them to maintain a high standard of faith and practice in the exercise of their profession.

Members must be communicants of the Church of England; they undertake to follow a simple rule of life and to attend the monthly

meetings so far as possible. The meetings are held on the first Wednesday in the month in the North-west Chapel, St. Paul's Cathedral, at 6.15 p.m. There is tea in the Chapter House at 5.45, followed by a short service, and an address by the Chaplain, Canon Newbolt.

Any student wishing to join or desiring further information on the subject is requested to communicate with the secretary, Mr. B. E. G. Bailey, 14, Woburn Square, W.C., or with the treasurer, Mr. R. Howard, Guy's Hospital, or to attend one of the meetings, when he would have an opportunity of judging for himself of the nature of the Guild.

WE ARE REQUESTED to state that the practices of the Choral Society take place on Friday evenings at 8.15. This Session the practices are being more largely attended than ever. Before long it is hoped that the Orchestral practices will be resumed on Friday afternoons.

IN CANON RAWNSLEY'S recently published *Ballads of Brave Deeds*, suitable reference is made to the bravery of Surgeon-Captain Whitchurch at the relief of Chitral. It is unnecessary to quote the stanzas, for every Bart.'s man knows the story.

ALL BART.'S MEN are proud of their museum, and justly so, as it undoubtedly contains the best collection of pathological specimens in London. In September we announced that the specimens added this year were on show, and we feel that special attention should be directed to them for two reasons; firstly, because they are nearly all preserved and mounted by a new method, and secondly, because there is no doubt that in the near future, specimens thus preserved will be shown at examinations in place of the present bleached spirit specimens. It will therefore be wise for men going up to accustom themselves to the appearance of those preserved by the new method.

About two years ago Dr. Kantack, following a method described by Jores (*Centralblatt für allg. Path. u. pathol. Anat.*, 1896), began experimenting with formalin as a preserving fluid. By this method the colour of the blood is fixed by the formalin, and the specimen is then mounted in glycerine. Last year a few specimens thus prepared were put in the museum, and they proved so satisfactory that this year nearly 170 specimens similarly preserved have been added. These are the result of two years' experience and experiment, and there can be no doubt that in future nearly all our museum specimens will be preserved by this or allied methods. Its advantages are obvious; the colour is apparently permanently retained, and a properly prepared specimen shows exactly as when first removed from the body; not only are those which would formerly have been preserved in spirit vastly improved, but interesting and valuable specimens, which before the introduction of this method were lost from inability to preserve their colour, are now among the most useful and beautiful specimens in the museum.

The important question as to whether their colour is permanent is answered by the fact that the specimens added last year are as good as ever, and they have been exposed to the full action of light for nearly two years; and it should be remembered that, other things being equal, the worst formalin specimen is better than the best spirit specimen.

We understand that the new specimens are to be kept separate at present from the general collection, and will be placed in the glass cases on the ground floor.

We are conservative in many ways at Bart.'s—perhaps wisely so,—but we can claim at any rate to be first, so far as England is concerned, in up-to-date museum preparations. Many other museums are now trying the same process with considerable success, and in a few years no doubt all will do so. The days of spirit specimens are numbered, and in the future they will only be found in museums of antiquities. We give below a short list of a few of the most striking specimens.

No. 380b	Exotosis.	No. 2301b	Tubercle of Spleen.
1233d	Subpericardial Hæmorrhages.	2331e2	Renal Infarct.
1678b	Subpleural Growths.	2334b	Contracting White Kidney.
1696a1	Broncho-pneumonia.	2341h	Tubercular Kidney.
1702a	Oedema of Lung.	2381e	Cystic Kidney.
1728f	Sarcoma of Lung.	2418b	Papilloma of Bladder.
1885e	Omental Cysts.	2904b	Multilocular Ovarian Cyst.
1935b	Carcinoma of Stomach.		
2203b	Nutmeg Liver.		

## Amalgamated Clubs.

### ANNUAL GENERAL MEETING.

THE Annual General Meeting of the Amalgamated Clubs was held in the Medical Theatre on Friday, October 15th, Mr. Furnivall in the Chair.

The business was to elect the Secretaries for the next year. Mr. C. G. Watson was elected as Senior Secretary, *vice* Mr. R. P. Brown, who had resigned, and Mr. H. J. Pickering as Junior.

### CRICKET CLUB SEASON, 1897.

The past season of the above club has been one of the most successful for many years.

Sixteen matches were played, of which 8 were won, 4 drawn, and 4 lost. The one disappointing feature of the season was our performance in the Cup Ties. After easily disposing of London in the first round, an unaccountable collapse of the last five batsmen lost us the match against University College.

Turning to individual performances, Greaves for the third successive season heads the batting table with the splendid average of 45. Rose and Bond both scored consistently throughout the season, and made a great advance on their figures of the previous year. In bowling, Pank, Rose, and Sale bore the brunt of the work. Pank heads the averages with a record of 41 wickets at a cost of 10 runs each, and showed a welcome return to his form of 1895. Rose did several good performances, notably *v.* M.C.C., but was hardly so reliable as last year.

It is unsatisfactory to have to record that the state of the pitch at Winchmore Hill is far from good. We are glad, however, to be able to state that forty square yards will be relaid during the winter; so it is to be hoped that we shall be able to note a marked improvement next year.

### BATTING AVERAGES.

	No. of innings.	Not out.	Total runs.	Highest score.	Average.
H. S. Greaves	14	2	548	152*	45.66
E. F. Rose	16	3	419	86*	37.23
H. Bond	17	3	352	83*	25.14
J. W. Nunn	13	1	208	44	17.33
J. C. Sale	13	1	198	69	16.5
H. E. Scoones	7	1	96	26	16
J. A. Willett	10	3	104	29	14.85
F. H. Maturin	12	1	148	39	13.45
H. Whitwell	16	3	162	36	12.47
E. Talbot	5	1	36	22	9
H. W. Pank	10	1	46	31	5.11

### BOWLING AVERAGES.

	Overs.	Maidens.	Runs.	Wickets.	Average.
H. W. Pank	210	69	422	41	10.29
E. F. Rose	245.1	74	544	30	15.11
J. C. Sale	186	40	532	36	17.73
H. S. Greaves	65.1	16	199	11	18.15
J. A. Willett	107	25	296	13	18.15
H. Bond	19.3	1	40	2	20
H. Whitwell	71	14	218	10	21.8
E. Talbot	16	3	45	2	22.5

## RUGBY UNION FOOTBALL CLUB.

### ST. BART.'S *v.* CIVIL SERVICE.

Played at Richmond on October 9th. This, our first game, resulted in a defeat by 1 goal to *nil*. The game was of a scrambling nature. Want of condition was very apparent amongst the forwards, and the outsides did not combine well together. Towards the end of the game we improved somewhat, but never managed to make the most of our superior weight. Two freshmen, Walker and O'Neill, showed good form.

Team.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, C. A. S. Ridout (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett (captain), A. J. W. Wells, C. H. D. Robbs, H. C. Adams, J. M. Plews, M. B. Scott, A. O'Neill, J. A. West (forwards).

### ST. BART.'S *v.* UPPER CLAPTON.

Played at Clapton on October 16th. A very close game, resulting in our favour by 1 goal 2 tries (11 points) to 3 tries (9 points). It took us some time to settle down, and Clapton started the scoring. Shortly afterwards Walker scored cleverly for us, and O'Neill only just missed a difficult kick. Just before half-time Bennett forced his way over the line. In the second half Upper Clapton again scored first. Bart.'s then pressed hard, and a very clever piece of passing amongst the outsides resulted in Plews scoring. This was converted by O'Neill. We still kept up the pressure, Mayo being conspicuous for several good runs. Just before the end Upper Clapton broke away and scored, but failed to convert.

Team.—T. M. Body (back); F. F. Shout, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West (forwards).

### ST. BART.'S *v.* KENSINGTON.

Played on October 23rd at Wood Lane. This was a well-fought game, resulting in a very creditable victory for us by 2 tries (6 points) to *nil*.

In the first half the game was very even, each side in turn pressing. Shortly before half-time a good piece of passing between O'Neill, Fleming, and Robbs resulted in the latter gaining a try, which O'Neill just failed to convert. In the second half we pressed hard for most of the time, but only scored once more, when Bennett ended a forward rush with a try.

Our forwards played very well all through the game, and the outsides kicked and tackled well.

Team.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); A. W. Nuthall, H. Walker (halves); W. F. Bennett, J. K. S. Fleming, A. J. W. Wells, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill (forwards).

### ST. BART.'S *v.* R.N.C. GREENWICH.

Played on Wednesday, October 27th, at Greenwich, and resulted in our favour by 2 goals (10 points) to *nil*.



At the beginning of the game we pressed strongly, and after some capital bouts of passing among the outsiders, Mason received a good pass from Mayo, and scored a try, which he converted. Almost immediately afterwards Mayo crossed the line, but was held up. The home forwards played much better after this, and we were driven back to our "25," where the game remained for the greater part of the first half. Dix, at back, had plenty of work to do to clear his lines.

After half-time play was very even. The outsiders several times gained ground, but nothing further was scored until the last minute of the game, when Mason intercepting a pass, eluded the back, and scored between the posts. This he converted easily. For the last twenty minutes we were without Adams, who damaged his knee.

*Team.*—C. Dix (back); S. Mason, T. A. Mayo, C. A. S. Ridout, J. M. Plews (three-quarters); H. Walker, A. L. Vaughan (halves); W. F. Bennett, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, R. im Thurn.

#### ST. BART'S 2ND XV v. CIVIL SERVICE 2ND XV.

October 9th. Played at Winchmore Hill, and resulted in a win for the visitors by a trice to 1 goal 6 points to 5 points.

#### ST. BART'S 2ND XV v. ROSSLYN PARK 2ND XV.

October 16th. Our opponents scratched, and the fixture consequently fell through.

#### ASSOCIATION FOOTBALL CLUB.

The list of fixtures for the coming season is again a long one, including out matches at Eastbourne, Tunbridge Wells, Dover, Sittingbourne, Salisbury, and Hastings. At the last-named place the team will be again entertained after the match by the old Bart's men resident there.

The second eleven also have a good list of matches to be played. With regard to the team several places have to be filled up. A goalkeeper has to be discovered; and at back, though we shall miss R. P. Brown, who captained the team for the last two seasons, yet we are lucky to have so good a player as Orton to fill the gap. At half-back the loss of Pickering, who has played so great a part in the successes of the last few seasons, will be keenly felt. In the forward rank Woodbridge and Robinson have left us, but with Willett, Talbot, Stone, and Marrett remaining, all of whom played last year, we should have a good line of attack.

Up till now, though there are several promising players, no great talent has been discovered amongst the freshmen. If there are any new players who have not yet had a chance to play, they should at once ask the secretaries for a game; and though owing to the number of players at the Hospital it is impossible for some to get regular places in the first or second elevens, yet all those, both freshmen and old members, who have therefore been obliged to join outside clubs should always allow the Hospital first call on their services.

#### ST. BART'S v. CHESHUNT.

In this match, the first of the season, played at Cheshunt on October 9th, the Hospital started well, and playing a good game in the first half-time, crossed over leading by 3 to 1; but in the second half, owing to want of condition, the pressure was not kept up, and, in spite of good back play by Whitaker and Orton, Cheshunt were able to score two more goals, and so to make the result a draw—three all.

Goals for Cheshunt—Barwell (2) and Christie; for St. Bart's—Stone, Watson, and Bostock. Considering this was the first match, the Hospital played well, as Cheshunt had a strong team, and two of their goals were very lucky. At back, Orton and Whitaker were safe, and Watson, in his new position at centre half, tackled well forward. Stone played well, and Murdoch made some good passes. The teams were—

*Cheshunt.*—W. Bain (goal); E. Warder, J. E. Jull (backs); W. J. Shepherd, M. Ellis, H. J. Hargreaves (half-backs); C. Virger, E. J. Christie, J. R. Barwell, B. Horley, W. K. Shearing (forwards).

*St. Bart's.*—E. F. Rose (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, R. Murdoch, G. W. Stone, L. E. Hughes, H. N. Marrett (forwards).

On Wednesday, 13th, Ealing were unable to raise a team, so the match was scratched.

#### ST. BART'S v. R.M.A.

Played at Woolwich on Saturday, 16th, and resulted in a win for the Hospital by 2 goals to 1. The Hospital were not at full strength, and though they had the rest of the game throughout they were only able to win by one goal. Walker scored both the goals for the Hospital. *Team:*

*St. Bart's.*—F. F. Rose (goal); L. Orton, L. E. Whitaker (backs); R. Bigg, C. G. Watson, E. H. Scholefield (half-backs); R. Walker, C. O'Brien, R. Waterhouse, G. W. Stone, H. N. Marrett (forwards).

#### ST. BART'S v. EASTBOURNE.

Played at Eastbourne on October 20th. Result, defeat by 2 goals to love. The Hospital had bad luck, for Whitaker missed his train and could take no part in the game. Watson, therefore, went back, and Bostock to centre half, and Wethered, who came down as linesman, to half on the left.

Eastbourne, with a full side, including Topham, Willis, and Stansborough, soon started pressing, and in the first half-time scored twice and in the second half still continued pressing, but were unable to add to their score. This was due to the good defence of Orton and Watson at back, and of Rose in goal, who saved some fine shots. The rest of the team did not seem to play together, and there was a lack of lasting power, though Wethered must be congratulated on his first appearance at half-back. The forwards had few opportunities to score, and the shots they sent in were always dealt with safely by Lawrence in goal. *Team:*

*St. Bart's.*—E. F. Rose (goal); L. Orton, C. G. Watson (backs); E. H. Scholefield, A. H. Bostock, E. Wethered (half-backs); T. H. Talbot, G. W. Stone, J. A. Willett, R. Murdoch, H. N. Marrett (forwards).

#### ST. BART'S v. REIGATE PRIORY.

Played at Reigate on Saturday, October 23rd. Reigate won by 6 goals to nil.

The game was played in a strong wind, which upset the Bart's defence—and the forward line was not at full strength. Reigate scored four goals in the first half, and two in the second.

Their first two goals certainly appeared to be won off side, and the decision of the referee affected the play of the Hospital. The best team undoubtedly won, but under conditions more favourable to Bart's the defeat would not have been so severe. *Teams:*

*Reigate.*—M. S. Barker (goal); W. A. Windsor, C. F. Holdsworth (backs); H. Dungate, E. J. Nighthingale, G. Goodwin (half-backs); H. S. Goodwin, C. S. Kirkpatrick, H. I. Rogers, F. P. Sladen, H. Budgen (forwards).

*St. Bart's.*—E. F. Rose (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, L. E. Hughes, R. Murdoch, H. N. Marrett (forwards).

#### ST. BART'S HOSPITAL v. WEST HERTS.

Played at Watford, October 27th. The Hospital were beaten by 5 to 1. The score by no means represents the state of the game. Though West Herts scored goals in the first half, St. Bart's had the best of the game in the second.

The large score against them was due to the inability of the forwards to shoot. Had they been equal to West Herts in this part of the game, and taken their opportunities, the scores would have been about level. Willett and Talbot played exceedingly well on the right wing, but the rest of the forwards lacked combination. The halves worked well, and Orton and Whitaker were as usual good at back; but Butcher, who was making his first appearance in goal for the Hospital, saved some shots very well. Talbot scored for Bart's. *Team:*

*St. Bart's.*—H. Butcher (goal); L. Orton, L. E. Whitaker (backs); R. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, C. W. Stone, C. O'Brien, H. N. Marrett (forwards).

#### ST. BART'S v. CROUCH END VAMPIRES.

Played at Wood Green, October 30th, and resulted in a win for the Hospital by 2 goals to 1.

The home team pressed at first, and scored a goal. Bart's then got together, and Stone scored with a long shot. In the second half Bart's still kept up the pressure, and Stone headed through a second goal from an excellent centre by Marrett.

Willett and Talbot were away from the team, Waterhouse and Walker playing well in their places.

On the whole the Hospital played better than before, there being more combination; but the forwards must shoot whenever they get a

chance, as at present the goal average will need a lot of scoring to bring it on the right side. Whitaker and Orton were very safe at back, and Butcher in goal did well. *Teams:*

*St. Bart's.*—H. Butcher (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); R. Walker, R. Waterhouse, C. W. Stone, L. Hughes, H. N. Marrett (forwards).

*Crouch End Vampires.*—W. L. Hollick (goal); G. S. Francis, C. M. Smith (backs); S. V. Windett, A. Sainsbury, W. Caldecott (half-backs); H. A. Potts, F. S. Windett, E. W. Newby, J. B. Nicmann, H. Flowers (forwards).

#### SECOND XI.

Below is a list of the results of the Association "Reserve" matches, not so discouraging as at first would appear, since all the men are strange to each other, and the team is steadily improving every match.

			For.	Against.
Sat.,	October	9th.—Beckenham II.....	2	... 4
"	"	16th.—Tonbridge .....	0	... 5
"	"	19th.—Forest School.....	0	... 1
Tues.,	"	23rd.—Barnes Incogniti ...	2	... 7
Sat.,	"	27th.—Proprietary School ...	0	... 0
Wed.,	"	30th.—Old Foresters H.....	1	... 3
Sat.,	November	3rd.—Berkhamsted School	5	... 4

#### Ibernetian Society.



Thursday, October 21st, the Society's first Clinical Evening of this Session was held, Mr. Langdon Brown in the chair. The following gentlemen showed cases or specimens.

Mr. Hussey showed two cases of coloboma iridis, the chief interest of the cases lying in the fact that they occurred in twin brothers. The malformation was situated vertically downwards in the left eye in both cases. There was no family history of the defect.

Mr. Morrison showed a case of supernumerary fingers and thumbs. There was a strong family history in the children, but none in the previous generation. He also showed a specimen of placenta previa with a velamentous insertion of the cord, which had been ruptured in turning the fetus.

Mr. Horder exhibited a case of supposed Addison's disease in a child of seven. The condition had greatly improved under treatment with supra-renal extract and iron. He added that Dr. Gee regarded the case as probably anaemia with "vagalond's bronzing."

Mr. J. P. Maxwell showed microscopic specimens of rodent ulcer and epithelioma of the scrotum.

Mr. Thursfield showed for Mr. Briggs a young man with a pulsating orbital tumour, over which a distinct bruit could be heard. This had been noticed one week after a bicycle accident.

Mr. J. L. Maxwell showed a child with a congenital sacral tumour. This was regarded pathologically as an adenoma of the post-anal gut.

Mr. Emery showed a specimen of carcinoma of pylorus, the peculiarity of the case being that although the pedunculated growth almost entirely occluded the pyloric orifice, there were no symptoms of it during life. He also exhibited three microscopic specimens of Molluscum contagiosum, showing their formation. He pointed out how the so-called cancer parasites were almost identical with the molluscum bodies.

This ended the meeting, which was a most successful one, both cases and specimens being considered highly interesting by all present.

On Thursday, October 28th, Mr. Hussey in the chair, Mr. J. D. Rawlings read a paper on "Some Diseases often Overlooked." A communication full of practical clinical interest was expected, and that this expectation was not disappointed will be clear to all who peruse his paper, which is published in *excerpts* in this issue of the JOURNAL. His audience was so conscience-stricken that some interval elapsed before the discussion began.

On Thursday, November 4th, Mr. Hussey in the Chair, Mr. T. P. Legg read a paper entitled "Appendicitis." This paper also we hope shortly to publish in these pages, as the careful work it embodied well merits attention, apart from the intrinsic importance of the subject both in its medical and surgical aspects.

#### EMPYEMATA OF THE NASAL SINUSES.

*Abstract of a paper read before the Society on October 14th, by J. J. GRACE, M.B., B.S., F.R.C.S.*

I MAKE no apology for the subject of my paper, for I think empyemata of the nasal sinuses are more common than is generally supposed. Most of those unaccountable abscesses, for instance, which occur in the orbit originate, I believe, in the nose.

In the first case of this kind with which I had to deal the patient had syphilis with the usual perforated palate, &c., and was complaining of severe headache. I treated her with potassium iodide, but did her no good. A fluctuating swelling appeared on her forehead, and looked very like an abscess. One day I examined her nose and removed some dead bone. An immediate outflow of most stinking pus followed. From this moment she got quite well and the lump disappeared. Subsequent experience has convinced me that this was a case of empyema of the frontal sinus, and the swelling an abscess in connection with it.

I would like before continuing to recall to your minds some of the anatomy of the middle meatus. Under cover of the anterior portion of the middle turbinate bone will be found a groove called the hiatus semilunaris, which is formed by the projection, in front, of the uniform process of the ethmoid, and, behind, by the projection of the bulla ethmoidalis, which latter is formed by some of the anterior ethmoidal cells. The hiatus semilunaris is continued above to form the duct of the frontal sinus, and below has the opening into it of the antrum of Highmore. Above the bulla ethmoidalis is the opening of the anterior ethmoidal cells.

The hiatus semilunaris is not always continued upwards to the frontal sinus, however, for that cavity often opens in front of the hiatus.

Into the superior meatus open the posterior ethmoidal cells, and above the meatus on the posterior wall opens the sphenoidal cavity.

The causes of nasal sinus empyema are rhinitis, acute and chronic, the former affecting the sinus by spreading directly to it, the discharge subsequently decomposing; the latter acting, I think, in the same manner, though some authorities are of opinion that chronic rhinitis simply blocks the opening into the sinus; that a partial vacuum, and so increased exudation to fill it, is the result. Polypi are said to act in the same way.

It is certain that polypi or chronic rhinitis are present in all cases, but I think they are due rather to the irritation of the discharge. Syphilis is undoubtedly a cause.

In the case of the autumn two more causes may be recognised. The proximity of the roots of the teeth renders it not uncommon for inflammation to spread from them, generally from the second bicuspids or first molar.

Owing to the relative anatomical positions of the opening of the frontal and maxillary sinuses, the latter can probably be infected from the former.

The symptoms differ as the orifices of the sinuses are closed or open. When the orifices are closed the symptoms are due to pressure.

Pain is severe and neuralgic, often associated with tenderness over the part affected. The severe pain is accounted for by the near neighbourhood of branches of the fifth.

Later, we have bulging of the walls of the cavity and the pointing of abscesses.

When the orifices are not occluded, pain is still present, but shifty in character. The main symptom, however, is unilateral nasal discharge. Other causes of unilateral discharge, such as foreign body, syphilis, or new growth, are of course easily excluded. In the case of the antrum this discharge is intermittent, for the opening being nearer the roof than the floor of the cavity, the discharge can only get out when it is tilted. Another feature of discharge from sinus disease is that the patient notices the smell himself, while it is not obvious to those around.

An examination of the nose should now be made. A mass of polypus or some chronic rhinitis may be seen. The latter is generally localised to the anterior part of the middle turbinate bone, or may affect the olfactory fissure. If nothing abnormal appears in front, examine the posterior nares.

Polypus or hypertrophic rhinitis will be found even in cases when the empyema is closed, for in every case there was a time when the orifice was not blocked. If polypus are present pull them out, and this may be followed by a gush of pus, immediately establishing a partial diagnosis. I will detail the method of completing this later on.

Let us suppose now that all polypus are removed and there is no hypertrophic rhinitis to deal with, but no pus has appeared. The

best thing to do is to make an experimental puncture into the antrum, for remember the patient's symptoms are grave. Before this, however, Heryng's method of transillumination may be employed, but it is uncertain owing to the fact that the antrum are often unsymmetrical. Another precaution is to see if the antrum cannot be entered by the normal openings. For this purpose the probe is bent outwards and a little downwards, one centimetre from its end, and the point is introduced into the middle meatus. It can be felt to pass over the raised edge of the hiatus, and should then enter the opening. In general, however, the middle turbinate bone overhangs too much to allow of this procedure. A second attempt may be made to enter by the accessory opening when present.

The experimental puncture is made in the inferior meatus halfway along the inferior turbinate bone and just below it. This will exclude the antrum. Next, we must exclude the frontal cavity. The lip of the probe is bent upwards nearly to a right angle 2 centimetres from the end and passed up the hiatus semilunaris into the sinus. If the middle turbinate body is in the way its anterior part must be removed. When the opening of the sinus is in front of the hiatus the manipulation is easier.

To exclude the anterior ethmoidal cells, the probe is passed in just behind the bulla ethmoidalis, between it and the root of the turbinate body. The probe is bent outwards and upwards not more than 1 centimetre from its end.

To probe the sphenoidal cavity the probe must be 6 centimetres long, 4 to 6 centimetres disappearing in the nose. It has a slight curve over its whole length. It is passed, with the concavity of the curve outwards, from the nasal spine of the maxilla upwards and backwards past the middle of the middle turbinate bone until arrested by the wall of the sphenoidal sinus. A few lateral or vertical movements of the point will then usually find the orifice.

I know no means of diagnosing disease of the posterior ethmoidal cells except by a process of exclusion.

It often happens that more than one sinus is diseased in the same patient. When the empyema is closed we can only judge of this complication by the persistence of symptoms when one abscess has been opened. The empyema is not generally closed, however, and by syringing out each cavity in turn and noting the reappearance of pus in the middle meatus we can complete the diagnosis.

Treatment consists in the general treatment of polyipi and hypertrophic rhinitis, followed by the washing out and draining of the cavities. In the case of the antrum the best place to conduct this is through an opening in the canine fossa, as it can be easily got at, and the cavity can be packed through it if necessary. In the case of the other cavities the treatment must be conducted through the natural openings. In the case of the frontal sinus an additional opening can be made by trephining the frontal bone over the inner third of the supra-orbital ridge.

### The Bahere Lodge, No. 2546.

**A**N Emergency Meeting of the Bahere Lodge, No. 2546, was held at Frascati's Restaurant on the evening of the 9th inst., Bro. W. J. Walsham, W.M., being in the chair.

Messrs. Cripps Lawrence, John Adams, M. L. Trechmann, and Ernest Westbrook were initiated into Freemasonry by Bro. Godson. Bro. Surgeon-Major J. G. Harwood, M.S., P.M., and Bro. Dr. H. A. Haviland, of Penang, the Straits Settlements, were elected joining members of the Lodge. Bros. McLean, Haines, Sargant, Matthews, and Shewell were raised to the third degree by the W.M.

The Secretary gave notice of the Bi-centenary of the opening of St. Paul's Cathedral, which is to take place on 2nd December, 1897, at 3.30 p.m. Tickets for the opening will be reserved for those members of the Lodge who send in their names to the Secretary (10A, Chandos Street, W.) on or before 21st November. There is no charge for the tickets. The service will be conducted with masonic

ceremony, and the brethren will attend in craft clothing and jewels.

Thirty-four brethren with their guests dined together after the work of the evening was ended. Bros. Burns, Robinson, Trechmann, and McCann gave a most excellent selection of music.

### An old "Pupil's Certificate."

**W**E are indebted to Mr. Wallace Candler, of Stone, Staffordshire, for the loan of an old "Pupil's Certificate" such as were formerly issued at this hospital to medical students. The *fac-simile* may prove of interest to our readers.

[FACE.]

*St. Bartholomew's Hospital*  
*Mr William Jackson*  
*Medical Pupil*  
*for 9 Months from this Date*  
*2 May 1831*  
*E. Roberts*  
*Chas*  
*J. Matthews*

[REVERSE.]

*No. 2447 May 6. 1831*  
*W. J. Walsham*

### Volunteer Medical Staff Corps.

**T**HE St. Bartholomew's Hospital Half Company of the V.M.S.C. will hold their Second Annual Ball on Monday, January 24th, 1898, at the King's Hall, Holborn Restaurant.

The ball will be managed on almost the same lines as that held last January; each gentleman's ticket entitles the subscriber

to one invitation lady's ticket, which can be obtained by application to the Ladies Committee through the Secretaries.

As the ball is intended entirely for past and present Bart.'s men and their friends, it is hoped that it will have their hearty support; the attention of old Bart.'s men is especially called to this notice.

The gentleman's ticket inclusive of lady's invitation ticket can be got from any of the Committee or either of the Secretaries, price 15s.; owing to a large number of those present last January having expressed a wish that supper should be supplied, the Committee have decided to provide a supper as well as refreshments during the evening; in order to do this, it has been found necessary to increase last year's subscription. Any further information will be supplied on application to any of the Committee, or to the Hon. Secretary, J. C. S. Dunn, St. Bartholomew's Hospital, E.C.

### The Month's Calendar.

#### NOVEMBER.

- Tues. 16th.—Dr. Brunton's and Mr. Butlin's duty.  
Wed. 17th.—Mr. Langton's Clinical Lecture, 2.45.  
Thurs. 18th.—Abernethian Society at 8 p.m.: Dr. Morrison on "Albuminuria in Pregnancy."  
Fri. 19th.—Dr. Church's and Sir T. Smith's duty.  
Sat. 20th.—R.U.F.C. v. Marlborough Nomads, at Stamford Bridge. A.F.C. v. Civil Service A.F.C., at Chiswick Park.  
Mon. 22nd.—Final Fellowship Examination. Bart.'s Cambridge Graduates' Dinner at Frascati's, 7 p.m., Dr. Hill in the Chair.  
Tues. 23rd.—Dr. Gee's and Mr. Willett's duty.  
Wed. 24th.—Mr. Langton's Clinical Lecture, 2.45. A.F.C. v. Casuals, at Winchmore Hill.  
Thurs. 25th.—Abernethian Society, 8 p.m.: Mr. Drury on "Shortness of Breath."  
Fri. 26th.—Sir Dyce Duckworth's and Mr. Langton's duty. Sir Dyce Duckworth's Clinical Lecture, 1 p.m.  
Sat. 27th.—R.U.F.C. v. Croydon, at Croydon. A.F.C. v. Marlow, at Marlow.  
Tues. 30th.—Dr. Hensley's and Mr. Marsh's duty.

#### DECEMBER.

- Wed. 1st.—Mr. Langton's Clinical Lecture, 2.45.  
Thurs. 2nd.—Abernethian Society, 8 p.m.: Discussion, Clinical and Pathological.  
Fri. 3rd.—Dr. Brunton's and Mr. Butlin's duty. Dr. Hensley's Clinical Lecture, 1 p.m.  
Sat. 4th.—R.U.F.C. v. Old Leysians, at Stamford Bridge. A.F.C. v. Tunbridge Wells, at Tunbridge Wells. Hockey Club v. Ealing 2nd XI, at Acton.  
Tues. 7th.—Dr. Church's and Sir T. Smith's duty.  
Wed. 8th.—Mr. Butlin's Clinical Lecture, 2.45. A.F.C. v. Sittingbourne, at Sittingbourne.  
Thurs. 9th.—Abernethian Society at 8 p.m.: Mr. F. C. Wallis on "The Treatment of Spinal Caries."  
Fri. 10th.—Dr. Gee's and Mr. Willett's duty. Dr. Brunton's Clinical Lecture, 1 p.m.  
Sat. 11th.—R.U.F.C. v. Old Merchant Taylors, at Richmond. A.F.C. v. Newbury, at Newbury.  
Tues. 14th.—Sir Dyce Duckworth's and Mr. Langton's duty. Meeting of the Bahere Lodge at Frascati's, 5 p.m.  
Wed. 15th.—Mr. Butlin's Clinical Lecture, 2.45.

### Reviews.

A HANDBOOK OF THERAPEUTICS, by Sydney Ringer, M.D., F.R.S., and Harrington Sainsbury, M.D., F.R.C.P.; 13th edition. (London, H. K. Lewis, 1897, 8vo, pp. 746; price 16s.)—A book which has reached its thirteenth edition can scarcely stand much in need of recommendation, and such as is required by this work will be freely bestowed by all who read it. Its interest is shown by the fact that we have read through the majority of its 700 pages, a feat of which the unaided conscience of a reviewer is barely

capable; its value may be clearly seen on perusal of such a section as that on the preparations of arsenic. In these paragraphs we find blended the clinical experience which can dictate the remarks on aberrant types of asthma and hay fever, and the theoretical deductions from laboratory work which help to explain the action of this drug upon the skin. And these remarks will apply to all the contents of the book, from the introductory observations on the tongue and the pulse to the concluding Epicurean receipts for invalid cookery. Some of the latter help one to realise vividly the point of Charles Lamb's remarks on the pleasures of the sick bed! The revisions bring the work thoroughly up to date, for there are disquisitions on serum therapeutics and glandular extracts, and an account of the Nauehm-Schott treatment. We notice a short account of papain, the active principle of the fruit of the papaw tree, but no mention is made of the curious fact that apparently it is the only vegetable ferment which is of any use in the manufacture of cheese; which is not only interesting, but important, as the employment of rennin prevents this nutritious food being taken by large sections of the population of our Indian Empire. The drawback to papain in this connection is that it gives the cheese a bad colour. Nor do we find quoted the striking observations of Miss Mary Kingsley on its very active digestive properties. She tells us in her *Travels in West Africa* that it is commonly believed that "even if you just hang a tough fowl or a bit of goat in the tree among the leaves it gets tender in no time." She adds, "I certainly did once myself hang the leg of a goat no mortal man could have got tooth into on to a papaw tree with a bit of string for the night. In the morning it was clean gone, string and all." But perhaps such evidence is beneath the notice of a scientific text-book.

CLINICAL METHODS: A Guide to the Practical Study of Medicine, by Robert Hutchinson, M.D., M.R.C.P., and Harry Rainy, M.A., F.R.C.P. (Edin.), F.R.S.E. (London: Cassell and Co., Limited, 1897, price 9s.)

The chief fault which we find with this book is one which concerns the publishers rather than the authors, and it is one shared by all their series of *Clinical Manuals*. A book which aspires to be read should be capable of remaining open without having the binding almost smashed by forcible bending back of the covers. In spite of repeated performances of this operation, the book in front of us declines to allow us to read the page on which we have set our mind.

The authors appear to have done their work thoroughly and admirably. In the resources of clinical pathology we have a new method of examining our patients which must in time, with fuller experience, lead to almost as great advances as did the introduction of auscultation and percussion. They therefore justifiably devote considerable space and care to the description of these methods, and the accompanying plates will prove a great assistance to the student. Indeed, the copious diagrams scattered throughout the work are to be commended; many points, parasites internal and external, surface markings, and many other subjects find appropriate illustration. The diagrams of the motor segmental functions of the cervical and lumbar enlargement strike us as quite new. Altogether this book forms a very useful work of reference.

THE LOCALISATION OF HEADACHES, by H. Bendelack Hewetson, F.L.S., Honorary Ophthalmic and Aural Surgeon, Leeds General Infirmary. (London: Simpkin, Marshall and Co., 1897.)

We must in the first place object to Mr. Hewetson's title-page.

Why an ophthalmic and aural surgeon should, when writing on a professional topic, simply label himself as a Fellow of the Linnæan Society we cannot imagine. Mr. Hewetson apparently does not despise such baubles as medical diplomas and degrees, for to Professor Clifford Allbutt, to whom the book is dedicated, he allots these honours lavishly. And while grumbling we may also raise an objection to the unlovely head adorned with red patches on the cover of the book, and to the rather free use of leaded type in its pages. All this gives an unprofessional aspect to the work, and might lead to its sterling merits being overlooked, which would be unfair to the author, who has devoted much time and thought to its production.

Few ailments among those labelled as "trifling" are a source of more inconvenience to the patient and difficulty to the medical man than headache. In this book the very frequent connection between headache and an uncorrected visual disorder is insisted on; and further, the fact that general neuroses may occasionally have an ophthalmic origin is clearly pointed out. In many cases of the latter type the visual disorder may have never attracted the patient's attention, but is only found on examination by the medical attendant. The diagrams, many of them modified from Dr. Lauder Brunton's originals, lend emphasis to the text. From them we realise how very localised these headaches may be, even causing a modification in the style of dressing the hair with women to avoid pressure on the tender spots. The author suggests that this avoidance of pressure is also the origin of the short hair adopted by many literary ladies. Lest Mr. Hewetson should think we have only glanced at his title-page and diagrams, we may add that in the next edition of his interesting work we hope he will correct occasional barbarities of style such as exist at the bottom of pages 29 and 54, and the misprint "caroidid" on page 133.

### New Productions.

GLANDULEN, prepared by Dr. Hoffman [Thos. Christy & Co., 25, Lime Street, E.C.].—It is claimed that these tabloids, prepared from the bronchial glands, have a specific action in tuberculosis of the lungs. Amid the glut of extracts now on the market, it is refreshing to find one that offers a theoretical *raison d'être*. Ignoring the fact that the original success with thyroid extract was based on a careful observation of the facts of "internal secretion," manufacturing chemists provide us with extracts of every gland, and nearly every organ of the body. According to them, therapeutics have now become an exceedingly simple matter; a gland or organ is diseased—give an extract of it by the mouth; as to its mode of action, trust to the chapter of accidents. This is abhorrent to anyone whose methods aspire to be something rather better than these rules of thumb. It is the degradation of a system which offered a scheme of rational therapeutics. That a substance having active bactericidal properties may be extracted from lymphatic glands was shown some years ago; we believe this was first considered to be identical with the substance obtained by Halliburton from the lymphatic glands, and called by him Cell-globulin  $\beta$ . Much of this work has now only a historic interest, but the fact that a bactericidal body can be thus isolated still holds. It is quite possible, therefore, that an extract of bronchial glands should contain it abundantly, but we would suggest to the manufacturers that they should undertake and publish experiments to prove (1) that their extract has this action; (2) that this action is not destroyed by the gastric juice to which it must be submitted. Pending the publication of such experiments we may state that these tabloids are palatable, and from personal experience quite innocuous.

### Appointments.

CHATER, J. S., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Surrey County Hospital, Guildford.

DYSON, M. G., M.R.C.S., L.R.C.P., appointed Second Assistant Resident Medical Officer to the Islington Workhouse and Infirmary.

HARRISON, L. K., M.R.C.S., L.R.C.P., B.A.(Cantab.) appointed Assistant House Surgeon to the General Hospital, Nottingham.

HOLMES, H., M.B., B.C.(Cantab.) appointed Junior House Surgeon to the Wigan Infirmary.

MANNING H. C., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Kent and Canterbury Hospital.

ROBINSON, C. A., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Hospital, Portsmouth.

THOMPSON, H. E., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed House Surgeon to the Eye Hospital, Birmingham.

WHINCUP, F., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Salop Infirmary.

WOOD, J. H., M.B., B.S.(Durham), M.R.C.S., L.R.C.P., appointed House Surgeon to the Stockton and Thornaby Hospital.

### Examinations.

D.P.H.CAMBRIDGE.—The following have passed both parts of this examination:—G. H. Cock, R. A. Farrar, S. Gillies, C. H. Graham, C. F. Lillie.

FIRST CONJOINT.—*Chemistry and Physics*:—H. H. Butcher, C. Dix, L. C. Ferguson, H. P. Margetts, W. G. Paget, R. C. Wilmot.

FIRST CONJOINT.—*Practical Pharmacy*:—H. E. G. Boyle, A. Butler, F. W. Cheese, A. G. Higgins, H. G. Finker, W. H. Randolph, R. Thompson, F. J. Wood.

SECOND CONJOINT.—R. Bigg, R. C. Bowden, H. A. Colwell, W. E. L. Davies, C. Fisher, E. V. Lindsey, H. E. D. Lloyd, H. W. Marrett, D. S. Sandilaud, G. W. Stone, L. E. Whitaker, T. Young, J. E. Griffith, J. Valérie. Under old regulations A. Farrington has passed in Physiology.

FINAL SOCIETY OF APOTHECARIES.—F. E. Fielden has passed in Medicine and Forensic Medicine. *Physiology*.—N. C. Beaumont, *Biology*.—H. M. Huggins. *Materia Medica and Pharmacy*.—H. F. Stilwell, R. Storrs.

### Correspondence.

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

SIR,—I notice in your report of the Old Students' Dinner you state that Sir James Paget and Sir Robert Craven, of Hull, were unable to be present. This is incorrect so far as I am concerned. I was present, and Sir Thomas Smith in his speech stated that I was the oldest student present at the Dinner. I qualified in 1846. Yours very truly,

ROBT. M. CRAVEN.

14, Albion Street, Hull;  
October 31st, 1897.

### Marriages.

CROSS—COURTNEY. On the 5th October, at St. Peter's Church, Kirkley, South Lowestoft, by the Rev. Charles Tregenna, M.A., Rector, Henry Wingfield, eldest son of William Henry Cross, of St. Bartholomew's Hospital, London, to Rosa Millicent, younger daughter of Charles W. Courtney, of South Lowestoft.

COULBY—ROFE. On the 19th August, at All Saints' Church, Bayswater, W., by the Rev. Charles Yeld, Vicar of Grassendale, Liverpool, and the Rev. C. H. Gern, Rector of Torpenhow, near Carlisle, uncle of the bride, George Arthur Coulbly, B.A., M.B., B.C.(Cantab.), of Woodborough Road, Nottingham, to Laura Louisa, only daughter of Henry Rofe, of 8, Powis Square, W., late of Cavendish Lodge, Sherwood, Nottingham.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette, The Gynaecologist, St. Thomas's Hospital Gazette, The Nursing Record, The Student.*

# St. Bartholomew's Hospital



## JOURNAL.

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### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C., BEFORE THE 1ST OF EVERY MONTH.

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### St. Bartholomew's Hospital Journal,

DECEMBER 14th, 1897.

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

### Exophthalmic Goitre.

A Clinical Lecture delivered November 5th, 1897.

at St. Bartholomew's Hospital,

By T. LAUDER BRUNTON, M.D., F.R.S.

GENTLEMEN,—The subject to which I wish to direct your attention to-day is Exophthalmic Goitre, and as we have recently had in the wards a very good example of this disease I have asked the patient to attend here to-day, so that you may have an opportunity of seeing him. I have two photographs which were taken of this patient, one of which shows the general aspect very well, and the other shows the enlargement of the neck which occurs in these cases. The name of exophthalmic goitre is frequently applied to this disease, but it is also known by the names of the two men who described it,—Graves, an Irishman, and Basedow, a German. The cardinal symptoms of the disease are denoted to a certain extent by one of these names, viz. exophthalmic goitre. Exophthalmos or protrusion of the eyeballs is one very prominent symptom; the second symptom is enlargement of the thyroid—goitre; and these are shown in the photographs. There is, however, another symptom which is not immediately obvious when you look at the patient, but which is quite as important as either of the two I have mentioned, viz. the exceeding rapidity of the heart's action—tachycardia. The three most important symptoms, then, are—

1. Protrusion of the eyeballs.
2. Enlargement of the thyroid.
3. Rapidity of the heart's action.

On examining the patient more closely, however, we may find that there are still other symptoms, affecting (1) the nervous system generally, (2) the eyes and the circulation. Sometimes these symptoms affecting the nervous system appear before either the changes in the heart, the changes in the eyeballs, or the changes in the thyroid. A good many patients whom I have asked about the subject have told me that the first symptom noted was an increased irritability of temper, or if this was not present, there was increased nervousness, so that they became apprehensive of accidents. One lady told me that one of her most striking symptoms was a fear of walking in the streets, lest the horses should leave the roadway, and come up on the pavement beside her. Many patients suffering from this disease dare not cross a street from fear of accident. The nervous symptoms are, therefore—

1. Increased irritability.
2. Increased nervousness.

On examining the eyes also it may be noticed that, in addition to the apparent protrusion of the eyeballs, in some cases the upper lid is more retracted than the lower, so that there is a large ring of white between the upper margin of the cornea and the upper lid. Along with this retraction of the upper eyelid and the greater width of

the space between the lids, one observes also that the eyes wink much less frequently than in the normal condition. These two symptoms together, the greater opening of the space between the lid and the unwinking eyes, are known as Stellwag's symptom. He was the Professor of Ophthalmology in Vienna at one time, and, many cases of eye disease coming to him, he observed this symptom. A more important symptom still was noticed by von Graefe, Professor of Ophthalmology in Berlin, and that is the want of co-ordination between the eyelids and the eyeball. In cases where you do not find a very large space of white between the cornea and the upper lid, you may get it becoming very evident by making the patient hold up the head and then follow your finger with his eyes. As you move it downwards you will notice that the eyeball follows quite easily, but the upper lid does not follow, and consequently we get this well-marked ring of white between the upper eyelid and the cornea, although it was not well marked before, and in cases where it is quite narrow it becomes quite broad.

Occasionally, too, we find that the eye when turned to one side or another does not move so readily as it ought to do, and when we make the patient converge his eyes upon the finger held a short distance in front of the face they do not remain steadily convergent, but one or other remains directed to the finger and the other moves aside. Other affections of the eye have been described, more especially loss of power in the various muscles of the eyeball, and certain affections of the pupil, but it is extraordinary how often you find that the pupil is hardly affected at all. In this patient you will notice first of all that the eyes are protuberant; they seem to come further forward than usual. You observe also that the neck is thick, and that the thickness is due to swelling of the thyroid gland, and you can see the enlargement of the lobes of the thyroid quite readily. When the patient looks up, you will observe that we get a broad ring of white sclerotic between the upper margin of the cornea and the upper eyelid. When he looks at my finger, as you see, convergence is very fair. You will also observe that when I press the eyeball it recedes, so that it clearly is not resting against something hard and resisting, but upon something soft and elastic, for on pressure the eyeball goes in and then comes out again as before. The patient experiences no pain on pressure. We shall consider presently the cause for the receding of the eyeball when it is pressed. Pulsation has been noted also in the arteries of the retina in these cases. One of the symptoms that I alluded to as very frequently present is absent in this case. He has not the irritability of temper which is such a common concomitant of this disease.

Another symptom that one notes in regard to the vessels is subjective fullness and heat. Patients usually feel very hot, and this feeling, although it may sometimes be accompanied by actual rise of temperature, very often is not so

accompanied. There may be no rise of temperature whatever, but the patient feels hot, and you can readily see the reason why. If you look at his hands you will see that they are fairly red, they are well coloured, there is no blueness about them, and the face is well coloured too. When you touch the hand it feels hot. Now you know that the feeling of heat, objective as well as subjective, is due to dilatation of the vessels of the skin, so that the warm blood flows from the interior of the body and circulates freely over the skin. In this way the patient himself feels hot, and anyone who touches the skin feels that it is warm. But it is not only warm, it is usually moist, and in consequence of the combined dilatation of the vessels and of the moisture, the electrical resistance of the skin is below the normal; there is less resistance to an electrical current passed through the body. A good deal of stress has been laid upon this of recent years. In the case before us we have no disturbance of the bowels nor digestive system, but in some other cases both occur. Although the disturbance of the digestive system has now passed off, the patient tells me that he did have one of the symptoms which is very common in this disease, namely, diarrhoea. He suffered at first very much from diarrhoea. Diarrhoea in these cases is sometimes almost choleraic, and apparently depends upon some deep-seated disturbance of the nervous system, and is exceedingly difficult to treat. The pulse in this case is 136, and the temperature I think we may be perfectly sure is at or about the normal; so you see here that one of the best-marked symptoms of this disease, viz. tachycardia, is present.

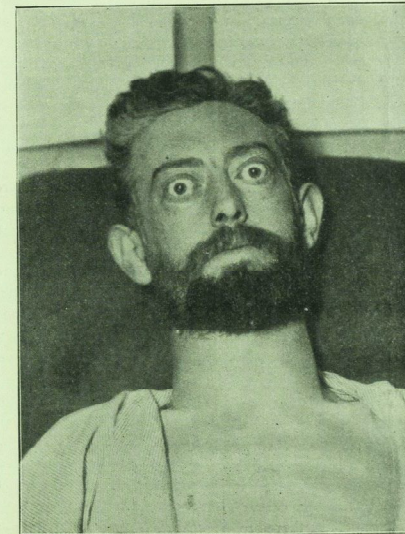
There is yet another symptom connected with the nervous system, which perhaps you may be able to see if I ask the patient to hold out a rod at arm's length. There is usually a constant rapid tremor of the arm, but instead of being magnified, as I expected, it seems to be almost steadied by the rod, possibly because the period of vibration of the arm and the rod eight feet long is too great. You will, however, see it readily enough if the patient holds out a sheet of note-paper. The tremor varies from four to ten vibrations per second.

On pressing over the thyroid you will be able to hear a regular well-marked systolic bruit, and on putting your hands over it you will feel that it pulsates freely.

Having considered the chief symptoms, we may consider the predisposing causes. This disease is much more common in women than in men. We have had two cases in "Elizabeth" Ward, but neither was so well marked as this. As a general rule, however, there are five to ten cases in women for every case among men. It generally comes on in the period of youth or maturity; it is not frequent amongst children nor amongst elderly people. Its onset is often moderately slow; sometimes the ingravescence of the symptoms may continue for a couple of years; sometimes, however, it comes on with great rapidity, and the case before us is, I think, one of the most rapid that I have

come across. The patient went out to work at 4 o'clock one morning. There was a thunderstorm, and this greatly agitated him. At 5 o'clock in the afternoon the eyes were protuberant, so that the disease came on in thirteen hours, which is a very short time. It generally comes on in consequence either of shock or of injury. In the present case it came on from the excitement of the thunderstorm. In another case, which I saw in private a number of years ago, it came on from sorrow and excitement within four or five days in a girl of nineteen, whose brother was accidentally shot when out shooting. His gun had become entangled in a hedge and shot him as he was crossing the hedge. He was her favourite brother, and, as I have said, within four or

may be produced secondarily upon the body by increased activity of the thyroid gland. We know now that the secretion from the thyroid gland possesses very great power in altering tissue change, because when we administer it in myxœdema we find the dull heavy appearance of the patient disappear, and we get a complete change in nutrition. But it is not merely the connective tissues that are altered by the secretion of the thyroid gland. We find that the nervous system is also acted upon by it, and that sometimes when the thyroid gland is administered, either in the form of a glycerine extract or tabloids of the compressed gland, for a long time to a patient, one is obliged either to lessen the dose or to stop the administration of the drug entirely.



five days she had very well-marked symptoms of exophthalmic goitre.

The pathology of the disease is still very obscure. In a paper which I wrote in the *St. Bartholomew's Reports* in 1874 I was inclined to locate the lesion giving rise to the symptoms in the ganglionic chain in the neck,—the sympathetic chain. Since that time, however, we have learnt a great deal more about the thyroid and its functions, yet even now it is exceedingly difficult to say what the cause of all these symptoms is, because we have to deal not only with the thyroid and with the symptoms which we see as being due to nervous lesions or alterations in tissue change in the thyroid itself, but we have to consider the effect which

because nervous symptoms appear. These nervous symptoms are increased excitability and increased irritability,—the very symptoms, indeed, that we find occurring in cases of exophthalmic goitre. I have noticed this condition come on not only in patients to whom I was giving thyroid tabloids for myxœdema, but in cases where I have given these tabloids for chilblains. The extract of the thyroid gland has the power not only of acting centrally upon the cerebrum and increasing its excitability, and giving rise to the symptoms I have just mentioned, but it also acts upon the vessels, causing dilatation; and this is rather of a permanent character, so that in patients who suffer from contraction of vessels, especially after exposure to cold, and

whose feet get blue and become affected with chilblains, the thyroid gland will probably cause the vessels to dilate, will stop this coldness of the feet, and arrest the formation of chilblains. We give this same substance in cases of Raynaud's disease where the vessels become contracted to a still greater extent, so that the fingers become blue, sometimes quite white, shrunken, and exactly like those of a corpse. As we happen to have a case of Raynaud's disease in the wards now, I have had the patient brought in for the sake of comparison of his case with this one of exophthalmic goitre.

We know that in cases of exophthalmic goitre we have great dilatation of the vessels, as evidenced by the subjective warmth, by the warmth to the observer's hand, and by the lessened electrical resistance. This dilatation of the vessels may be partly the cause of the rapid heart; because, like many other muscles, the heart when it has little resistance to overcome tends to beat quickly. Probably, however, this is not the only cause. The heart generally is kept beating at a moderate rate because it is restrained by the vagus, and most people's hearts beat somewhere between 60 and 75 or 80 per minute. If you were to cut the vagi their hearts would beat at the rate of about 120 per minute, and in many cases of disease in the wards, especially those of fever, you will probably be struck by the constant recurrence of the number 120 in cases where you are counting the pulses of febrile patients. The reason is that the heart, when unrestrained by the action of the vagus, generally beats about 120 per minute. You may ask, how do we know it? because of course we cannot cut the vagi in our patients, and see what rate their pulses will go afterwards. But every now and again we get the same thing. It is not necessary to cut the vagus trunk in order to abolish its effect upon the heart. It can be done by giving belladonna, and in cases of poisoning by belladonna, such as one of which we had an example in the Casualty Ward about three or four weeks ago, we find the pulse going at 120, and where too much belladonna has been given, say for enuresis, the pulse is often found to be going at 120 also, but in the case of exophthalmic goitre before us it is more. This, therefore, seems to show that here we are having not merely the absence of the controlling effect of the vagus, but we have also stimulation of the accelerating nerves of the heart.

The enlargement of the thyroid depends upon dilatation of the vessels in it, and probably also to some extent upon increased formation of the gland tissue itself, so that we probably get a larger internal secretion from the thyroid. I wish you to particularly notice that when I press my fingers upon the eyeball, it goes back into the socket as if I had been pressing against some elastic body. Now the protrusion of the eyeball is said to depend upon one of three things, or perhaps upon two of three things, or upon all three together. It is said that there is an increased amount of fat in the orbit which tends to make the eyeball protrude, but it is quite

certain that this fat is not the main factor in the protrusion of the eyeball. It depends chiefly either upon dilatation of the vessels in the orbit or upon the action of the so-called Müller's muscle, which tends to press the eyeball forwards; and both of these factors, the muscular contraction of Müller's muscle and the dilatation of the vessels, and their repletion with blood, would be abolished for the time being by the counter-pressure of the hand upon the front of the eyeball. Now it is very hard, as I have said before—and I do not think that I shall succeed at present—in completely disentangling those symptoms which are due to increased internal secretion and those which are due to primary nervous derangement. For first of all, before we get increased internal secretion something must have made the thyroid itself enlarge, and in all probability the first thing to be affected is some part of the cerebrum. In the first place we get a shock which acts upon the nervous system generally, and through it appears to react upon the thyroid and upon other parts of the head and neck which are innervated by the sympathetic. The probability is that the lesion really is somewhere in or near the medulla oblongata; and Filehne, of Breslau, was able after injuring the restiform bodies to produce in animals the three cardinal symptoms of the disease, namely, exophthalmos, enlarged goitre, and rapidity of the heart, although he very rarely, if ever, succeeded in getting all three in one animal.

We have just asked the patient to retire because we come now to a question which is better discussed in his absence, namely, the prognosis. The prognosis in these cases is a very uncertain one. The remark has been made that cases of exophthalmic goitre are not very often seen in the post-mortem room, and this is wonderfully true. A great number of these patients go on for a number of years, eight, ten, or more, and then they may either gradually recover, or they may die from some intercurrent affection. Some of them, however, last only a short time.

One of the ways in which patients are carried off is by the choleraic diarrhoea from which this man suffered at the commencement. The girl whom I mentioned before as having suffered from exophthalmic goitre, in consequence of the death of her brother, only lived, I think, some four or five months. She came up from Yorkshire, went down to Hastings, and while there she was seized with a choleraic diarrhoea which nothing would stop. It continued in spite of every remedy, and then she became so weakened that she died. Another cause of death is, as I have said, some intercurrent disease. One patient whom I watched for about ten years remained very fairly well, sometimes a little better, sometimes a little worse, but able to go through all her duties, to attend to her family, and entertain her friends, although she did not like the excitement of society. Unfortunately she contracted pneumonia. In all probability, as the pneumonia was not a severe attack, she would have recovered from it had it not been that the heart was too

feeble to stand the increased strain put upon it. You know that in cases of pneumonia a heart which is ordinarily beating sixty per minute will go up to 120, or even more, and you can readily understand that if you get this increased pulsation occurring in a normal heart, from the increased temperature, the heart which is day by day beating 120 per minute cannot go up to 200, as it ought to do in proportion to the rise in temperature, and so it beats itself out, and the patient dies. Death occurs not so much from the symptoms of the pneumonia itself, as from the exhaustion which comes, from weakness of the heart.

Well, now, what are we to do to prevent death? How are we to treat our cases? The way in which I used to treat them was by putting them upon chloride of calcium, prescribing about a drachm of the liquor three times a day, and as a rule they seemed gradually to improve. I usually saw them for several months at intervals, and then I lost sight of them, which I took to mean that they had become so much better that they did not want to see a doctor any more. Lately, however, we have been treating them either with thymus or with extract of the supra-renal capsules. The extract of supra-renal capsules is the substance that seems most indicated in the treatment of such cases, because while the thyroid gland or its extract dilates the vessels, the extract of supra-renal capsules has perhaps the most powerful effect in contracting the vessels of any substance we know. In one case that I have been treating lately in the country with extract of supra-renal capsules there has been a very marked improvement indeed.

Whether the patient is going to get well or not I cannot say, but she has very greatly improved. For one thing, the nervous symptoms appear to have gone, as she is no longer so frightened, and no longer so irritable. She seems also to have increased in strength, and apparently is on the way to recovery; but, as I said, these patients are apt to go up and down, and unless you find that they have actually got well you cannot say precisely what is going to happen, and one must remember that the symptoms do sometimes after a few months spontaneously begin to get less, and finally disappear.

Another method of treatment is galvanisation applied to the sympathetic. The usual practice is to put one electrode, very often the negative, on either the spine, the sternum, or the sacrum, and apply the other electrode just under the ear on either side. Under treatment of this sort a certain amount of improvement may take place, but I confess that I have been rather disappointed in it, and of late I have not used it very much, trusting much more to the use of such things as chloride of calcium and supra-renal tabloids. In addition to these definite remedies, one ought to be careful of the general health of the patients. All excitement is bad, and it is necessary to insist that they shall take things quietly, that they shall avoid worries as much as possible, and that they should not subject them-

selves to overstrain. You can readily see that overstrain of any kind, mental or bodily, is not good for their heart. Besides this, especial care must be taken to guard against chills, because with a heart beating so rapidly as it usually does in such cases, if the patients catch a chill, get a bronchitis or a pneumonia, then the result may be fatal, although they might have pulled through if they had not been suffering from this disease.

### Some of those after whom the Wards are named.

*Being the Inaugural Address of the 103rd Session of the Abernethian Society, delivered on Thursday, October 7th, 1897.*

By JOHN LANGTON, F.R.C.S.



WHEN I was asked by the honorary secretaries of the Abernethian Society to give the Inaugural Sessional Address, I readily consented to do so, for during the many years I have been connected with the School and the Hospital I have always recognised the good work the Society was doing among its junior members.

While, however, the consent was easy, the choice of the subject was difficult. I have selected, as you know, the subject, some of those after whom the Wards are named. Other subjects naturally occurred to me. I might have selected the high aims of our profession; the connection of the Abernethian Society and the Hospital; the causes of our successes and our failures; or many a wide field of kindred topics. I feel, however, that in many of these one is somewhat apt to wander into transcendental ideals which practically have little share in the choice and practice of our profession.

Some of the wards are named after Scriptural persons and divine gifts; some after official positions and persons—President, Henry, Alexandra, and Edward; some after benefactors—Colston, Darker, Sitwell, Kenton, Harley, Coborn, and Lucas; and some after former members of the Medical Staff—Radeliffe, Pitcairn, Lawrence, Stanley, Abernethy, and Paget. I shall start to-night with Rahere, the ward first visited officially on the Annual View Day, and named after our founder—Rahere.

#### RAHERE.

Most Bartholomew men know somewhat of the origin of our Royal Hospital, first as an integral part of an important monastic institution founded in 1123 by the King's minstrel, Rayer, who later on founded the Priory of St. Bartholomew. The Hospital was possessed of means outside the control of the Priory. Rayer died on September 20th, 1143, leaving thirteen monks on the foundation of the Priory. The monastery at that time was one of the largest and most important in London, the houses belonging to it reaching as far back as Aldersgate Street. Later, the Hospital was severed from the Priory, on the suppression of monastic institutions by King Henry VIII. It was not till 1546 that the Hospital was re-endowed by that monarch to the extent of 500 marks a year out of its former revenue, with the proviso that a similar sum should be contributed for ever by the citizens of London. To what extent the yearly revenue has increased is a standing memorial of the sagacity, liberality, and business capacities of those who have in former times, and of those who still govern, the financial destinies of the institution.

Of the old monastic fabric nothing, I believe, exists at the present time, although some of the cloisters were still standing within the memory of living persons.

The Church was erected shortly after Rayer's return from Rome. The tower, or at any rate part of it, still contains some of the original Norman arches. It was modernised by Dance in 1789, and was practically rebuilt by Hardwick in 1823.

The tomb of Rayer was erected in the fifteenth century on the north side of the choir of St. Bartholomew the Great, and is surmounted by a beautiful groin canopy, situated opposite to Prior

Bolton's pew. The figure of Rayer is recumbent; at its foot is a crouching angel, while on each side is a monk with a Bible opened at Isaiah li.

It is reported of Rayer that "he had not the cunning of liberal science, but having that which is more eminent than any cunning, for he was richest in purity of conscience."

## COLSTON.

The opposite ward is named *Colston*, after Edward Colston, who was born in 1636 and died in 1721. He must not be mistaken for John Colston, who was elected Surgeon to the Hospital in 1608.

Edward Colston was born at Bristol in 1636, being the son of William Colston, who in 1645 was removed from his office of alderman by order of the House of Parliament. It was in consequence of this that he removed to London, which explains the fact of Edward Colston, the son, being educated at Christ's Hospital. He was elected Governor of Christ's Hospital in 1680, and gave from time to time the sum of £2000 to that Hospital.

He was one of Bristol's most munificent merchants, his trade being chiefly with the East Indies, in which he made a large fortune. Edward Colston was made free of the City of Bristol in 1683, where he then resided; but he left Bristol in 1689, and lived at Mortlake, in Surrey, where he died, unmarried, in 1721.

While he gave largely during his lifetime to public and private charities, the amount being not less than £140,000, he was not unmindful of his obligations to those who were connected with him by ties of common blood. He founded and endowed many schools and almshouses in his native town.

He was elected Member for Bristol in 1710, which he held till 1713, when he retired owing to ill-health. On his retirement from the representation of the city he was presented by the corporation with a gross of bottles of sherry of the value of £16 18s. 6d.

During his lifetime he gave to our Hospital and to four others the sum of £5500.

He died in 1721 at Mortlake, where he had resided many years. The affection in which his pious memory is held at Bristol is proved by the fact that flowers are deposited every Sunday on his tombstone. Four portraits of Colston are extant—1. In the School of St. Augustine's. 2. In the Council House. 3. In the Merchant's Hall at Bristol. 4. In the Committee Room of St. Bartholomew's, which was painted by Kneller.

His memory is yearly honoured at Bristol on the 12th of November in each year. "Colston's day" is celebrated in the early day by religious services, while banquets are held in the evening. Collections are made at each for the continuation of his good work at Bristol. Two of them are associated with the rival political parties, viz. the Dolphin Society, established in 1749, patronised by the Tories; and the Anchor Society, inaugurated in 1769, is attended by the Whig party—usually a Cabinet Minister is present at one of the banquets, whichever party happens to be in power. The other two—"the Colston or Parent Society," founded in 1726, and the Grateful Society in 1758,—are independent of any political bias. He was a strong churchman and an ardent Tory, and it will be noticed that his munificent gifts are all devoted to the interests of the Church of England.

## RADCLIFFE.

*Radcliffe* acquires its name from Dr. John Radcliffe, who was born at Wakefield, in Yorkshire, in 1650. He proceeded to University College, Oxford, and thence came to London in 1684, where he rapidly acquired a large practice. Soon after he removed to London he became a Court physician, and though offered the post of physician in ordinary to King William III at a salary of £2000 more than any other, he declined the post. Although not attached as the physician to His Majesty, Radcliffe's professional opinion was often sought by the King, but he frequently fell into disfavour owing to the freedom with which he expressed his opinions whilst in attendance on his patient. King William had much respect for his professional opinion, which was often in direct antagonism to the physicians who came over from Holland with the King,—and his opinion, especially in the forecasting of events, was usually correct. With the consort of William, Dr. Radcliffe was in much favour.

It is stated that the earliest record of our School dates from 1662, although Harvey appears to have delivered his first lecture in 1616. Encouraged by the Governors, who thus showed their enlightened views, the School soon assumed an important position, and to such an extent that in 1725 accommodation was provided for a Museum of Anatomical and Chirurgical Preparations under the charge of John Freke, then Assistant Surgeon to the Hospital. Freke was an accomplished carver in wood, and an elaborately carved gilt chan-

deler now suspended from the ceiling in the Steward's office is attributed to his diligence and skill.

Radcliffe practised his profession in Bow Street, Covent Garden, his next-door neighbour being Sir Godfrey Kneller, who painted his portrait which now hangs in the College of Physicians.

He was never married, although it is recorded that he was on the point of being so when certain circumstances transpired which led to the engagement being broken off. It is stated that on his return home after the interview he retired to his room, and was heard to exclaim, "Well! they say hanging and marrying go by destiny, and I hardly see that if I had been guilty of the last, how I could have escaped the former!"

He retired to his country house at Carshalton, and died in the year 1714.

Dr. Radcliffe was the first possessor of the "gold-headed cane." At that time a cane was one of the compliments of physicians, and nearly always figures in prints as an adjunct to their persons. This gold-headed cane passed by gift to Dr. Mead, Askew, the two Pitcairns who were connected with St. Bartholomew's Hospital, and lastly to Dr. Baillie, a nephew of John Hunter. By him it was presented to the College of Physicians, where it now lies in departed glory in a glass case in the library of that College.

Through the descendants of Dr. Baillie the College of Surgeons have become possessed of several important pieces of furniture which formed part of the environment of the great John Hunter.

I have said that Radcliffe was never married, and he says it did not become him to speak of his good or ill fortune in that line. Science, however, is all the richer by his fate, for he left a considerable portion of his large wealth to Oxford University, where permanent records of his benefactions still flourish.

He bequeathed £40,000 to build and found a library at Oxford; also £5000 for the enlargement of University College.

Our hospital also profited by his will, for he left £500 a year in perpetuity for mending the diet of the patients in St. Bartholomew's Hospital.

His trustees, to whom a large property was entrusted for charitable purposes, allotted sufficient funds for the Radcliffe Library, which was completed in 1749, for the reception of books in medicine and natural history. They also erected the Observatory and the Radcliffe Infirmary, which are evidences of the care they had for science and humanity. The Observatory is one of the finest buildings in Oxford, and possesses a staircase worthy of notice. The Infirmary, which at the present time affords the best medical and surgical aid to the sick and the suffering, was opened for the reception of patients in 1770.

The liberality of the trustees has also been extended by the creation of two Radcliffe Travelling Fellowships, bequeathed out of his Yorkshire estate to the Master and the Fellows of his College at Oxford, and they further subscribed the sum of £2000 towards the erection of the College of Physicians in Pall Mall East, where his portrait hangs.

Apart from his wit and humour, to which no doubt much of Radcliffe's success was due, he seems to have been a physician of much resource and of much prescience in the prognosis of his cases, which made him very confident of his own opinion.

## PITCAIRN.

Dr. William Pitcairn was the eldest son of the Rev. David Pitcairn, minister of Dysart, in Fifeshire.

He studied at Leyden for some time, but eventually graduated M.D. at Rheims.

He was elected Physician to our Hospital in 1750, and shortly afterwards received the degree of M.D. of Oxford. In 1775 he was elected President of the College of Physicians, which office he resigned in 1784. He resigned his physicianship in 1780, but four years afterwards he was elected by the Governors, Treasurer of the Hospital, where he resided.

In conjunction with some others, Dr. Pitcairn inaugurated the delivery of lectures on Anatomy, Physiology, Medicine, Surgery, and Chemistry, though it would seem probable that those on Medicine, at any rate, prior to this date, were delivered only occasionally.

Pitcairn died in 1791, and was buried in a vault believed to be outside the walls of the Hospital Church of St. Bartholomew the Less. His portrait by Sir J. Reynolds is placed in the Censors' room of the Royal College of Physicians, of which he was four times Censor.

He was an able physician, and he advocated very strongly the administration of opium in cases of typhoid fever.

Dr. David Pitcairn was the nephew of Dr. William Pitcairn, and a son of Major Pitcairn, who was killed at the battle of Bunker's Hill.

Educated at Edinburgh and Glasgow, he then entered Corpus Christi College, Cambridge, graduating M.B. in 1779 and M.D. in 1784.

He was Censor of the College of Physicians no less than five times, and was Harveian orator.

Dr. Pitcairn was elected physician to the Hospital in 1780—prior, therefore, to his admission as Doctor of Medicine at Cambridge,—and afterwards came to London, living in Lincoln's Inn Fields for many years, and whilst enjoying a lucrative practice, he gained the confidence and the recommendation of his uncle.

His manner was described as simple, gentle, and dignified. He was unusually mindful of his patients, which often led to the establishment of life-long friendships with them. His personal gifts were stated to be unusual, and the picture painted by Hoppner, which is hung in the Censors' room at the College of Physicians, appears to bear out this statement.

Delicate for many years from tuberculous disease, he was compelled to sojourn abroad for many months. He so much improved that he returned to England after a residence of eighteen months in Portugal, and resumed the practice of his profession for some years in comparatively good health, but died of an acute laryngeal disease of three days' duration, on the 17th April, 1809.

He, like his uncle, was buried in the Church of the Hospital he had loved and served so well.

## KENTON.

*Benjamin Kenton* was born in 1719 in Fieldgate Street, Whitechapel, and was educated in the school founded by Sir John Cass, situated in the parish in which his mother kept a greengrocer's shop. He was early apprenticed to the landlady of the Angel and Crown Inn at Whitechapel, and subsequently became waiter and drawer at the Crown and Magpie. The landlady of the Crown allowed the sign of the Magpie to decay, and so altered the name of the inn to "The Green." As the result of this parsimony, the profitable custom of the sea-captains of the ships in the docks, who not only drank deeply but also provided their ships with stimulants from the inn, so lessened as to largely affect the prosperity of the establishment. The owner dying at this time, Kenton became the purchaser at a very moderate figure. He resuscitated the business by his courtesy and assiduity, and later on restored the sign of the Magpie. His business prospered, and he was enabled to increase his turnover by having learnt the secret of bottling ales for the Indian market. Kenton acquired great wealth, which he increased by judicious investments made on the advice of the alderman of his Ward, Thomas Harley, whose name is given to the Ward opposite to Kenton.

He retired from business, and lived in Gower Street till his death in 1800. He had one son, whom he established as a druggist. This son dying early he was left with an only daughter, who also died unmarried. Kenton's clerk, who was much attached to her, behaved so honorably that Kenton bequeathed to him the sum of £300,000. Kenton was made Master of the Vintners' Company in Upper Thames Street, in 1776, having been a member of the guild for thirty years.

He bequeathed £5000 to the Hospital, of which his friend and financial adviser, Thomas Harley, was the Treasurer. He was buried in Steppney Church, and a sermon is preached once a year in the church to commemorate his benefactions.

## HARLEY.

*Harley* is called after Thomas Harley. He was the third son of the third Earl of Oxford, and was born in 1730. His education was conducted at Westminster.

At the age of thirty-one he became Alderman of Portsoken Ward, and six years later, in 1767, was elected Lord Mayor of London. During this period he was created a Privy Councillor, being the second Lord Mayor on whom this honour was conferred.

A wealthy marriage enabled him to join the then important banking house of Sir Charles Raymond in George Street, Mansion House. He amassed considerable wealth during the partnership, so that he was enabled in conjunction with Mr. Drummond to obtain the Government contract for paying the English army in America with foreign gold, and shared the profits, amounting to £600,000; at the same time he was the clothing contractor to the army. Whilst he was connected with the Corporation he was the means of establishing a system of bounties for bringing fish to Billingsgate Market, which enabled him to sell fish at low rates.

He subsequently entered the arena of politics, contesting the representation of the City against Wilkes. Harley was victorious; but Wilkes was elected five days afterwards for the county of Middlesex. The mob were so incensed at Harley's victory over Wilkes that they broke the windows of the Mansion House.

He seems to have come into collision not infrequently with the people. On one occasion, when going to St. James's to present an address to the King on the birth of Princess Elizabeth, he was interrupted by the mob, and not allowed to proceed. He was, however, thanked by the Houses of Parliament for his conduct on several occasions, though once the Corporation of London refused to ratify it.

France being somewhat aggressive about the year 1797, and threatening an invasion of England, Harley's bank became deeply involved. He honorably discharged all his liabilities, and retired to his house at Berrington, near Leominster, which he had bought many years previously, and died after a lingering illness in 1804.

After the closing of the banking house he was asked to become a candidate for the lucrative office of Chamberlain of the City after Wilkes's death. Although impoverished, he would not contest the election of his friend Richard Clarke.

He was President of the Hospital and also Lord Lieutenant of Radnorshire.

Harley not only displayed great powers of administration, but was most judicious in his advice to his friends as to investments; and he gave many proofs of vigorous action in times of great emergency.

Harley and Kenton, long associated in life, are not divided in death, for the two wards which bear their names are directly opposite one another.

## DARKER.

Of *John Darker* not much seems to be known. In the year 1742 he gave £100 towards the building of the third wing, and in 1760 a further £50 towards the general funds of the Hospital.

He was Treasurer from 1760 to 1784. Mr. Darker made whilst he was Treasurer, on June 26th, 1772, the following announcement:— "That he had never used any of the Hospital money, and had made it a general rule to deposit with a banker or bankers. The failure of his bankers compelled him to repay to the Hospital the moneys he had lost; but to prevent any such future loss from falling upon him, he no longer chose to place out or deposit the Hospital money with any banker without the concurrence of the Committee. The Committee resolved that the same in future be deposited or invested with Sir Robert Ladbroke during the pleasure of the Governors of the Hospital."

He bequeathed to the Hospital £100, and all his books, pictures, and prints, which were sold for £1574 10s. 6d., for the best interests of the charity.

## SITWELL.

He was the son of William Sitwell, of Renishaw, in Derbyshire. He was the Auditor-General of Bridewell and Bethlem Hospitals, and he left the great bulk of his property to his nephew Francis Hurt, who later on by Royal licence assumed the name of Sitwell. During his lifetime in 1742 he gave a sum of £50 towards building the third wing, and in 1752 he gave a further sum towards the general funds of the Hospital.

## LUCAS.

*Matthias Prime Lucas* in 1820 was an Alderman, and subsequently Lord Mayor of London, the latter office being served in 1827.

He was a President of the Hospital, and gave a donation of £200, the interest of which was devoted to the award of a yearly prize to a sister or nurse who had faithfully discharged her duties in the wards. His portrait is in the Great Hall of the Hospital.

## LAWRENCE (1783—1867).

*William Lawrence* was born in 1783 at Cirencester, where his father was a medical man; he came to London, and was apprenticed to Abernethy. He was appointed Demonstrator at an early age, and became Assistant Surgeon in 1813, and full Surgeon in 1824. He filled the office of President of the College in 1846, and again in 1855, and he delivered the Hunterian Oration in 1824 and in 1846.

His pupils were all deeply attached to him, and though not always in consonance with the opinions of the majority, he was most deeply respected and admired. Later in life he was appointed Sergeant-Surgeon to the Queen, after having been Surgeon Extraordinary for some years. He was made a baronet a year before his death, and was succeeded by his son, Sir Trevor Lawrence, who happily for us still guides the destinies of our Hospital.

## STANLEY.

*Edward Stanley* was born in 1702, and received his education at our Hospital. As in those days all aspiring to become surgeons to

the Hospital became pupils of one of the surgeons, Stanley was apprenticed to Mr. Thomas Ramsden, and on his death was passed on to Mr. Abernethy. Mr. Stanley was elected Assistant Surgeon in 1816, and full Surgeon in 1838. He became Surgeon Extraordinary to the Queen in 1858. His exterior was rugged, but his manner was generally kind, and his list of dressers was always full, showing how much he was esteemed as a teacher. He lectured somewhat laboriously, but he was always strong in laying down points in surgical anatomy. While he was generally very sound in his lectures, his practice did not always bear out the theory of his teaching.

He died one Saturday afternoon in 1862, whilst going round the ward of Henry with his former colleague Mr. Lawrence.

#### ABERNETHY.

John Abernethy was born in 1764. His father belonged to London, and was partly of Scotch and partly of Irish extraction.

He went to school at Wolverhampton, but came to the Hospital at the age of fifteen, when he was apprenticed to Mr. Charles Blicke. He was for twenty-eight years Assistant Surgeon, becoming full Surgeon in 1815. He lectured on Anatomy, Physiology, and Surgery, and died in 1831.

His great success in life was due to his strong individuality and his clear description of disease. Few men have secured to themselves greater admiration and love of their pupils than did Abernethy. His power of attracting his students to himself amounted almost to a fascination, and they with much truth are prone to regard Abernethy as the greatest teacher ever attached to our Hospital.

Our Society, as you know, has perpetuated his memory by being named after him.

Lawrence and Abernethy were not infrequent antagonists, both being of indomitable pertinacity; but Lawrence, always reactive under control, was gracious enough to allow that in all his quarrels Abernethy was in principle in the right. Innumerable anecdotes are told of him, some true, many false; while his memory has suffered at the hands of some, who, failing to imitate him, have maligned him by vapid caricature.

#### PAGET.

James Paget.—The full history of the man from whom this Ward takes its name is happily for us incomplete. Full of years and honours Sir James Paget is still with us. Of his work it is not necessary for me to speak; few, however, if any, have received a larger recognition of public esteem and confidence. Sir James Paget's work must always take the highest rank, and his contributions to the literature of our profession are models of masterly thought and extensive knowledge.

### On Intra-uterine Douching of the Puerperal Uterus.

By G. D. ROBINSON, M.D., B.S.Lond., M.R.C.P.,

Assistant Obstetric Physician to the West London Hospital; Physician to Out-Patients at the British Lying-in Hospital.

**I**N the number of the JOURNAL for June of this year there is published a paper, originally read before the Abernethian Society by my friend Dr. James Morrison, on "The Treatment of the Puerperal Uterus."

In it is advocated a line of treatment so at variance with the teaching of our School from the days of Dr. Matthews Duncan up to the present time, and to the practice of obstetricians of to-day, that I am surprised that only one of the many readers of the JOURNAL has in any way alluded to it, since its publication six months ago.

Such a silence may suggest to some that Dr. Morrison's views are accepted by the majority of the readers of his paper. This, unless I am greatly mistaken, is far from

being the case, and it seems to me that a discussion of some of the points raised may be of use, since the matter is one of great practical importance.

Dr. Morrison suggests that—

(i) "In every case of a puerperal woman, on the third or fourth day after delivery an intra-uterine douche should be given, and the uterus thoroughly washed out." [The italics here, as elsewhere in the quoted remarks, are mine.]

(ii) "Should any signs at the time indicate that the uterus contains any large amount of clot, the cavity of that organ should at once be explored preliminarily to the antiseptic douche."

(iii) "Should the temperature rise after the intra-uterine douche with symptoms of sapremia, the uterus should be explored at once, with or without chloroform being administered."

In the following remarks I shall strictly limit myself to the chief subject of Dr. Morrison's paper, namely, the routine practice of intra-uterine douching in apparently healthy lying-in women. The treatment of the uterus after symptoms of sapremia have developed is not here considered.

The reasons for Dr. Morrison's recommendations seem to be based entirely on theoretical considerations. He says that what he advises "is the proper antiseptic treatment of the placental site and genital tract, and is based on those principles of antiseptics which guide surgeons in their treatment of wounds in other parts of the body." But can the inner surface of the puerperal uterus be compared in all surgical respects to "wounds in other parts of the body"? It is true that there "we have solution of continuity of a surface," but does it follow, as Dr. Morrison asserts, that therefore "the process becomes pathological"?

This view, held by some in former times, was vigorously opposed by Dr. Matthews Duncan.

In his *Researches in Obstetrics*, p. 189, in the chapter on "The internal surface of the uterus after delivery," he remarks, "It appears wonderful that so many physiological paradoxes should have been so easily adopted by the profession, and that so much of what is essentially morbid should have been invoked to aid in the performance of a natural function in a healthy body."

Again, p. 215, "The chief analogy of the internal uterine surface after delivery is not with a stump so far as it consists of incised and denuded tissues, but only in both surfaces presenting numerous open veins, liable to become inflamed or to absorb the obnoxious materials which may be brought into contact with them."

And he quotes with approval (p. 200) the remarks of Priestley: "When the membranes are thrown off in the third stage of labour a portion of decidua remains attached to the uterine surface as a protection against external agencies."

That the decidua that remains after labour does constitute "a protection against external agencies," by acting as a filter to keep out germs from the deeper tissues, has

been shown by Vidal (best known in connection with the serum diagnosis of enteric fever) in his work *Étude sur l'infection puerpérale, la phlegmatia alba dolens, et l'érysipèle*.

Can this be said of "wounds in other parts of the body"?

Again, Döderlein (*Arch. f. Gyn.*, Bd. xxxi, 1887, p. 412) has demonstrated that the cavity of the puerperal uterus is normally free from micro-organisms of any sort. Can this be said of surgical "wounds in other parts of the body"?

If the shedding of the placenta and the superficial layers of the decidua is indeed "pathological," then we must revise our definition of that term.

It is true that "the vagina and external genitals contain the various germs of decomposition, and even of specific infection;" also that there are blood-clots in the puerperal uterine sinuses and cavity, and that there is a constant stream of lochial discharge flowing from the uterus and vagina.

But in what percentage of cases does "the process of putrefaction spread gradually up into the uterus by means of this unbroken stream of favorable medium, to cause almost certain trouble afterwards"?

"In private," says Dr. Morrison, "where vaginal douching is not carried out, I believe that practically every woman is at about the end of the first week after delivery slightly sapremic or septic."

Dr. Morrison is careful to admit that "nature" started with excellent intentions, and "may probably have intended parturition to be a physiological process;" but she unfortunately allowed "pathological" "solution of continuity of surface," and clots in the uterus, together with a constant lochial discharge into a germ-inhabited vagina, with the result that the germs "will get up sooner or later into the uterus," "to cause almost certain trouble afterwards."

If the risk run is indeed as constant and great as Dr. Morrison maintains, then much may be said in favour of the routine intra-uterine douche in guarding the unhappy woman against the evils to which "nature" has so thoughtlessly though "probably" unintentionally exposed her.

There is a constant stream of blood from the (possibly denuded) endometrium to the germ-containing cervix and vagina during menstruation, but I am not aware that any man or woman of sufficient enterprise has yet arisen (even in America) to recommend and practise routine intra-uterine douching on women during the performance of that function, "to destroy the line of communication which otherwise exists between the vulva" and uterine cavity, and to prevent the germs from swimming up-stream like salmon.

I believe there are still a few of us who have a little confidence in "nature."

Dr. Morrison believes that germs "will get up easily enough in time into the uterus," so that in cases left to nature "every woman" suffers more or less from "sapremia or sepsis," but he does not place the facts on which this conviction is based at our disposal.

Döderlein's experiments, and the practical experience of

most obstetricians, are both against this view; and the presence of microbes in the uterine cavity is usually looked upon, and I think rightly so, as an occasional abnormal condition, and not, as Dr. Morrison states, one that occurs in every puerperal woman who is not douched.

But apart from theoretical opinions, does practical experience teach us that routine intra-uterine puerperal injections are desirable? "There is nothing new under the sun." Twenty years ago prophylactic post-partum intra-uterine douching was very largely employed, especially in Germany. J. Veit (who together with Ruge is so well known for his admirable work on *Cancer of the Cervix Uteri*, published a paper in 1879 (*Berlin. klin. Wochenschr.*, 1879, No. 23) in which he advocated the prophylactic intra-uterine irrigation then so commonly employed.

In a recent letter to me (which accompanied a copy of the paper just mentioned) he appears somewhat surprised at my interest in the subject, since he considers that the perfecting of our methods of the management of normal labour has long since rendered such treatment quite unnecessary. This view has gradually gained ground, and with the vast majority of obstetricians of to-day I venture to say that prophylactic intra-uterine douching has now become a thing of the past. The universal experience of obstetricians, therefore, seems to me to show that such meddling with the uterus is quite uncalled for.

But are there no positive objections to routine intra-uterine douching? I think there are.

Dr. Morrison thinks that the danger of introducing germs into the uterus with the douche is only a theoretical one. If the douche apparatus is clean to start with, any germs introduced on the catheter by contact with the vagina are immediately washed out again—drowned or poisoned. I confess that I have more respect for germs than Dr. Morrison appears to have. Those who have done some practical bacteriology are aware that germs are not always so easily destroyed by chemicals as we should wish them to be. But let me quote Dr. Morrison's own exceedingly instructive remarks on this very point.

"Another point seems to be brought out by the cases I have treated, and that is, if there is any mass of clot and debris left in the uterus after an intra-uterine douche the mass immediately begins to decompose, so that in a day or two you have pyrexia and well-marked symptoms of sapremia."

How does he account for the clot first beginning to decompose immediately after the douche, if the catheter does not introduce germs? "Do not say the douche only made the woman septic, and therefore should not have been given; rather rejoice that by this means you discovered the mass, and were able to remove it whilst the woman was still under observation," is, I think, a clear admission that the catheter does introduce germs into the uterus after all, and apparently pretty constantly too. If the germs introduced in this way are only those of putrefaction, the patient may escape with

a sapremic attack; but suppose that they are virulent septic organisms (streptococci), such as Dr. Morrison says are sometimes found in the vagina, then the result of the douching may indeed be disastrous. Certainly until Dr. Morrison can convince us that if the aseptic clot in the uterus is left undisturbed it will "cause almost certain trouble afterwards," such as "white leg or pelvic inflammation," we feel strongly inclined to use his own words, "The douche only made the woman septic, and therefore should not have been given."

But there are other dangers associated with this treatment "mentioned in books as having occurred," but which Dr. Morrison tells us are excessively rare. The following cases I have found recorded.

Bailly (*Arch. de Toccol.*), 1887, vol. iv, p. 663:—Two cases of acute peritonitis following intra-uterine injection.

Gördes (*Central. f. Gyn.*), 1892, p. 473:—Severe abdominal pain, collapse, and general tetanic spasm of muscles after intra-uterine injection of iodine solution.

Haynes (*American Journ. Obst.*), 1889, p. 113:—No. 1. Case of severe abdominal pain, lasting twenty-four hours, after an intra-uterine carbolic acid douche.

No. 2. Case of perimetritis with "parchment induration" after an intra-uterine douche. The pain came on immediately after the douche, and fever two hours later. Illness lasted a month.

No. 3. A case of severe abdominal pain and collapse immediately after an intra-uterine douche.

No. 4. Case of perimetritis following immediately after an intra-uterine douche.

No. 5. *Death* in seven hours following severe abdominal pain and collapse during intra-uterine douching.

Haynes also states that tinnitus aurium is experienced in 20 per cent. of cases, and syncope in 5 per cent. He records—

No. 1. A case of tinnitus aurium and convulsions with syncope during intra-uterine douching.

No. 2. A case of severe syncope during intra-uterine douching.

No. 3. A case of three rigors, each rigor following an intra-uterine douche.

No. 4. A case of five rigors, each rigor following an intra-uterine douche.

No. 5. A case of rigors (no number given), each rigor following an intra-uterine douche.

No. 6. A rise of temperature without rigor following an intra-uterine douche.

J. Veit, in the paper above mentioned (*Berlin. Klin. Wochenschr.*, 1879, No. 23), quotes seven cases of accidents during or immediately after intra-uterine douching recorded by Richter, Künstler, Fritsch, and Hergeden, and adds ten others from his own experience, making seventeen in all. The accidents included unconsciousness, hystero-epileptic convulsions, cyanosis, slowing of pulse, stopping of respira-

tion, and later stertorous breathing. These symptoms lasted from half an hour to a day. Rigors and discharges of blood from the uterus were common. The injection material was acid. carbol. 1 per cent., or salicylic acid.

Garruges (*American System of Obstetrics*) mentions a fatal case of perforation of the uterus and injection of fluid into the peritoneal cavity which occurred at his lying-in hospital during the administration of an intra-uterine douche, and a similar fatal and unpublished case in this country has come to my knowledge.

It is difficult to estimate the exact frequency of accidents during or following intra-uterine douching, since accurate statistics are wanting. It is probable that many accidents occur that are never recorded—the fatal case just mentioned as having come to my own knowledge is one in point. If such be the case they are more common than Dr. Morrison imagines. The only source I know of from which reliable conclusions can be drawn is the paper of Veit's above quoted. Veit had ten accidents in 400 consecutive cases of intra-uterine douching—that is one accident in every forty cases; Dr. Morrison's opinion that "intra-uterine douching is not at all dangerous" is based on thirty-eight consecutive cases.

Space forbids that any other points raised in this paper should be touched on; such, for instance, as the hitherto unrecognised pathology and treatment of certain cases of mammary abscess, propounded by the author in the words, "A localised and tender spot in one breast is also very often a diagnostic sign of decomposition occurring in the uterus, and if the uterus is not washed out may lead to mammary abscess."

I have limited myself to the discussion of the practice of routine intra-uterine douching on the third or fourth day of the puerperium in patients who have shown no sign of fever, and I do not in any way refer to the treatment of the uterus in patients who exhibit symptoms of sapremia.

If Dr. Morrison can produce facts to prove that an aseptic blood-clot contained in the aseptic puerperal uterine cavity necessarily sooner or later becomes infected from the cervix and vagina, and that germs "will get up easily enough in time into the uterus" "to cause almost certain trouble ["white leg, pelvic inflammation, &c.]" afterwards," it will then be time for us to reconsider our treatment of the puerperal uterus. If, as I believe, routine intra-uterine post-partum douching is both unnecessary and also fraught with danger, then the unchallenged statements of Dr. Morrison cannot, I fear, fail to do harm. It is for this reason that I have raised the subject, hoping that we may learn the experience of readers of the JOURNAL, so many of whom are qualified by large midwifery practices to speak with authority. For, after all, the value of any line of treatment can only be judged by the accumulated experiences of practical men, and this I am sure, from my knowledge of him, Dr. Morrison will be the first to admit.

### Formalin Methods for the Preservation of Museum Specimens.



WE have received so many requests for more details of the formalin methods alluded to in the Notes last month, that Prof. Kanthack has kindly provided us with the following description, which we hope will prove of value to those interested in the preservation of museum specimens.

#### METHOD I.—JORES'S METHOD (slightly modified).

A. If the original cut surface is to be preserved,

- (1) The specimen is first rinsed in cold tap water and cleansed on its surface, and then placed in the following solution:
 

Formalin . . . . .	20 parts.
Tap water . . . . .	100 "
Sodium chloride . . . . .	1 "
Sodium sulphate . . . . .	2 "
Magnesium sulphate . . . . .	2 "

(2) The specimen remains in this solution for forty-eight hours, and is then transferred to pure strong spirit for ten minutes, and then

(3) Transferred to fresh spirit. Here the specimen must be carefully watched. Soon the colour, which had disappeared to a great extent in the formalin solution, slowly and gradually comes back, but after about half an hour to an hour it begins to fade.

(4) Immediately it begins to fade the specimen must be placed in a mixture of glycerine, water, and potassium acetate.

Water . . . . .	1000 c.c.	If this solution is turbid
Potassium acetate . . . . .	30–50 grms.	or milky, it must be
Glycerine . . . . .	1000 c.c.	filtered before use.

In this glycerine mixture the colour becomes intensified, and regains much of its natural appearance.

(5) Finally, it must be mounted in the same glycerine mixture.

B. (1) If it is not necessary to preserve the original cut surface or the natural surface of the specimen, as the case may be, then the specimen, after having been carefully suspended in the formalin solution for about forty-eight to seventy-two hours, according to its thickness and consistence, should be placed in spirit for one to five hours. It is impossible to state the exact time for all cases, for this depends greatly on the firmness, size, and nature of the organ.

(2) At the end of this time a fresh surface is obtained by removing a thin slice with a long and sharp knife. The specimen with its renewed surface is then put back into the formalin solution for another twelve to twenty-four hours, and then passed through the two changes of spirit as described above, and treated with the glycerine solution in the same manner.

Jores's method gives extremely good results with kidneys (especially large white), brains, and malignant disease of the liver.

#### METHOD II.—KAISERLING'S NEW METHOD.

This method, which, according to Kaiserling, gives better results even than the two previous methods, is a compromise between Jores's and Kaiserling's original method.

- (1) The specimen is fixed in the following solution:
 

Formalin . . . . .	200 c.c.
Water . . . . .	1000 c.c.
Potassium nitrate . . . . .	15 grms.
Potassium acetate . . . . .	30 grms.

In this solution it remains at least twenty-four hours, and longer if the specimen be large, hard, and tough, but, as before mentioned, never more than five times twenty-four hours.\*

\* If the specimen is voluminous and still uncut, it is often advisable to inject it with formalin solution, both through the main arteries and main veins, which of course must then be tied. The formalin solution to be used for injection must be made up as follows:

Formalin . . . . .	400 c.c.
Water . . . . .	1000 c.c.
Potassium nitrate . . . . .	30 grms.
Potassium acetate . . . . .	50 grms.

- (2) The specimen is then placed in 80 per cent. spirit until the colour returns—i. e. for two to sixteen hours; and
- (3) Finally it is placed in the following glycerine solution, in which it is also mounted:
 

Water . . . . .	2000 c.c.
Potassium acetate . . . . .	200 grms.
Glycerine . . . . .	400 grms.

This method may prove to be the best of the three, and therefore it may be useful to copy a few directions from Kaiserling's last paper for future guidance. These may be given in tabular form.

TABLE PREPARED FROM KAISERLING'S PAPER IN *Virchow's Archiv*, vol. cxlvii, No. 3.

	Formalin Solution.	80 per cent. Spirit.	Remarks.
Heart . . . . .	(1) Small heart, 24 hrs. (2) Large heart, 3 days	4 hrs.	Easily fixed.
Aorta and vessels . . . . .	(1) Not hæmorrhagic, 12 hrs. (2) Hæmorrhagic, 24 hrs.	2–3 hrs.	
Lungs . . . . .	(1) Uncut; inject bronchi, arteries, & veins, 4 days (2) Cut; 2–4 days, according to density	5–6 hrs.	Very difficult. Gives beautiful results.
Larynx . . . . .	3 days	6 hrs.	
Spleen . . . . .	(1) Cut: 24 hrs.–3 days (2) Uncut; inject every 6 hrs., and keep in solution 4–5 days	4–12 hrs. 4–12 hrs.	Easily fixed.
Kidneys . . . . .	(1) Uncut; inject and fix for 4–5 days (2) Cut: 3 days	6–10 hrs. 8–12 hrs.	Easily fixed. If cysts are present, fix the kidney <i>in toto</i> , pass through spirit, and place in glycerine for 24 hrs. Then fill cysts with glycerine solution by injecting either into the ureter or through the renal parenchyma. Easily fixed.
Liver . . . . .	(1) Uncut; inject repeatedly through the hepatic artery, portal vein, and bile ducts (2) Cut: 3–5 days according to size	8–12 hrs.	So far all attempts to fix yellow bile colour have been unsuccessful.
Gut . . . . .	(1) Uncut; fill with formalin (2) Cut open: 24 hrs. if not hæmorrhagic 48 hrs. if hæmorrhagic	2–4 hrs. 8 hrs.	
Brain . . . . .	Cut: 3–5 days Uncut: 8 days	6–12 hrs. 8 hrs.	Difficult.
Muscle . . . . .	3 days	5 hrs.	
Bone . . . . .	Always unsawn; 4–5 days	12 hrs.	Saw only after it has been in glycerine for 14 days, then place again in alcohol, and mount.

A few more points require mention:

- (1) A renewal of the surface by a fresh section must never be made, according to Kaiserling's latest instructions, until the specimen has been in glycerine for at least fourteen days, and it must then again be placed in alcohol for two to three hours, to freshen up the colour.



- (2) The formalin solution can be used repeatedly, and therefore one must not be sparing with it. After it has been used twice for big specimens, add about one fifth of the chemical ingredients, and then it may be used again twice.
- (3) Old solution may always be used for the initial fixation, so that a specimen which requires twelve hours' hardening may be placed in an old solution for six hours and into a fresh solution for further six hours.
- (4) If the glycerine solution is turbid, it must be filtered through cotton wool.
- (5) If pigments pass into the glycerine solution, the specimen must be taken out, and the solution filtered through thick layers of cotton wool and charcoal. The pigments have generally come from the substance, and not from the surface of the specimen.
- (6) It appears that Formaldehydum Solutum is better than the less pure formalin.
- (7) To save the hands, india-rubber gloves should be worn.

With these directions, care, and common sense, extremely beautiful results can be obtained.

LITERATURE.—Jores, *Centralblatt für allg. Pathol. u. pathol. Anat.*, 1896, No. 4; Kaiserling, *Berliner klin. Wochenschr.*, 1896, August 31st; Kanthack and Shaw, *Transactions of the Pathological Society, London*, vol. xlviii; Kaiserling, *Virchow's Archiv*, vol. cxlvii, Heft 3.

### Notes.

DR. GRIFFITH has been elected President of the Medical Defence Union.

We desire to call special attention to the Mid-Sessional Address of the Abernethian Society, which is to be delivered by Dr. Lovell Drage on January 13th, 1898, the subject being "The Coroner's Court." Dr. Drage, being himself a coroner, can speak with authority on this topic. While at St. Bartholomew's he was House Surgeon to Sir Thomas Smith, and Midwifery Assistant to Dr. Matthews Duncan.

THE Smoking Concert of the Cambridge Medical Graduates Club was held as usual at the Banqueting Hall, St. James's Restaurant, on Wednesday, November 17th. There was a large attendance, over 300 members and guests being present. The Oxford Medical Graduates Club were invited as the guests of the sister club. Among the more specially appreciated items were Dr. Shadwell's songs, Dr. Blumfeld's recitation of the "Notes of a Case," and Mr. Llewelyn Powell's song, "Would I were a surgeon!" The words of the last song, by the way, appeared originally in the *St. George's Hospital Gazette*, and three of the stanzas were quoted in the JOURNAL. The evening was the occasion of many pleasant reunions, and its undoubted success was largely owing to the efforts of the Secretaries, Dr. Kollleston and Dr. Morley Fletcher.

THE following evening the Oxford Medical Graduates Club dined at Limmer's Hotel. Mr. Tomes, F.R.S., was in the Chair, and about forty members and guests were present. The speech-making was commendably brief, nor did this appear to damp the pleasure of the club. Afterwards many of the members adjourned to the conversazione of the

Society of Anaesthetists, which was held the same night in the rooms of the Royal Medical and Chirurgical Society.

THE tale of dinners is still incomplete, for a number of old Bart's men have decided to show their appreciation of Dr. W. J. Collins, Chairman of the County Council, in a practical shape at the Trocadero Restaurant on Thursday, December 16th. Mr. Howard Marsh will preside. A goodly and representative number have expressed their intention of being present. And, by the way, when is Dr. Collins going to delight us again at the Abernethian Society? We hope amid the stress of his many engagements he will not altogether desert the Society of which he is an ex-President.

CONTRIBUTORS are reminded that the date of publication of the JOURNAL is the 15th of each month. Punctuality in issue is impossible if reports of club meetings and other events are not forwarded to the editor at the proper date. As to what that date is, reference need only be made to the first page of this number.

WE are requested to call the attention of our readers again to the claims of the widow and children of the late Mr. F. W. Ellison on Bart's men. Considering the generous way in which the *Lancet* has responded to the appeal, it is not fitting for members of this Hospital to be behindhand. Particulars will be found in our September issue; subscriptions may be forwarded either to Mr. Howard Marsh or Mr. Hatfield, York House, Park Road, Forest Hill, S.E.

WE regret to announce the resignation of Mr. James Berry from the post of Surgical Registrar at the end of this month. All who have come into contact with him will bear witness as to his great kindness and consideration in the performance of his duties; we are sure that no house surgeon or student has ever sought his aid in vain, despite the heavy routine work which falls upon the Surgical Registrar.

MR. H. J. WARING has been appointed Surgical Registrar, and Drs. Calvert and Garrod have been re-elected Medical Registrars and Demonstrators of Morbid Anatomy.

THE *Guy's Hospital Gazette* still maintains its high position among our contemporaries. The last issue contains a lecture by Dr. Pye-Smith on "Life Assurance," a subject in which he is well versed. Considering how many medical men have to act as referees in this matter without special training, an utterance from one of such experience is of great value. There are also notes of a very interesting case of transverse presentation, for which Caesarean section had to be performed after embryotomy had failed. But we could not find any pelvimetric record; surely this is an extraordinary omission?

WE congratulate Mr. J. W. W. Stephens on his appointment as John Lucas Walker Student at Cambridge. The Studentship is of the annual value of £200. Mr. Stephens was the Treasurer's Research Student at this Hospital from 1895 to 1897, and President of the Abernethian Society. He subsequently became Assistant to the Imperial Bacteriologist of India, and has only recently returned from that appointment.

MR. H. K. ANDERSON, Demonstrator in Physiology at the University of Cambridge, has been elected to a Drosier Fellowship at Caius College.

IN OUR *Appointments* column will be found a list of the six Bart's men who have been appointed temporary officers by the Indian Government to assist in coping with the outbreak of plague. We wish them all success in their endeavours. While speaking of Bart's men who are going abroad, we may mention that Mr. P. O. Andrew is leaving us to take a practice in Wellington, New Zealand.

MR. ALFRED S. COOKE, an old Bart's man who qualified in 1863, has been elected President of the Gloucestershire Branch of the British Medical Association for the ensuing year. His presidential address, delivered at Gloucester on November 16th, embodied his experience of over 2000 cases of midwifery. Out of the thirty or forty who sat down to supper at the close of the meeting there were no less than fifteen Bart's men.

At the moment of going to press we learn that Mr. E. J. Toye has maintained the Hospital tradition by obtaining the Scholarship and Gold Medal in Obstetric Medicine at the London M.B.

THE *Lancet* for December 4th publishes Dr. Norman Moore's highly interesting inaugural lecture for the session on the Pulse. It is hard to realise that the frequency of the pulse was not noted earlier than the beginning of last century.

WE hear that the Chancellor of the University of London has invited all the Institutions named in the Report of the Cowper Commission to send delegates to confer with representatives of the Senate of the University in regard to the proposed legislation for the reform of the University. It will be remembered that a "London University Commission" Bill was introduced into Parliament last session, and after passing the House of Lords was withdrawn by the Government owing to pressure of business.

Meanwhile a scheme for the establishment of a second University in London, under the name of the "University of Westminster" has been started, and appears to have obtained some adherents amongst the teachers in the London Medical Schools. We think it is to be regretted

that this alternative scheme has been mooted until it is finally shown that legislation on the lines of last year's Bill is impossible.

WE understand that the contract for the building of the new school of Christ's Hospital at Horsham has been definitely accepted, and that Messrs. Longley & Crawley will be the builders, the cost being £294,243. It is estimated that three and a half years will be required to build the new school.

IN the competition for the Naval Medical Service recently held, Mr. W. J. Codrington, M.B., Mr. A. Woolcombe, and Mr. W. H. Pope were successful in obtaining commissions.

### Amalgamated Clubs.

#### RUGBY UNION FOOTBALL CLUB.

##### ST. BART'S v. WICKHAM PARK.

Played on October 30th at Wembley Park. Losing the toss, Bennett kicked off, and for some time Bart's pressed hard. The ball was very slippery, and the outsiders found it difficult to hold. In consequence of this the game was chiefly confined to the forwards, where the sides were very evenly matched. Wickham at last got away and scored a try after the only good bit of passing in the match. Directly afterwards one of their outsiders made a splendid run from half-way, and grounded the ball between the posts, a goal resulting.

In the second half our forwards played up hard, breaking away from the "scrumms," and dribbling well, but though very near it on several occasions, we never actually scored. Body fielded and kicked very well. The three-quarters should give him more support in tackling.

Teams.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, J. M. Pleas (three-quarters); H. Walker, A. W. Nuthall (halves); W. F. Bennett, J. K. S. Fleming, A. J. W. Wells, C. H. D. Robbs, H. C. Adams, A. M. Amster, A. O'Neill, J. A. West (forwards).

##### ST. BART'S 2ND XV v. ST. MARY'S HOSPITAL 2ND XV.

October 23rd.—Played at Winchmore Hill, resulting in a win for the Hospital by 6 goals 0 tries to nil—57 points to nil.

From the kick-off Bart's asserted their superiority. At an early stage Marrack passed neatly to Sale, who scored a try, which he subsequently converted into a goal. The game now became very much in favour of the Hospital, whose three-quarters, playing well together, scored whenever the halves fed them.

The halves, Spaight and Marrack, played a good game, and the three-quarters left nothing to be desired. Of the forwards the following were conspicuous for good play—N. Maclaren, E. H. Stanges Leathes, A. J. West, and H. M. Huggins.

##### ST. BART'S 2ND XV v. UNIVERSITY COLLEGE SCHOOL.

October 27th.—Played at Winchmore Hill, and resulted in a win for the Hospital by 4 tries to 1 goal 1 try—12 points to 8 points.

The game was of a very scrambling nature, as the Hospital forwards were too heavy for the visitors, and they refused to heel the ball out to the halves.

##### ST. BART'S 2ND XV v. UPPER CLAPTON.

October 30th.—Played at Winchmore Hill, and resulted in a win for the Hospital by 1 goal (dropped) 1 try to nil (7 points to nil).

The teams were evenly matched, and a good game resulted. The dropped goal was scored by W. S. Danks, and the try by F. H. Spaight. At back H. W. Pank played well.

#### ASSOCIATION FOOTBALL CLUB.

##### ST. BART'S v. HAMPSTEAD.

This match was played on the Hospital ground at Winchmore Hill on Saturday, November 6th. Owing to the very late appearance of

the Hampstead team the game could not be commenced until nearly four o'clock, when Bart's kicked off, Hampstead being still all short. For the first quarter of an hour the Hospital had matters all their own way, and Hughes soon opened the score with a good shot. Continuing to press, the Bart's forwards had numerous chances of scoring, but their shooting was decidedly weak; only one more goal was scored before half-time, Walker putting the ball through after a good run by Marrett. The second half was of a much more even character, but owing to the late start the light was very bad, and the game suffered in consequence. Talbot and Marrett made several brilliant runs down the wings for the Hospital, but their centres were not taken advantage of; on the other hand, the Hampstead forwards gave the home backs plenty to do, and on two or three occasions looked like scoring. They failed to do so, however, and Bart's were left the victors by two goals to nil. The game was a great deal spoilt by the late start, as the Bart's team were waiting nearly an hour and a half, and consequently played rather a slack game; while the Hampstead team never got together at all until the second half—their last man appearing at 4.15. For the winners Marrett and Talbot were the best of the forwards, while Schollefeld played a sound game at half-back. For Hampstead the outside right caught a good deal of trouble, and the backs kicked well.

**Team.**—H. H. Butcher (goal); L. Orton, L. E. Whitaker (backs); R. Schollefeld, C. G. Watson, R. Aldersmith (half-backs); T. H. Talbot, R. Walker, G. W. Stone, L. E. Hughes, H. N. Marrett (forwards).

#### ST. BART'S v. HASTINGS.

Played on November 10th at Hastings. A good and fast game, in the first half of which there was no scoring, though Bart's did most of the pressing. Middleditch, just on half-time, made a good shot for Hastings, which Butcher saved in magnificent style.

In the second half the Hastings attack was mastered, and Whitaker and Hughes both scored for Bart's, leaving us victorious by 2 goals to nil.

Hastings had their full team, which included a good defence in Brown and Bond at back, and Middleditch at half-back.

Bart's had the services of Pickering at centre half, and Whitaker went centre forward, Watson taking his place at back. Willett, Talbot, and Whitaker did some very pretty work forward. At half Pickering was first-rate, and Schollefeld, whose play improves every match, tackled exceedingly well. Watson put in some heavy work at back. The Hospital have now won three successive matches, and are beginning to get together and into form. **Teams.**

**St. Bart's.**—H. H. Butcher (goal); C. G. Watson and L. Orton (backs); R. Schollefeld, H. J. Pickering, and A. H. Bostock (half-backs); T. Talbot, J. A. Willett, L. E. Whitaker, L. Hughes, H. N. Marrett (forwards).

**Hastings.**—C. Slaughter (goal); R. Brown, G. H. Bond (backs); Newman Hall, B. Middleditch, J. Osborne (half-backs); W. L. Donaldson, Herbert Hemmings, T. Kennard, S. Hadden, and A. J. Kent (forwards).

After the match the team were entertained at high tea and smoking concert by Dr. Gabb and the old Bart's men in Hastings, to all of whom the best thanks of the Hospital Football Club are due.

J. Valerie, who came down and acted as linesman, contributed a song to the programme.

Mr. Coventon proposed the health of St. Bartholomew's Hospital Football Team. After commenting on the game he said that they all knew St. Bart's Hospital; it was *the* Hospital. There was only one hospital team, and that was the football team of *the* Hospital. It was only natural that such a team should be victorious, and there was no disgrace in the Hastings team being beaten by it. He gave them the toast of "the football team of the Hospital."

To which the captain, Mr. L. E. Whitaker, replied. He thanked them very much for the very kind way in which they had received the toast. It gave the team very great pleasure to visit Hastings year after year. They all knew how hard hospital men worked in London, and what a great deal of good even a breath of sea air did them. They looked forward to the visit to Hastings for two reasons. First, because they would receive a perfectly fair game, they were content to win, and if they could not do that, then they would be content to lose; secondly, they had the pleasure of being entertained by their chairman and their hosts to a high tea and an excellent smoking concert.

Saturday, November 13th. Berkenham match was scratched owing to their engagement in a cup tie.

Wednesday, November 17th. Cinque Ports, Dover, scratched, as they were unable to raise a team.

#### RESERVE MATCHES.

Sat., Nov. 6.—	Ealing II.	Ealing	For.	Agust.
Wed., "	10.—Felstead School	Felstead	1	2
Sat., "	13.—St. Mary's Hosp.	Winchmore Hill	2	8
Wed., "	17.—Emanuel School	New Wandsworth	0	0
Sat., "	20.—Crouch End II	Winchmore Hill	1	4
Wed., "	24.—City of Lond. Sch.	Deckenham Hill	3	3
Sat., "	27.—Norsemey	Winchmore Hill	1	1

The matches v. St. Mark's College, Chelsea, and Tonbridge F.C. were unfortunately scratched.

#### Abernethian Society.



ON November 11th, 1897, Mr. Langdon Brown in the chair, Mr. Hooper presented to the Society a certificate signed by Abernethy and Stanley in the year 1827. This we hope shortly to have framed and hung in the Society's room.

Mr. Stawell then read his paper on "Perforating Gastric Ulcer." He drew up his conclusions from a large quantity of statistics, which must have entailed an enormous quantity of work. One could not do the paper justice by any extracts of it here; we hope to publish it *in extenso* before long.

On Thursday, November 18th, 1897, the Society held a clinical evening, as, owing to unavoidable circumstances, Dr. Morrison's paper had to be postponed until December 2nd. Mr. Hussey was in the chair.

Mr. Hussey demonstrated the method of illuminating a stomach by means of an electric glow-lamp passed down the oesophagus in a woman of middle age with a dilated stomach, which had previously been carefully washed out. When the electric current was turned on, the position of the stomach and its upper and lower limits could easily be seen; also if there had been a growth in the anterior wall, it appeared that it would have been fairly easy to see a shaded portion corresponding to the growth. The patient was an extremely good subject for the demonstration, which was a complete success.

Mr. Hooper then showed a case for Mr. Langdon Brown—a woman who had been sent to the Dermatological Society's meeting the previous week for diagnosis. The question was as to whether it was a genuine case of pemphigus or whether the lesions were self-inflicted; from the subsequent history the latter was undoubtedly the case.

Mr. Hooper then showed a case of Dr. Gee's. The patient was a baby six months old, with oedematous patches which appeared in various regions. The original diagnosis was scleroderma, but recently two abscesses had formed. The question of pyæmia following vaccination was raised, but there was a great difference of opinion.

Mr. Drury showed a case of splenic leukemia with an excellent microscopic specimen of the blood. The spleen filled up the greater part of the abdomen.

Mr. Gilbert Smith showed a case for diagnosis. The patient was a man with a syphilitic history, and an undoubted old hemiplegia. He had now developed spastic symptoms, well marked on the right side. A hot discussion followed, but no diagnosis was arrived at.

Mr. Lance then read a short but extremely interesting commentary upon the case of hydrophobia lately in the Hospital.

Mr. Pigg exhibited some specimens of a series of melanotic sarcomata in unusual situations, prepared by the new formalin method, and some specimens of what he believed to be alveolar sarcoma. He then showed a chain of femoral and inguinal glands from a patient suffering from the bubonic plague which had just been sent over from near Bombay, and obtained by an old Bart's man at considerable personal risk. The formalin specimens were most admirable, and the new method has certainly created quite a revolution in the preparation of museum specimens.

On November 25th, 1897, Mr. Langdon Brown, President, in the chair. The President showed an interesting case of multiple subcutaneous nodules, probably of syphilitic origin.

Mr. Drury then read a paper on "Shortness of Breath." The paper dealt most thoroughly with all the various forms of dyspnoea and their causes, and entered into a lengthy argument of Cheyne-Stokes breathing, and the various theories projected as to its causation.

On Thursday, December 9th, Dr. Morrison read a paper entitled

"Albuminuria in Pregnancy." Mr. Langdon Brown took the chair. Dr. Morrison's papers are always interesting and original, and this proved no exception. The paper went most fully into the relation of the diminution of the total excretion of urea to the onset of eclampsia. He considered that if the amount of uric acid passed is 50 oz. or more, and that there is 15 per cent. or more of urea, there is no immediate danger of a fit.

#### Dinner to Sir Thomas Smith.



OUR readers will be interested to hear that on November 24th, at Limmer's Hotel, Sir Thomas Smith was entertained at dinner by thirty-eight of his past and present house surgeons. A gold watch and a handsome piece of antique silver plate were also presented to him as a token of the affection and esteem in which he is held.

Mr. Harrison Cripps, his first house surgeon, took the chair, and proposed the health of the guest in a graceful and witty speech; to which Sir Thomas, who was in excellent form, replied in a characteristic and amusing manner.

Sir Thomas, during the twenty-six years in which he has been surgeon to the Hospital, has had forty-eight house surgeons. Of these, three have since died, and three (A. P. Trinder, E. Humphry, and H. J. Walton) are at present abroad; of the remainder, four (E. S. Greensill, E. J. Burgess, D. A. Coles, and R. F. Jowers) were for one reason or another unavoidably prevented from being present at the dinner.

The thirty-eight who were present were, in order of seniority, Harrison Cripps (London), G. S. A. Waylen (Devizes), H. Dutt (Brentford), M. H. Vernon (Horsham), R. Thomas (Exeter), A. J. Bathe (Southampton), S. S. Durn (Richmond), E. S. Tait (Highbury), H. G. Cronk (Repton), W. P. Herringham (London), J. E. Square (Plymouth), J. Berry (London), S. Paget (London), H. P. Taylor (Bradford-on-Avon), L. Drage (Hatfield), H. A. Haviland (Penang), P. H. Dunn (Stevenage), F. C. E. Eville (Barnet), C. P. White (London), C. P. Crouch (Weston-super-Mare), H. Huxley (London), C. H. Cosens (London), R. E. Crosse (East Dereham), R. A. Bickersteth (Liverpool), A. B. Rendel (London), C. E. Baker (London), C. B. Dale (London), H. O. Davies (Ealing), A. N. Weir (London), C. Buttar (London), Martin Jones (Aberdare), A. M. Mitchell (Guildford), C. H. Drake (Brixton), S. P. Cornish (London), G. V. Worthington (London), J. E. C. Calverley (London), H. W. Lance (London), Gilbert Smith (London).

#### The Cambridge Graduates Club of St. Bartholomew's Hospital.



ON Monday, November 22nd, the Annual Dinner of the above-mentioned Club was held at Frascati's Restaurant. The Vice-Chancellor of Cambridge University, Dr. Alexander Hill, himself an old student of the Hospital, was in the chair.

The Dinner, as the Senior Secretary pointed out in his speech, was memorable in two ways: firstly, because this was the first occasion in

the history of the Club that a Vice-Chancellor had taken the Chair (seeing, however, that the Club is not yet twenty years old, and that it is nearly two hundred years since a graduate in Medicine was last Vice-Chancellor, this is, perhaps, not to be wondered at), and secondly, because the number who sat down to dinner was again a record. Including twenty-three guests the total was seventy-five, thus beating the former record of last year by three.

The Dinner was in every way a great success, and it is very pleasing to find that each year it becomes more popular, since it must be to the advantage of both Seniors and Juniors to be thus thrown together.

During the evening music was provided by the following gentlemen:—Mr. Myers, Mr. Pollard, Mr. Sandilands, and Mr. Nixon, and to them the Club is greatly indebted, as also to Dr. Shelley for his admirable recitation.

After dinner, the Queen's health having been drunk, the Chairman proposed the toast of the evening, namely, "the Club." He took for his text the title of the Club, first giving a learned disquisition on the origin and meaning of the word. He then considered the two component parts of our own Club,—the Cambridge life followed by the training at St. Bartholomew's. Dr. Hill also alluded, amid general cheers, to the great acquisition which the Club had lately made in the person of Dr. Kanthack, the Professor of Pathology, the latter being present that evening for the first time as a member of the Club.

Dr. Hensley then proposed the health of the Chairman in very felicitous terms; in the course of his speech remarking that Dr. Hill was one before whom just now we should all be only too pleased to kneel. To judge from the applause which came from the junior members of the Club, candidates for the M.B., B.C. degree, this remark struck home.

Dr. Hill having responded, Dr. Norman Moore then proposed, in his usual happy vein, the health of the guests. These, he showed, contained among their number several distinguished men, representatives of other universities and other schools. The Press also—that powerful factor in modern life—was, he pointed out, not forgotten. It was indeed worthily represented in the person of Dr. Meakin, until recently the very successful editor of our Hospital Journal.

Dr. Chamneys and Mr. Parker then replied.

At this point it was announced from the Chair that the Guy's Hospital Cambridge Club, which was also holding its Annual Dinner that evening at Frascati's, had just drunk the health of the Vice-Chancellor. The company immediately responded to the toast by drinking success to the Guy's Club.

This ceremony ended, Professor Kanthack, in conclusion, proposed the health of the Secretaries, Dr. Morley Fletcher and Dr. Horton-Smith; and their health having been drunk with musical honours, and this honour duly acknowledged by them, the proceedings, after a most enjoyable evening, were brought to a close.

#### Volunteer Medical Staff Corps Ball.



BRIEFLY announced last month, the members of the St. Bart's Hospital Company of the V.M.S.C. will hold their second Annual Ball on Monday, January 24th, 1898, at the King's Hall, Holborn Restaurant. The date has been altered from the 19th in order not to clash with the Hospital examinations.

The Ball will be under the patronage of Dr. Church, Sir Thomas Smith, Bart., representing the Staff of the Hospital; and the Warden, Dr. Shore, will represent the Medical School.

Mrs. Walsham will again act as Lady President, supported by a Ladies' Committee.

In response to a very generally expressed wish, a supper will be provided in the hall adjoining the ball-room, and consequently the Committee have been able to secure the whole suite of rooms connected with the King's Hall, ensuring complete privacy during the evening.

The band of the Royal Artillery will supply the music, and Surgeon-Lieutenant W. E. Miles, F.R.C.S., will officiate as M.C.

The Committee can only issue tickets to gentlemen, but each subscriber will be entitled to apply to the Ladies' Committee, through the Secretaries, for one lady's invitation. Subscribers' tickets are 15s. each (including supper), and are strictly limited to past and present members of the Hospital and their friends. The increase in the price of tickets is due solely to the addition of a light supper. Members of the regular and volunteer forces are requested to wear

mess dress. No member of the corps will be permitted to attend in ordinary uniform.

Mrs. Walsham will receive the guests at 8.20, and dancing will commence at 8.30 p.m., supper at 11.30 p.m., carriages 3.30 a.m. This is the only intimation the Committee will be able to give to past members of the Hospital, but it is hoped that as many as possible residing within reach of town will endeavour to be present. Tickets, which are strictly limited, can now be obtained from the Secretaries and Committee, and it is requested that early notice be given, as they will be issued in strict order of application.

#### COMMITTEE.

**Chairman and Treasurer.**—Surgeon-Lieut. W. F. Miles, F.R.C.S. Sergeant A. J. W. Wells; Lance-Corporal J. J. Scrase; Privates A. M. Dalzell, G. S. Ewen, W. C. Douglas.

**Honorary Secretaries.**—Serjeant-Major J. C. S. Dunn, St. Bart's Hospital; Sergeant E. A. May, 3, Gordon Villas, East Sheen, S.W.

### St. Bartholomew's Hospital Boxing Club.



I should like to draw the attention of Bart's men to this Club, as we do not think that men make enough use of it; there are several great advantages attached to this Club, which perhaps new men are not aware of.

1. The rooms are situated within two minutes' walk of the Hospital gates.

2. There is no expense whatsoever incurred by any who make use of it.

3. It is one of the best known forms of exercise.

4. On Fridays instruction is given by Alec Roberts, who is acknowledged to be one of the best instructors of the day.

5. It is the easiest way of training for football and hockey, and in no way interferes with Saturday games.

The rooms are situated under the St. Bartholomew's Great Schools in Red Lion Court; but as there is sometimes a difficulty in finding them, the Honorary Secretaries will be pleased to take any man over if would be members will communicate with them.

The rooms are open from 4.15 p.m. till 6.30 p.m. on Mondays, Wednesdays, and Fridays during the winter session.

A competition will be held at the end of the season, the date of which with all arrangements will be announced later.

The Honorary Secretaries will be pleased to answer all inquiries.  
J. C. S. Dunn, } Hon. Secs.  
G. E. Catheart, }

### The Month's Calendar.

[Secretaries of Clubs, &c., are invited to co-operate in making this Calendar of forthcoming events as complete as possible by forwarding particulars to the Editor.]

#### DECEMBER.

Wed. 15th.—Mr. Butlin's Clinical Lecture, 2.45 p.m.  
Thurs. 16th.—Dinner to Dr. W. J. Collins at the Trocadero, Mr. Marsh in the Chair.  
Fri. 17th.—Dr. Hensley's and Mr. Marsh's duty.  
Sat. 18th.—R.U.F.C. v. Upper Clapton, at Winchmore Hill.  
Tues. 21st.—Dr. Brunton's and Mr. Butlin's duty.  
Thurs. 23rd.—Winter Session divides.  
Fri. 24th.—Dr. Church's and Sir Thomas Smith's duty.  
Sat. 25th.—Christmas Day.  
Tues. 28th.—Dr. Gee's and Mr. Willett's duty.  
Fri. 31st.—Sir Dyce Duckworth's and Mr. Langton's duty.

#### JANUARY, 1898.

Tues. 4th.—Dr. Hensley's and Mr. Marsh's duty. First Conjoint Examination begins.  
Thurs. 6th.—Winter Session resumes. Second Conjoint Examination begins. Christmas Entertainment in Great Hall at 7 p.m.  
Fri. 7th.—Dr. Brunton's and Mr. Butlin's duty. Christmas Entertainment in Great Hall at 7 p.m.  
Tues. 11th.—Dr. Church's and Sir T. Smith's duty. Final Conjoint Examination begins.  
Thurs. 13th.—Mid-Sessional Address, Abernethian Society. At 8 p.m. Dr. Lovell Drage on "The Coroner's Court."  
Fri. 14th.—Dr. Gee's and Mr. Willett's duty.

### Appointments.

BARFORD, P. C., M.R.C.S., F.R.C.P., appointed House Surgeon to the Bridgewater Infirmary.

BUTLER, Chas., M.D. Brux., M.R.C.S., L.R.C.P., appointed Anæsthetist to the Samaritan Hospital for Women and Children.

FOX, E. H. BRUCE, M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal South Hants Infirmary, Southampton.

PAGET, C. E., M.R.C.S. Eng., L.R.C.P. Lond., D.P.H. Eng., appointed County Medical Officer of Health for Northampton.

ROACHE, W. H., M.B. Lond., M.R.C.S., L.R.C.P., appointed House Surgeon to the General Infirmary, Hertford.

ROCK, F. W., L.S.A., appointed one of the Medical Officers to Colonel Lagard's field force.

SHULER, G. P., M.B., B.C. Cantab., D.P.H., appointed Honorary Medical Officer to the Hospital of St. Joseph.

BARROD, W. N., M.R.C.S., L.R.C.P.  
BALAL, R. D., M.R.C.S., L.R.C.P. } Appointed Temporary  
JONES, T. C. L., M.R.C.S., L.R.C.P. } Plague Officers  
McLEAN, W., M.R.C.S., L.R.C.P. } by the  
SELBY, H. C., M.B., B.C. Cantab. } Indian Government.  
WINTER, E. S., M.R.C.S., L.R.C.P. }

### Examinations.

LONDON UNIVERSITY.—M.B. EXAMINATION.—1st Division.—Tove, E. J., B.Sc., 2nd Division.—Bennett, H. C. P., Calverley, J. F. G., Cornish, S. P., Dunn, W. E. N., Robertson, F. W., Woodfield, T. H.

FINAL FELLOWSHIP.—Christopherson, J. B., Maxwell, J. P., Pearson, M. G., Phillips, L. C. P., Heath, A., Cholmeley, W. F., Blair, C. S., Dickinson, H. B.

PRIMARY FELLOWSHIP.—Fraser, J. E. S., Worth, C. A., Walker, L. A., Massina, H. M.

FINAL M.R.C.S., L.R.C.P.—Palgrave, E. F., Henshaw, W. H., Jones, T. C. L., Cruddas, H. M., Beif, F. V. O., Lloyd, E., Waterhouse, R., France, C. H. G., Roman, A. H., Boulton, H., Brickwell, F., Weaver, F. K., Baylis, H. E. M., James, P. W., Beath, W. L., Oldfield, J., Cholmeley, M. A., Gutch, J., Verdon-Roe, S., Bousfield, S., Hornbrook, R. W., Rowe, W. T., Leclezio, G. E., Jones, E. S., Corfield, E. C., Clarke, F. A. H.

SOCIETY OF APOTHECARIES.—Midwifery.—Greenwood, F. R. (Diploma).

### Birth.

HEATH.—November 18th, at No. 3, Cavendish Place, Cavendish Square, W., the wife of Charles J. Heath, F.R.C.S., of a daughter.

### Marriages.

DECK—DAVIS.—On October 13th, at St. Michael's, Highgate, by the Rev. Wilfrid Ogilby and Rev. T. A. Davies, Edward James Deck, M.R.C.S., L.R.C.P., of 13, Warrior Gardens, St. Leonards, only son of Edward Deck, of Blyford Hall, Suffolk, to Florence Matilda Davis, youngest daughter of Henry J. Davis, of Earlsmead, Hornsey Lane, Highgate.

SPACKMAN—NEWTON.—On October 12th, at St. Saviour's, Paddington, by the Rev. Marshall Tweddell, M.A., vicar, Coniston Spackman, M.R.C.S., L.R.C.P., of Gloucester House, Faringdon, Berkshire, to Ada, third daughter of Frederick Newton, of 9, Warrington Crescent, Warwick Road.

### Deaths.

ARMITAGE.—On October 23rd, on board ss. *Armand Behic*, Joseph Armitage, M.B. Oxon., F.L.S., late of Einu Bay, Tasmania, aged 44 years.

JOWERS.—November 12th, at Haywards Heath, Sussex, Gwendoline Amy, eldest daughter of the late Frederic W. Jowers, Esq., of Haywards Heath and Brighton, aged 33.

ACKNOWLEDGMENTS.—*Magazine of the Royal Free Hospital School of Medicine for Women, The Student, Guy's Hospital Gazette, University College Gazette, The Nursing Record, St. George's Hospital Gazette, The Hospital.*

# St. Bartholomew's Hospital



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### NOTICE.

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The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

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### St. Bartholomew's Hospital Journal,

JANUARY 14th, 1898.

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

### On Appendicitis.

A Paper read before the Abernethian Society on  
November 4th, 1897,

By T. P. LEGG, M.D., F.R.C.S.



HOUGH appendicitis is so common a disease, it is only within the last few years that attention has been prominently directed to the importance of the pathology of the appendix vermiformis and the results of disease of that organ. In 1888 Tréves read a paper before the Royal Medical and Chirurgical Society "On the Operative Treatment of Relapsing Typhlitis," and from the publication of that paper attention has been given to the surgical aspects of the subject.

At the present time the chief differences of opinion among surgeons are when to operate in the acute stages, and whether the appendix should or should not be removed in all cases.

As regards the anatomy of the appendix, the relations of the peritoneum and its position are the most important.

There are three peritoneal pouches close to the appendix: (1) the ileo-colic; (2) the ileo-caecal; and (3) the sub-cæcal, immediately behind the caecum. They are of interest, as they may lodge the appendix or become the sheath of a hernia of the small intestines. (For a detailed account see Lockwood and Rolleston's paper, *Journ. Anat. Soc.*, xxvi.)

A meso-appendix is almost always present. It is a double fold of peritoneum, and contains between its layers the blood-vessels, lymphatics, nerves, and a single gland into which the lymphatics of the appendix pour their contents. Its length varies; Lockwood and Rolleston state that it rarely reaches more than half or two thirds the length of the appendix, "but in the adult it reaches only to the centre of the tube or the junction of the middle and distal thirds."

In connection with the vascular supply it should be noted that there is only one artery derived from the ileo-colic; it runs along the free border of the mesentery.

Not infrequently the appendix is curled on itself as if the mesentery were too short for it.

The position the appendix occupies is subject to wide variation; and probably it varies at different times in the same person, as it is a movable body; the length of the mesentery as well as its breadth, and the length of the organ, doubtless determine in great measure where it lies. The appendix is almost always an intra-peritoneal organ, which is of great importance when considering the position of an abscess connected with it. Usually it is found behind the lower end of the ileum, with its extremity pointing to the spleen. Frequently it hangs over the brim of the pelvis. In other cases it passes right across the sacrum or last lumbar vertebra; not infrequently it is retro-caecal, and can only be seen on turning up that organ; lastly it may come off from the lower end of the caecum, as in the fetus.

**Structure.**—The appendix is almost entirely composed of lymphoid tissue, which is diffuse and not in isolated masses or groups. Lieberkühn's follicles are present even to the tip. Surrounding the mucous membrane are two layers composed of fibrous tissue and some muscular fibres, forming an outer and inner coat, and surrounding all is the peritoneum.

**Function.**—The function of the appendix is unknown. It has been suggested that its use is to lubricate the adjacent caecum, where faeces are apt to accumulate. In the fetus it is not infrequently distended with meconium, and in the adult fecal concretions are found, which have produced no effect whatever. It has a distinct and pervious lumen throughout its whole length in the majority of cases; in old people in many instances it is only partially pervious, and in the canal is a certain quantity of mucus with semi-fluid fecal material; fecal concretions not being uncommon—50 per cent. of 121 cases examined by Fitz. The appendix is the remnant of the elongated caecum of the lower mammals. In the gorilla and chimpanzee it exists as in man—a process attached to the caecum, and representing the lower part of that organ. (In birds a double caecum is met with.) It is also of interest to know that in the higher apes morbid conditions are by no means uncommon (Bland Sutton).

**Ætiology.**—Appendicitis occurs at all ages, but the most common time is from 10–30 years. During the last five years 156 of the 220 cases admitted to this hospital occurred during that period of life, the figures being 37 cases 10–15 years, 54 cases 15–20, and 65 cases 20–30 years. There was only 1 case under 5 years, and that was in 1893, and he was admitted for strangulation of the intestine by an

adherent and ulcerated appendix; he was 4 years old. In later life the disease is not so uncommon; there were 12 cases in patients of 40—50, and 4 in patients of 50—60, and some of these were infirmities. Males are much more frequently attacked than females; the statistics of this hospital during the last five years show that nearly four males were admitted to one female, or more accurately 79.5 per cent. of the cases were males, and 20.4 per cent. females. This agrees very closely with Treves, who says about 78 males to 22 females is the proportion of the sexes. The frequency of attacks varies enormously. Many cases after having had one attack recover completely; others are reminded of their trouble by any indiscretion in diet or by constipation. But a large proportion of cases relapse, and the number of relapses varies both as to frequency with which they occur and the severity. The percentage of relapses has been estimated at 23.6 per cent. by Dr. Hawkins, and 44 per cent. by Fitz. Treves considers this latter the more accurate figure. There are cases on record with as many as twelve or fifteen attacks in a year or eighteen months; or one attack may occur, and then freedom for several years. Further, some of the relapses may be quite trifling, and others very severe, and any one of them may end in suppuration, or cause the speedy death of the patient.

As to the question of foreign bodies and their relation to appendicitis much has been written: many so-called foreign bodies are not anything of the kind, and Treves goes so far as to say, "I have never found such seeds or fruit-stones in the appendix, and I believe them to be exceedingly rare." Among the varieties of foreign bodies met with in the appendix are pins, nails, &c.; that these do occur occasionally there can be no doubt, for in all museums are such specimens to be seen, and they have been found during operations. But as regards "grape seeds," "cherry stones," "orange pips," and "date stones," there is no doubt that in the larger number of cases these are really fecal concretions, and on section they are clearly demonstrated to be so. They consist usually of a nucleus formed of dried mucus, and outside layers composed of carbonate of lime, phosphates of magnesia and lime, and a little fecal matter. In size they vary from a "grain of wheat to a date stone." In other cases they are really fecal pellets, hard or soft.

Though these bodies are so frequently found in connection with cases of appendicitis, many surgeons consider them the result of a catarrhal process, rather than the cause. Certain it is they are frequently found post-mortem in otherwise apparently healthy appendices, and in patients who have had no symptoms during life. And those who consider them of secondary importance look upon the retention of mucus as a chief cause of the disease, the appendix being regarded as a diverticulum of the intestine which readily allows the stagnation and accumulation of fecal matter. This, with the mucus, leads to fermentative and putrefactive changes, setting up catarrhal inflammation, which may be followed by ulceration and perforation, or thickening of its walls, which is most commonly met with in the recurrent forms. The fecal concretions or foreign bodies must tend to keep up and excite recurrent inflammation.

Constipation alone is not a sufficient cause of perityphlitic; constipation is more common in women than men, yet the disease occurs four times as often in men as women. As a factor it may be of importance, and more especially so in cases of relapsing perityphlitic, especially when at the same time an indigestible or unassimilated meal is present.

A history of injury is obtainable in a few of the cases, usually a blow or strain. The symptoms may come on rapidly, and in some of these cases a past history of constipation and pain is obtainable, which may have been a slight attack, and the injury merely relighting up old mischief.

Among other causes, Dr. Haig believes gout to be exceedingly common, so much so that if all cases were at once treated by salicylates, further troubles requiring surgical interference would be rare. The classification of the varieties of appendicitis has been done in several ways. Usually three varieties—the simple, perforative, and relapsing—are described; to these may be added the specific varieties—typhoid, tuberculous, actinomycotic, and the gouty.

In the last volume of the *Hospital Statistics*, Mr. Berry divides all the cases admitted during the year 1896 under the following heads, and for clinical and practical purposes this list includes all the varieties:

- (1) Mild cases without suppuration.
- (2) Chronic relapsing cases without external suppuration.
- (3) Acute with suppuration.
- (4) Chronic with abscess.
- (5) Chronic with strangulation of intestine by adhesions.
- (6) Old appendicitis with sinuses.

As to the frequency of these varieties, those included under mild

cases without suppuration far and away outnumber all the others, considerably over 50 per cent. coming under this head.

The symptoms of appendicitis are well known. The first and one of the most prominent is pain in the right iliac fossa, which may be localised here, but in other cases it is general and diffuse, or referred very frequently to the umbilicus. As the intensity increases it becomes more and more localised to the right iliac fossa, and at any rate is most marked here in those cases where it is diffuse. Now and again it is referred to the left iliac fossa. The onset is generally sudden—in some cases there is a preceding uneasy sensation in the belly. Besides the pain in the belly, it radiates to the back, the thighs, and may, in some cases, extend into the testicle.

Tenderness is a marked symptom in all cases; it may be all over the belly, but is most marked in the right iliac fossa, and a spot, called McBurney's point, can frequently be demonstrated as a point of maximum intensity. This point is generally on a line drawn from the anterior superior iliac spine to the umbilicus, and about  $\frac{1}{2}$  inches, or halfway, from the spine. As the disease advances this tenderness becomes more marked, so that not even the slightest pressure in the most acute cases can be borne. Further, this tenderness is persistent, and lasts long after all acute symptoms have passed away, and convalescence is established. It should, however, be noticed that this tenderness may be much more marked in non-suppurating cases than in those with suppuration, so that its degree is not a sure guide to the amount and extent of inflammation going on.

As a rule, the bowels are constipated, though they may act daily up to and during the attack, even without evacua or the use of aperients. Diarrhoea is present in a small number of cases; there was a case in Charity in May this year with well-marked diarrhoea; the patient died, and post-mortem, general septic peritonitis due to a perforated appendix was found. Vomiting is a variable and irregular symptom; it generally occurs at the onset, but is rarely severe or prominent, and may be generally controlled by suitable treatment.

Fever is generally present, but the variations in temperature are marked. A temperature of  $103^{\circ}$  or  $104^{\circ}$  may occur in those cases which yield readily to treatment, and do not suppurate. In such cases the temperature generally falls in twenty-four to forty-eight hours. In other cases, with abscess and general peritonitis, the temperature may be not higher than  $100^{\circ}$  or  $101^{\circ}$ . Indeed, several such cases occurred in the hospital last year. There was a boy in Charity in the early part of this year who had a large abscess and a temperature of  $104^{\circ}$  before operation; afterwards it fell, in the course of twelve hours, to  $99^{\circ}$ , and though general peritonitis set in, and he died in about thirty-six hours, his temperature never rose above  $102^{\circ}$ . So that too much stress must not be laid on temperature as an indication of the presence or absence of pus. On the other hand, the temperature may rise to a great height— $105^{\circ}$  or  $106^{\circ}$ —with general peritonitis, before death.

The condition of the pulse is, perhaps, of more importance than the temperature; a small, thready, rapid pulse indicates grave disease, and, combined with a temperature of  $100^{\circ}$  or  $101^{\circ}$ , a bad prognosis. A pulse which diminishes in frequency and increases in volume is a good sign; a pulse which increases after operation, becoming more thready, is a bad sign.

The abdomen is frequently distended, immobile, and rigid; this last sign being more marked in the right iliac fossa. But not infrequently these signs are absent, and the abdomen is quite flaccid, not distended, and moves with respiration, even when an abscess is present or general peritonitis. In other cases these conditions are limited to the right iliac fossa or lower part of the abdomen. As the abdomen becomes less distended and less tender, a tumour is to be felt in the right iliac fossa, the size of which is dependent on the extent of the disease; further, this tumour is dull on percussion, though not always absolutely dull. The shape of the tumour varies, and sometimes it is quite defined in outline, at others very indefinite. Its consistency varies; it may be nothing more than a resistance, or it may be hard. It is formed by inflammatory effusion matting together the intestines, distended by gas or filled with fecal material, the omentum, and the inflamed appendix. As the inflammation subsides and its products are absorbed, and the intestines emptied, the tumour becomes smaller, until finally nothing may be left at all, or only a round or elongated sausage-shaped swelling—the enlarged appendix. The size of the swelling does not bear any definite relation to the gravity of the case.

In all cases of doubt as to whether there is anything in the region of the appendix, a careful examination under an anesthetic is indicated, and examination *per rectum*, more especially in children, will often aid in detecting a fulness or resistance in the right iliac fossa. In women *per vaginam* examination is an additional help.

Constitutionally the patient is more or less prostrate, lying on his

back with, perhaps, the right leg flexed or drawn up; the tongue is furred, in the worst cases dry and cracked. Thirst and headache are often prominent symptoms, the thirst being very persistent. With the constipation no flatus at all may be passed. The appetite is bad in most cases.

The formation of the abscess.—There is unfortunately no one sign or symptom by which the presence of pus can be definitely decided. For at first the pus is deeply seated in the iliac fossa, and it takes some time to come to the surface, and if so, it may not be in sufficient amount to give rise to fluctuation. As the abscess comes forwards the abdominal walls become infiltrated, brawny, and oedematous, and this condition, combined with the rigidity, may entirely obscure fluctuation. Nevertheless, the combination of the signs mentioned above, aside, for in the worst cases it may be subnormal or only slightly raised, and not infrequently the bursting of the abscess, with the result usually of general septic peritonitis, is the first sign of its presence, followed by speedy death. A rigor is rare.

The situation of the abscess depends on the position of the appendix; in most cases it is in the right iliac fossa, and comes forward above Poupart's ligament, internal to the anterior superior iliac spine. In other cases it is mostly situated in the pelvis, in Douglas's pouch, as when the appendix is hanging over the brim; if the appendix is behind the cecum the abscess is there too, and it may be as high as the brim of the pelvis in the lumbar or hypochondriac regions, or even perinephric. Its walls are formed by matting together by lymph of the small intestines, cecum, omentum, mesentery, and appendix. The pus which is contained in it is generally exceedingly foul, with a fecal odour; not unfrequently free gas is present. Besides the main cavity, pockets or diverticula are very commonly found. The amount of pus may be small or several ounces, usually there is three or four ounces. The time which elapses between the onset of the disease and the formation of an abscess varies. In some cases it may be only twenty-four or forty-eight hours, in others a week or still longer; a high temperature may be present for some weeks (three or four), and no evidence of pus be present. The abscess may point and burst externally, which is the most common occurrence in neglected cases; the next most common place is for it to burst into the bowel, generally the cecum, and lastly, the general peritoneal cavity. It may track in all sorts of directions, simulating a psoas or a nephritic abscess. Primarily the abscess is intra-peritoneal, as from the relations of the appendix to the peritoneum it must be; secondarily it becomes shut off from the general peritoneal cavity by the adhesions. But some abscesses may be extra-peritoneal from the onset.

In the chronic relapsing cases a small collection of pus quite shut off may be found, or the pus may be in the appendix itself. There was a case in the hospital this year where the appendix was found thickened, and in the mesentery a suppurating gland. This gland was possibly tuberculous. It was removed; the cavity left was scraped and touched up with the actual cautery, the patient making an excellent recovery.

Here it may be mentioned that the formation of an abscess does not lead in all cases to cure, and this has been put at about 5 per cent. of all cases operated on, in which simple incision and drainage only were done. As a rule, the relapsing abscess appears in a short time after the wound has healed (this is generally three or four weeks), and in most cases they are due to too early removal of the tube, allowing the external wound to close before the abscess cavity is soundly healed, thus allowing pus to accumulate in the depths. In other cases the abscess does not form again for some months after the primary one, and in these cases it is due to some concretion left behind. Thus in June, 1896, a boy was in this hospital with acute suppurative appendicitis, the abscess was opened and drained; tube removed fifth day, and the wound healed in thirty-one days. Five months later he was readmitted with a second abscess; this was opened, and an ounce of pus let out; no search was made for the appendix, but a few days later two inches of it sloughed out, and the boy left the hospital in thirty-five days with the wound opened and drained. The last time it burst spontaneously, and some tissue like "pieces of appendix" came away. It then healed soundly.

A patient who has once had a perityphlitic abscess is very unlikely to have another attack of perityphlitic, the reason being that the appendix is cast off as a slough or in the debris, or it becomes destroyed and its cavity obliterated by inflammatory material.

Pathology.—Mention has already been made of the part which concretions and foreign bodies play in appendicitis. Fitz of Boston,

out of 321 cases, found fecal concretions present in 50 per cent., and foreign bodies in 12 per cent. Treves says foreign bodies are present in 3 per cent. Murphy 3.5 per cent. In 400 post-mortems of all kinds, Ribbert found them in 10 per cent. More important is the part which micro-organisms play, and the most frequently found is the *Bacillus coli communis*. In thirty-four out of thirty-five cases this organism was found. These micro-organisms are, perhaps, the most important factor in the development of the disease, but not in its primary origin. Normally they are found in human intestines, and if any part becomes inflamed, they become very virulent. In some cases they occur in pure culture, in other cases in association with streptococci, and much less frequently with staphylococci.

This same organism is also found in the exudation of the general peritonitis, and it is not necessary that in all cases of general infection a perforation of the appendix should be found, for the bacilli have the power of passing through its walls when their vitality is lowered by inflammatory processes. The extent of peritonitis will depend on the extent of the invasion by the bacilli; a sudden, rapid, and large invasion will lead to wider mischief, and produce more marked symptoms than a slow and gradual invasion. It is not uncommon to find the whole peritoneum involved, even that portion between the diaphragm and liver; in other cases the peritonitis may be limited to the lower part of the abdomen or the iliac fossa only, and in these cases death may be very rapid, only few signs being present post mortem. We must here assume that the poison was so virulent that death occurred before the physical signs had time to develop. The amount of effusion varies; usually it is not very great, and may be serous, sero-fibrinous, or purulent.


The actual condition of the appendix varies according as to whether it be met with in the acute stage, or in the relapsing cases. In the former it is enlarged, soft, very red, and acutely inflamed, covered by more or less lymph; adhesions may be completely absent, or so slight and slender as to be readily broken down. The whole organ may be gangrenous or separated as slough, and this may have happened in twenty-four hours. In other cases the gangrene may be limited, and in patches. Perforation may take place at any spot, and lead either into the general peritoneal cavity or into a part shut off by adhesions; the perforation may be of any size or shape, and occurs in 60—70 per cent. of all really acute cases; it is generally situated near or at the tip.

If an abscess be present the appendix may be found lying loose in its cavity, or it may be found projecting from the walls. In other cases it is intimately bound up with the adhesions, and not to be found except on careful dissection.

In chronic relapsing cases, numerous adhesions are generally found, though they may not be present. The appendix is thickened, more especially the lining membrane; the cavity may be distended, so as to become cystic, or it may be obliterated in part or wholly; kinking is not infrequent. The mucous membrane may be ulcerated in one or more places and nearly perforated. The secretion is increased in amount, and may be actually purulent; concretions are not infrequent. The adhesions may be so dense and firm that the appendix is not to be distinguished.

(To be continued.)

## Two Cases of Malignant Disease of the Stomach.

 THESE two fatal cases of malignant disease of the stomach, one followed by intestinal obstruction, the other by sub-phrenic abscess, are reported by permission of Dr. Brunton.

CASE I. Carcinoma of stomach and obstruction of transverse colon by a band of adhesion.—H. L., 43, a coal-heaver, was admitted into Rahere Ward on October 15th, under Dr. Brunton's care, complaining of weakness and a swelling of the stomach.

History of present illness. Patient was quite well up to beginning of June, 1897, when he felt persistent pain in epigastrium, not increased after food, nor relieved by vomiting. Occasional vomiting had occurred (about once a fortnight), which had at times been "black"; and he had also occasionally passed "black" motions; he never brought up or passed pure blood. He has lost flesh rapidly in last six months; his weight used to average 12 st. 6 lbs., but is now less than 8 st.

**Present condition.**—Sallow complexion; much wasted; neck very thin; aortic arch felt in supra-sternal notch. Chest tender on percussion; right lung resonant as far as fifth rib in front, then a line of dullness for one and a half inches, and below this tympanic resonance continuous with abdominal resonance; breath-sounds natural; left lung, percussion note impaired at the apex, and the breathing accompanied by sibilant sounds. Heart natural. Pulse 92, regular, good volume and tension; no thrill felt, or change of resonance in the flanks on altering position. A large indelible mass is felt reaching almost to Poupart's ligament on the right side, with no definite edge. The tenderness and tense condition of the abdomen prevent a satisfactory observation. No oedema of the legs. Urine 1022, acid; bowels open after H. Sennæ Co. Examination of rectum reveals nothing. Maximum abdominal girth, 33½ inches.

October 17th.—Patient vomited a quantity of foul-smelling brown fluid of a thick soupy consistency, acid in reaction. This occurred twice also in the evening, with some relief of the pain. An injection of morphia was given at 6 p.m. He slept fairly, but hicough and flatus by the mouth were troublesome. Unable to pass flatus *per rectum*.

18th.—Thrill felt across lower part of abdomen. Severe pain, relieved by morphia. The stomach was washed out, but only a few flakes of food were brought away.

19th.—More pain in the night. Vomited twice.

22nd.—Patient passes scarcely any motions, and very little flatus *per anum*, and vomits nearly all his food. The distension has increased, and the abdomen is tympanic all over. No increase of ascites. Sir Thomas Smith and Mr. Butlin were called in; they were of opinion that the obstruction was probably between the splenic flexure and the sigmoid, and that colotomy either of the transverse or descending colon was indicated. Patient, however, refused an operation.

23rd.—Patient weaker and depressed. Pain for the most part yielded to morphia injections. Vomiting practically continuous; no food wholly retained. Many enemata were tried (simple, dill water, asafetida), and a fair amount of fecal matter came away in some instances, but scarcely any flatus was passed.

24th.—Patient remained greatly distended. Vomiting distinctly feebler in odour and appearance. Respiration failed, and patient died at 7.30 a.m.

**Post-mortem.**—**Abdomen:** when opened much gas mixed with some red fluid came spouting out. In the peritoneal cavity there were three pints of ascitic fluid. The entire peritoneum was dull and injected, with patches of yellow lymph here and there, and in the pelvis some fœces. The small intestine was blown up to three or four times its usual size, and beneath the abdominal wall three coils of it placed side by side reached from the liver to the pelves, and completely obscured the underlying contents. When the small intestine was removed the cœcum was found to be greatly distended by gas and fœces; it was five or six times its usual size, and on its inner surface there was a small perforation through which fœces could be pressed. The peritoneal coat over part of the cœcum had given way. The ascending colon was also distended, and the cause of obstruction was found in the transverse colon close to the hepatic flexure: here the intestine was nipped in two different places by cicatricial tissue in association with enlarged glands in the neighbourhood. There was no growth in the colon itself, the constriction admitted the little finger, and the mucous membrane was not ulcerated. The stomach was not dilated; the œsophageal half was infiltrated throughout its whole extent by new growth, so that the wall was about one sixth of an inch thick. The pyloric end was natural, and a fairly sharply defined line could be made out between the two halves. Some of the veins were dilated, but no ulceration was found. The glands in the lesser omentum were enlarged, white, and hard; similar glands were found in the mesocolon, and in the aorta just below the origin of the cœliac plexus. There were no growths in the lungs, liver, spleen, kidneys, and pancreas. The glands around the head and tail of the pancreas were enlarged by growth. Both lungs were œdematous, the left almost universally adherent, with about a pint of fluid in the pleura; the right pleura contained a little fluid.

**Case 2. Carcinoma of stomach; perforation; subphrenic abscess and secondary growths.**—John B., æt. 44, engineer's labourer, was admitted into Rahere under Dr. Brunton's care on August 25th, 1897, complaining of pain in the left side of the chest.

**History of present illness.**—March 25th, 1897, patient fainted while at work.

On March 26th he vomited about half a pint of blood, and was admitted to Rahere, where he remained six weeks, and was washed

out three or four times with great relief. He then went to Swanley, and returned as an out-patient, still complaining of pain in chest.

August 16th, 1897.—Vomited after every meal, the vomit being "like beef tea."

24th.—Vomited three or four times; great pain in splenic region.

25th.—Hæmatemesis (slight).

**Past history.**—Dyspepsia for two years: enteric fever, aged twelve; has lost 2½ st. in last two years.

**Present condition.**—Patient very weak and wasted, face almost bloodless. Tongue moist, slight fur. Temp. 99.2°.

**Chest:** thin, moves well. Percussion note is impaired below the level of the nipple on the left side in front, and in the axilla. Over this area breathing is weak and vocal vibrations absent, and to this area the pain is referred.

**Heart:** apex beat in fifth space in nipple line. Cardiac dullness upper border of third rib and left border of sternum.

**Abdomen:** on admission the abdomen was flaccid, and moved freely. The percussion note was tympanic all over, the stomach area being increased. Liver dullness did not extend below the ribs. There was tenderness in the splenic area. Patient passed some blood *per rectum* after enema.

12 noon.—Since admission the abdomen has become somewhat distended and firm, resisting palpation and moving less. Pain in the side has increased. *Per rectum*, nil.

3 p.m.—Patient was seen by Dr. Church, and a needle was passed into the tenth interspace (left) in the posterior axillary line, and about a c.c. of blood drawn off. A perforate ulcer was thought unlikely, and feeding by the mouth advised.

6 p.m.—After an injection of morphia patient became free from pain, and slept.

August 30th.—Has passed dark-coloured blood in motions since admission. Has had no vomiting. Pain in side continues. Still very anæmic. Temperature normal.

September 12th.—Signs and symptoms continue the same. Oedema of the legs well marked.

25th.—Two pints of clear serous fluid drawn off by puncture in seventh space (post-axillary line).

October 3rd.—Dullness now extends to the third rib in front. Left lobe of liver felt to be enlarged. There is a little blood in the stools, no vomiting.

12th.—Two and a half pints of blood-stained serum drawn off from left pleural cavity. Oedema of legs and hands increasing.

20th.—Pain much less. Temperature has continued normal.

27th.—Patient distinctly weaker. Change rather sudden. He complains very little of pain, and is very apathetic.

29th.—Patient sank very rapidly. Pulse imperceptible for about twenty minutes. Respiration very slight and sighing. Corneal reflex present till 4.30, when patient died.

**Post-mortem.**—**Lungs:** right 24 ounces. Some recent adhesions in connection with patches of new growth in the lung. Fluid (about ½ pint) in pleura. Left 15 ounces. Adherent to apex, diaphragm, and mediastinum. Collapsed owing to a large serous effusion, greenish in colour, not blood-stained, and containing flakes of lymph. Both lungs studded over the surface with small, white, hard nodules, any size up to a hazel-nut.

**Heart:** probably somewhat atrophied, and brown in colour. Mitral and tricuspid valves somewhat thickened.

**Abdomen:** no general peritonitis. Recent lymph and old thickening round spleen. About one pint of greenish ascitic fluid.

**Stomach:** on opening the stomach along the lesser curvature it was found full of "coffee-grout" grumous material, and when this was washed away a large round hole (1½ inches in diameter) was seen at the cardiac end on the greater curvature. This hole opened into a cavity which was bounded above and behind by the vault of the diaphragm, in front by the left lobe of the liver, the greater splenic omentum, and spleen; below it extended to the pancreas and just behind it, and in front of the upper part of the left kidney. The edges of the hole were heaped up, and there was thickening for some way round. The walls of the cavity were ragged, and in parts sloughing. New growth in small patches was seen on the peritoneum in the neighbourhood. The contents of the cavity were similar to those of the stomach.

**Intestines:** the splenic flexure was imprisoned by adhesions round the abscess, but no ulceration anywhere.

**Liver:** fatty. A few nodules of growth, none larger than a shilling.

**Spleen:** a few small round patches on its surface, but in its substance only such as occur from infarction.

**Glands:** those near the pancreas and round the cœliac axis were enlarged, white, and hard.

**Kidneys:** one rounded white growth in one of the pyramids.

## Boys and Firearms.

By HAROLD MEAKIN, M.D.LOND.

"There is a peculiarity, but no mystery, in gun-shot wounds."

JOHN BELL.

THE possession and use of pistols by small boys has recently been the subject of much correspondence in the daily press. The experience of a house surgeon in regard to wounds caused by so-called "toy" pistols may therefore be of interest. In the first place such wounds are in no sense a rarity, and few house surgeons finish their term of office without having a considerable number under their care. I refer to accidental wounds caused by "toy" pistols in the hands of small boys, and do not include wounds caused by the larger weapons generally used by adults.

I have before me a series of these small but dangerous weapons, taken *aut vi aut fraude* from their wounded owners. It is a curious collection. Differing slightly in construction, they are alike in bad workmanship and cheapness of appearance, and particularly in the absence of any maker's name. The barrels vary in length from two to two and a half inches, with a bore of .22, firing a rim-fire cartridge with a round bullet. The hammers can be placed on half or full cock, but the trigger drops them from either position with equal ease. There are no trigger guards. The total length varies from four and a half to five inches. Messrs. J. and W. Tolley, of Bond Street, to whom I have submitted some of them, tell me that they are of American manufacture in distant imitation of the "derringer" pattern, and that they are probably supplied to the public at a cost of about two shillings each.

In spite of the small size of the weapon, it carries with quite enough force to cause serious injury. I have myself put a bullet through a deal plank ½ inch in thickness with one of them.

From the description it is not difficult to realise that accidents are exceedingly likely to happen with such a weapon. In the active fingers of a small boy such a short barrel can be directed to all points of the universe in succession, in an incredibly short space of time, and it becomes a source of surprise that accidents are not even more frequent.

The situation of the wound is interesting. If, as is usually the case, the holder of the pistol wounds himself, the wound is nearly always on the palmar surface of the left hand, just at or near the base of the forefinger. Entering at this point the bullet either passes straight through the finger, sometimes splintering the proximal phalanx, or passes up towards the wrist on either the palmar or dorsal surface of the hand. The position of the wound can be explained by the fact that at the time of the accident the boy is raising

or lowering the hammer with his right hand, and holding the barrel in his left. The spring is too strong for his small thumb, and the hammer slips from his grasp.

Occasionally an envious and admiring friend receives the bullet, but this seems to be the exception. Under these circumstances I have seen bullet wounds in the arm, leg, and face, but happily my experience does not include any fatal case.

As regards the progress of the wounds, with the exception of a very small percentage they healed without suppuration. This was no doubt due to the fact that great care was taken to clean and disinfect the surrounding skin,—special attention being paid to mechanical as well as chemical means. The wound was scrubbed vigorously with a nail-brush, hot water and soap being freely used; this was followed by syringing with a 1 in 1000 solution of perchloride of mercury, and the application of the usual dressings wrung out of the same lotion. A splint and sling completed the treatment.

In one case the bullet had separated a longitudinal splinter from the basal phalanx of the left forefinger, and this was sticking out of the wound of exit on the dorsal surface. The fragment of bone was removed, and the wound—treated in the usual manner—healed without suppuration.

In those cases in which there was no wound of exit the bullet could sometimes be felt beneath the skin on the opposite side of the hand, and was easily removed through a small incision; in others, where the bullet was more deeply buried, the Kontgen process was resorted to, but though it showed a shadow of the bullet, the photographs were not, I am sorry to say, of much service in localising its position, and so assisting in the ultimate attempt at its removal.

The age of the patients varied from nine to seventeen. Inquiries as to the source of the weapon generally elicited the answer that it had been bought from some "other boy." I don't think any patient ever admitted that he was the original purchaser.

I am told that these accidents are commoner in the Casualty Department of St. Bartholomew's than in those of other London hospitals. Certainly I saw fewer while House Surgeon to the Metropolitan Hospital than while House Surgeon to this Hospital, but even at the former hospital they could not be called rare. It is possible that the boys of Clerkenwell are of a more warlike disposition, or that they are less skilful in the use of their weapons, than the boy warriors of other districts.

It is strange that such dangerous forms of amusement should be permitted, but the police say they have no authority to interfere unless *intentional* harm is done.

In one instance, where a girl of seventeen was shot in the side of the face, the police were notified from the Hospital, since the ultimate recovery of the girl seemed uncertain; but

they said they were unable to act, as the wound "seemed to be the result of an accident."

It appears that excise officers alone can take action against unlicensed persons who carry firearms, and it seems doubtful whether these small weapons come within the scope of the Licensing Act. It is at least certain that great numbers of them are in the possession of the small boys of London, who presumably are unlicensed.

### A Case of Retro-oesophageal Abscess.

By G. S. HAYNES, M.R.C.S., L.R.C.P., House Physician to the Metropolitan Hospital, and formerly House Surgeon, Belgrave Hospital for Children.



H. G., a boy 2½ years, was admitted into the Belgrave Hospital for Children under Mr. Waring on May 18th, 1897, with the following history.

On March 20th, 1897, he was first brought to the hospital for "lumps in the neck." He was found to have slightly enlarged cervical and submaxillary glands, large tonsils, and adenoid vegetations. The mother was advised that the latter had better be removed when patient was in a better state of health, he then being convalescent from an attack of whooping-cough. He was given tonics and attended as an out-patient.

April 23rd the operation was further postponed, owing to the boy having some slight coryza and bronchitis. This cleared up, and on May 18th patient was admitted. It was noticed that his breathing was somewhat noisy and difficult; the mother said this had come on in the last week and was getting worse. The temperature was 98.8°. It was supposed that the dyspnoea was caused by the enlargement of the tonsils, which met in the middle line. Chloroform was administered, and some adenoid vegetations with the enlarged tonsils were removed. Patient took the anæsthetic well, and nothing extraordinary was noted.

May 10th.—The dyspnoea was more marked, and there was some recession of the lower ribs. Patient vomited twice after food.

20th.—About midday the dyspnoea became urgent, so tracheotomy was performed under chloroform. The child stopped breathing before the trachea was opened, but respiration was restored artificially. A silver tube was inserted, the dyspnoea being entirely relieved. A good deal of thick green viscid mucus was coughed up. In the evening after the operation the temperature rose to 101.6°.

21st.—Patient was more comfortable and had no dyspnoea, respiration being 30, pulse 112, good volume and tension. Temp. 99°. He vomited twice after milk, and coughed up a good deal of mucus through the tube.

22nd.—The temperature last night 100.6°, but this morning was normal. An unsuccessful attempt was made to leave the tube out, the dyspnoea becoming well marked at once on removal. Patient vomited twice after milk.

23rd.—Patient looked fairly well, though he appeared to be losing flesh. He slept well, but took food badly, and occasionally vomited after it. The wound showed slight signs of suppuration, and the temperature was 100°. Another unsuccessful attempt was made to leave out the tube.

24th.—The child was drowsy and irritable. Temp. 99.6°. Patient coughed up a good deal of viscid mucus, which was on one occasion slightly blood-stained. He took food badly, and vomited after it three or four times in the twenty-four hours. He was losing flesh and strength markedly. A rubber tracheotomy tube, size No. 1, was inserted in place of the silver one, a free opening being made in upper surface of tube.

27th.—To-day it was noticed that milk given by mouth flowed out through the tracheotomy tube. Patient had a great aversion to milk foods, but there was apparently no dysphagia, as he would eat a biscuit eagerly. The wound was granulating up, and the skin round it looked red and swollen. Temperature the last two days reached 102°, to-day it was 99.8°. Dyspnoea became urgent in about fifteen minutes on leaving out tube.

Subsequent progress.—Patient went on in much the same manner till the second week in June. He vomited occasionally after food and

had a great dislike to taking it, but there was never any dysphagia or regurgitation of food. Several attempts were made to leave the tube out, but on every occasion dyspnoea occurred, coming on sometimes in a few minutes, sometimes after half an hour. Sometimes it was noticed that the tube was more difficult to replace, and would go in with a jerk as though some obstruction were suddenly overcome. The wound granulated up satisfactorily, though the neck round the incision was sometimes red and swollen.

On June 4th chloroform was administered and the larynx examined with the laryngoscope. A clear view of the cords was obtained. They appeared slightly congested but otherwise natural. Nothing was seen to account for the dyspnoea which occurred while the patient was anæsthetised on closing the opening in the trachea.

On June 11th it was noticed that the child would frequently put his fingers down his throat, as though he were in pain. He also tried to pull the tracheotomy tube out. He was wasting more than could be accounted for by his anorexia and occasional vomiting.

From this day the patient got rapidly worse. He vomited almost invariably after food, and became very weak and exhausted. There was good air entry throughout, and dyspnoea never occurred while the tube was in place and free. The patient's temperature between May 27th and June 14th was only once (on June 3rd) over 100°. It was usually about 99°. On the evening of June 14th the temperature was 101.2°. On June 15th in the evening the temperature rose to 103°, and pulse became rapid, feeble, and irregular. Patient had three convulsive attacks, and died after the last one at 6 a.m. on June 16th.

Post-mortem examination.—The body was considerably wasted. The usual incision was made, and the tongue and floor of the mouth brought downwards with the pharynx and larynx. While removing the oesophagus from the vertebral column an abscess cavity was opened. This was found to contain about a drachm of thick yellowish pus, and to be situated between the oesophagus and the last two cervical vertebrae. It was about 1½ inches long by ½ inch wide, and did not communicate with the oesophagus. Its walls were thick and tough, and the anterior surfaces of the bodies of the sixth and seventh cervical vertebrae were roughened and carious, the discs on either side of the seventh being eroded. The tracheotomy wound through the upper two tracheal rings was on a level with the centre of the abscess cavity. A small ulcer was found on the anterior wall of the trachea about one inch below the opening, evidently caused by the tube being pressed forward by the bulging of the abscess.

The submaxillary lymphatic glands were enlarged but not caseous. The lungs were somewhat congested. No naked-eye evidence of tubercle was found in any organ. The vertebrae were sent to the Pathological Department of the JOURNAL for examination, and the following report has been received:—"On microscopic examination the tissue from specimen of carious vertebra proved to be typical tubercle."

Remarks.—The case is one of some interest, owing to its rarity, and to the difficulty of diagnosis.

In Holt's book on *Diseases of Infancy and Childhood*, retro-oesophageal abscess is said to be commonly due to Pott's disease of the lower cervical or upper dorsal vertebrae, the symptoms being obscure, and an exact diagnosis not often made during life. There is rarely dysphagia, but in all cases symptoms of irritation of the pneumogastric. In most cases there are no external signs of disease. The prognosis is exceedingly bad, death usually resulting from pressure on the vagus.

Donkin, in his *Diseases of Childhood*, "very strongly contradicts the prevalent belief that either spinal caries or the serofulous condition is a common cause." A certain number of cases follow measles or scarlatina, but the majority are traumatic in origin, due to laceration of the oesophagus by foreign bodies, such as fish-bones, crusts of bread, &c.

In *Pædiatrics* for June 1st, 1897, there is a report of the Ninth Annual Meeting of the American Pediatric Society, when a paper was read by Dr. J. P. C. Griffith on "Retro-oesophageal Abscesses," in which he reported a case, and emphasised the difficulty of diagnosing this condition during life. It was not necessary to dwell at any length upon the symptoms,—in fact, there seemed to be none absolutely characteristic. If analysed, dyspnoea at least was present in nearly all cases. "This seemed to be the result of reflex irritation." "As to caries of the spine, he found it mentioned in seven cases, and proved by autopsy to have been present in two."

A discussion followed, and a few cases were reported. I have not gone thoroughly into the literature of the subject, and I find the disease barely mentioned in the ordinary text-books. As far as I can ascertain, the following facts may be taken as a summary of the condition.

1. That it is essentially one of infancy and early childhood.
  2. That its causation may be primarily due to tuberculous disease of the bodies of the lower cervical or upper dorsal vertebrae, or to abscess formation in the pre-vertebral tissues, due to laceration of the wall of the oesophagus, with possibly consequent caries of the vertebrae.
  3. The symptoms are obscure, but dyspnoea, vomiting, and wasting were prominent in this case.
  4. The diagnosis is exceedingly difficult.
  5. The most rational treatment is external incision and drainage.
  6. The prognosis is exceedingly bad.
- I am indebted to Mr. Waring for his kind permission to publish these notes.

### Ophthalmic Notes.

Four cases of Injury or Disease of the Orbit, recently in the Ophthalmic Ward under the care of Mr. Vernon, and reported with his permission.

1. Extensive hemorrhage into orbit; recovery.—W. D., æt. 14, was brought to the surgery with the history that on the previous day his brother hit him in the right eye with a stick. On examination there was found a slight degree of proptosis, and a small speck of blood beneath the conjunctiva to the outer side of the cornea (the true "blood-shot" eye). Next day he was brought up again in extreme proptosis, the lids purple, swollen, and so tense that they could not be separated. The mother now volunteered the further history that ten days ago the sash-line of a window breaking let the window down on the child's head; that the child's head was bruised, but the eye was not damaged. The child was at once admitted, and on examination under chloroform the subconjunctival hemorrhage was found to have extended all round the cornea, which was itself clear; there was a slight abrasion of the conjunctiva of the lower lid, and much chemosis.

For several days the proptosis continued slightly to increase, the lids becoming more and more tense, not covering now the edematous ocular conjunctiva, which protruded from between them. No movement of the eye was possible; the pupil reacted sluggishly. In other respects the child appeared quite well. His appearance was very remarkable. Six days after admission the condition began to improve; the lids closed again, the eyeball began to retreat, and to regain its mobility. The fundus could now be seen to be normal. In three weeks the condition was almost precisely the same as when seen in the surgery the first time.

The interest of the case lies in the following points:—(1) the question which injury was responsible for the hemorrhage; if, as seems more probable, it was the injury to the cranium, the length of time before the proptosis occurred is remarkable; (2) the suddenness of the proptosis, and the extreme grade to which it reached without any other untoward symptoms; and (3) the absence of any signs of pressure on the optic nerve.

2. New growth in orbit.—H. T., æt. 41, a farmer, admitted November 10th, gave the following history. Six weeks ago a bramble struck him across the right eye; he pulled out a piece an inch or so in length from a wound in the upper eyelid, which suppurred, was incised, and healed a week later. Since this time he has had a gradually increasing swelling in the right orbit. Patient further states that nine months ago a tumour in his left loin was removed. His doctor told him that this was a "fatty tumour," but privately communicates his opinion that it was a "spindle-celled sarcoma."

The patient is a healthy man with sound organs. He says his sister died of "cancer." The right eye is protruded to the extent of half an inch. On its outer side both above and below is felt a hard, slightly elastic mass; and on the external wall of the orbit is a swelling extending backwards into the temporal fossa, and upwards towards the scalp, its most prominent part being an inch behind the external canthus; the skin over it is reddened; there is no tenderness or fluctuation, and no enlargement of lymphatic glands. The movements of the eyeball are impeded in all directions, with consequent diplopia; the veins of the conjunctiva and sclerotic are injected. Distant vision is reduced to ⅙; near vision to 1/10 at ten inches. There is optic neuritis in both eyes, but the vision of the left is unimpaired. The fields of vision of both eyes are uniformly contracted, not exceeding 45° on the temporal side.

On examining the back an operation scar is seen over the left wing of the sacrum; this appears quite healthy, and there is no sign of recurrence. But now another tumour is found, 6 inches by 4 inches, lying to the left of and partially concealing the dorsal spines from second to sixth; it is smooth, very resistant, not attached to the skin, and not moving with the scapula. This is probably a bony growth, and the patient says he has been aware of it for twelve months, and believes it to be increasing.

The sequence of this perplexing history is, then, briefly—(1) twelve months, bony tumour in dorsal region; (2) nine months ago, "fatty tumour" removed from loin; (3) six weeks ago, injury to orbit, suppuration; (4) four or five weeks, growth of tumour in orbit; (5) ten days, spreading to temporal fossa.

November 14th.—An exploring needle was passed in several directions into the swelling on the temple, and only drew off a little blood.

19th.—Under chloroform an incision was made along the outer wall of the orbit, into which the orbital fat at once bulged; a little deeper a mass of soft growth was found, with the lacrimal gland embedded in it; a considerable extent of bone forming the roof and outer wall of the orbit was honeycombed and crumbling away, so that a director easily passed into the temporal fossa. The wound healed by first intention. Under the microscope the growth appears to be a species of "round-celled sarcoma" of unusual character.

Prognosis unfavourable. Chances of recurrence great, and further operation hardly possible.

3. New growth in orbit.—L. P., æt. 9, admitted November 3rd, was taken nine weeks ago to see an ophthalmic surgeon on account of a small lump growing at the inner angle of the right orbit. He removed a small hard growth connected with the ethmoid, and not encapsuled, and after ten days allowed the wound to granulate up. Microscopic examination gave no clue to the nature of the growth. Since the operation the right eye has looked downwards, and the child has had diplopia.

On examination the right eyeball is seen to be pushed forward; movement outward and upward is impaired. The operation scar is seen just below the eyebrow. A hard, lobulated mass is felt above the eyeball, between it and the upper margin of the orbit. There is optic neuritis in both eyes, more marked in the right.

November 5th.—Under chloroform an incision was made just below the old scar along the whole length of the lid, and a firm lobulated mass removed; at one point this was attached to the orbital plate of the ethmoid, in which a small hole was left on its removal. Microscopical examination showed it to be an "alveolar sarcoma." The wound healed by first intention, and the child has made an uninterrupted recovery, suffering no inconvenience except that she cannot raise her upper lid, and if the eye is opened she sees double.

4. Injury to optic nerve (?), followed by optic atrophy.—S. P., a boy æt. 9, two years ago fell from a hayrick on to a fork, which pierced his left eyebrow and upper lid. He was seen within an hour by a medical man, who found the eyeball uninjured, but within a week he completely lost the sight in that eye.

Now there is a scar at the margin of the upper lid, and some ptosis; well-marked strabismus of the left eye upwards and inwards; the optic disc is white, and the arteries rather small. He has no perception of light in it. Probably the hayfork penetrated the orbit above the globe and wounded the optic nerve without passing on into the brain, and perhaps the inflammatory contraction around its track accounts for the unusual direction of the strabismus of the blind eye.

### Notes.

MR. BRUCE CLARKE has succeeded Mr. Walsham as Surgeon in charge of the Orthopaedic Department.

BY MR. WARING'S ELECTION as Surgical Registrar, Mr. Bailey becomes Senior Demonstrator of Anatomy, while the vacant Demonstratorship has been filled by the appointment of Mr. Furnvall.

MR. LI. C. P. PHILLIPS has been appointed to the con-

sequent vacancy among the Assistant Demonstrators. These changes have necessitated a rearrangement of the hours of attendance of the Demonstrators and Assistant Demonstrators in the "Rooms." It will probably be convenient if we give the new time-table here.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Mr. Bailey.....	10-1	1-4	10-1	10-1	1-4	
Mr. Furnivall ..	1-4	10-1	1-4	1-4	10-1	
Mr. Sloane.....	10-1	1-4	10-1	10-1	1-4	10-1
Mr. Miles .....	1-4	10-1	1-4	1-4	10-1	10-1
Mr. Phillips ...	10-1	1-4	10-1	10-1	10-1	10-1

DR. JAMES MORRISON has been elected Demonstrator of Midwifery in succession to Dr. C. H. Roberts. It is worth recalling the fact that during Dr. Roberts's five years' tenure of this office the Gold Medal in Obstetrics at the London M.B. has fallen to a Bart.'s man on the last four occasions.

MR. T. STRANGEWAYS PIGG has been elected Demonstrator of Pathology in the University of Cambridge.

DR. H. MORLEY FLETCHER has been appointed Assistant Curator of the Museum.

THE WALSHINGHAM MEDALS at Cambridge, for the best research in Biological or Geological Science by candidates under M.A. standing, have been awarded to two Bart.'s men—Mr. V. H. Blackman and Mr. W. Morley Fletcher—both of them being scholars of our Medical School.

WE CONGRATULATE Mr. Emery on obtaining qualifying marks for the Gold Medal at the recent London M.D. examination, and Mr. Toye on securing a similar distinction in the Examination for Honours at the B.S.

MR. F. W. ROBERTSON, M.B., B.S., has been appointed Extern Midwifery Assistant.

SO OUR light-hearted contemporary, the *Guyoscope*, has expired; in its last number the editor pronounces its funeral oration. Alack! it

"Did but drift a little way  
Adown the stream of time."

AGAINST this lamented death may be set the birth of the *Sphygmograph* at the London Hospital. From the first number it appears to be chiefly retained in the athletic interest. Surely this could have been served more usefully by hearty co-operation with the *London Hospital Gazette* than by dividing the interests in this way. The *Guyoscope*, to give it due credit, had, at least, a more definite *raison d'être*.

THE ENERGETIC *Student*, the organ of the Edinburgh Students' Representative Council, has produced an admirable souvenir of the opening of the McEwen Hall, one well

worthy of such an interesting occasion. The photographs give a very vivid idea of the beautiful building presented to the University by Mr. McEwen's munificence. We congratulate the management on their enterprise.

THE Hospital Museum has, we understand, come in for two valuable presents. Sir Robert Craven, of Hull, has given an excellent collection of calculi, and Miss Palmer the unique microscopical preparations of the diseases of the central nervous system made by her father, the late Dr. Palmer, Superintendent of the Lincoln Asylum, and an old Bart.'s man.

DR. MORRISON'S views on routine douching of the puerperal uterus, as recently expressed in our pages, continue to excite discussion. Pressure on our space prevents the publication of a communication from Mr. L. A. Winter on this subject till our next number.

Amalgamated Clubs.

RUGBY UNION FOOTBALL CLUB.

ST. BART.'S v. R.I.E.C.

This match, played at Cooper's Hill on November 6th, resulted in a severe defeat by 2 goals, 2 penalty goals, and a try (19 points) to nil.

The first stages of the game were fairly even, the forwards being very evenly matched. The home outsides combined well, and brought the game down to our 25, where from a free kick for off-side play they placed a goal. After this Bart.'s played in ragged fashion, and two more goals were obtained before half-time.

After the resumption our forwards played a much more spirited game, and on several occasions we got near the line. Eventually the ball was taken back and another penalty goal kicked against us, and just at the call of time the home team scored another try.

Body at back played well, but the other outsides did not give him enough support in tackling. This fault should be remedied at once. The foot work of the forwards was good, and Bennett and Amsler were often conspicuous in defence.

Team.—C. A. S. Body (back); S. Mason, C. Dix, T. A. Mayo, J. M. Pews (three-quarters); A. W. Nuthall, A. L. Vaughan (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, F. H. Noke (forwards).

ST. BART.'S v. R.M.C.

On Saturday, November 13th, at Sandhurst. The home team had a very heavy lot of forwards, and beat us by a goal and 3 tries (14 points) to nil.

The first half was well contested, R.M.C. scoring only 1 try, but afterwards our play fell off, and the defence was decidedly weak.

Body was unable to play owing to an injury, and Dix had to take his place at back; the three-quarter line was consequently somewhat disorganised.

Team.—C. Dix (back); S. Mason, T. A. Mayo, G. C. Marrack, J. M. Pews (three-quarters); H. Walker, A. W. Nuthall (halves); W. F. Bennett (capt.); A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. MARLBOROUGH NOMADS.

Saturday, November 20th, at Stamford Bridge. Playing with a weakened team, we were no match for the Nomads, who beat us by 2 goals, a dropped goal, and 2 tries (20 points) to nil.

We held our own fairly well in the "scrum," but when once the ball was loose our weakness was apparent.

The two halves and Bennett and O'Neill played best for us in a very disappointing game.

Team.—C. Dix (back); T. A. Mayo, J. C. Sale, J. M. Pews,

C. A. S. Ridout (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, H. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. CROYDON.

On November 27th, at Croydon. The home team beat us by a goal, a penalty goal, and a try (11 points) to nil.

We were very unlucky to be beaten by so much, as we had quite as much of the game as our opponents, and had had luck in not scoring. We went off with a good dash, and pressed hard for some time. The home team managed to clear their lines, and worked the ball down, and kicked a penalty goal for which off-side play was responsible. Directly afterwards Croydon got another goal from a try. After half-time our outsides were conspicuous for some excellent runs, both Mayo and Mason nearly scoring, and the forwards made some excellent dribbles. Croydon scored once more, after an excellent run by one of their three-quarters.

ST. BART.'S v. OLD LEYSIANS.

December 4th, at Stamford Bridge. After a succession of defeats we managed to win this match by the wide margin of 4 goals 2 tries (26 points) to 1 try. Directly after the kick-off Bennett dribbled down to the line, and passed to Robbs, who easily scored. Shortly afterwards Dix intercepted a pass and transferred to Mayo, who after a good run scored between the posts. We scored twice more in the first half through Wells, who made two excellent runs. The O.L.'s back received a nasty kick, but pluckily continued to play.

In the second half we had nearly all the game, and scored twice more through O'Neill and Robbs; O'Neill converted 3 tries, and Mason converted 1. The form displayed by the whole team was excellent. The passing was particularly good. The Old Leysians were not at full strength, and were never dangerous except when they scored their try by a good forward dribble.

Team.—C. A. S. Ridout (back); S. Mason, C. Dix, T. A. Mayo, J. M. Pews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. OLD MERCHANT TAYLORS.

December 11th, at Richmond. This match after a close game resulted in favour of the O.M.T.'s by 1 try to nil. During the first half the game fluctuated considerably, both lines being invaded, but at half-time there was no score. Shortly after the resumption the Taylors scored a rather lucky try. This roused us, and we very nearly equalised, Dix being pushed into touch at the crucial moment. Nothing further was done.

Team.—C. A. S. Ridout (back); S. Mason, C. Dix, T. A. Mayo, J. M. Pews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. UPPER CLAPTON.

December 18th. This match had to be abandoned owing to a dense fog.

ASSOCIATION FOOTBALL CLUB.

ST. BART.'S v. CIVIL SERVICE.

Played at Chiswick Park on November 20th. Result, a win for Bart.'s by 3 goals to 2.

This was a very creditable performance on the part of the Hospital, as Talbot did not turn up at all, and Marrett was *hors de combat* in the second half, so practically the Hospital played with three forwards, and each of these three, Whitaker, Willett, and Hughes, scored a goal in the second half.

Civil Service went off with a rush, and had the best of matters for the first quarter of an hour, scoring their first goal in that time. Then Bart.'s settled down, and though they played fairly well together they did not score, although Whitaker had hard luck on one occasion when he put in a clever last shot, but later on Civil Service got the lead again; Bart.'s were then fairly on their mettle, and in the last quarter of an hour scored twice more, thus leaving the held with a well-deserved victory.

Butcher kept goal well, and Stone made a good show in his first appearance as a back. All the halves worked well; their passing is improving, being not so hard, and more along the ground. The play of the three forwards mentioned above was excellent, and Marrett, while fit, played a dashing game.

Team.—H. H. Butcher (goal); G. W. Stone, L. Orton (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); J. A. Willett, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

On November 24th the Casuals were unable to bring a team, so their match was scratched.

LONDON SENIOR CUP TIE.

ST. BART.'S v. BARNET.

On November 27th at High Barnet. Result, defeat by 4 goals to nil.

The first half-time, though Barnet had the best of it, St. Bart.'s managed to keep the home team out; thanks chiefly to some splendid "saves" by Butcher, and good work by the backs and halves.

Stone got away once for the Hospital, but shot over; this was hard luck, and due to the long grass and the downhill nature of the ground, as he was going at a tremendous pace.

In the second half Barnet gradually asserted their superiority, and soon scored a goal. An odd decision of a penalty by referee soon gave them another. After that in the failing light Barnet added two more, Bart.'s not knowing the ground well enough.

Several factors combined against Bart.'s and caused their defeat. The ground was as bad as could be wished, and the gale of wind made matters worse. The Barnet team did not play the game that Bart.'s are accustomed to; hence the disappointing game and result. There is one bright spot, however, and that is the magnificent display of Butcher in goal; he did many brilliant things, and made no mistake. Orton at back was also very sound.

Team.—H. H. Butcher (goal); L. Orton, C. H. Turner, E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, L. E. Whitaker, G. W. Stone, H. N. Marrett (forwards).

Barnet.—C. W. Cloutte (goal); J. T. Easton, S. G. Slack (backs); A. Belcher, W. Kinsley, J. McCleod (half-backs); W. James, C. Langley, J. Prince, T. H. Edey, and P. Cocks (forwards).

ST. BART.'S v. TUNBRIDGE WELLS.

Played at Tunbridge Wells on December 4th. Tunbridge Wells were without Wilson and Vace, while Willett, Talbot, and Bostock were absent from the Hospital team.

Whitaker won the toss, and after a few minutes Hughes had hard luck in not scoring with a hot shot that hit the bar. Tunbridge Wells then had a turn, and though Butcher saved from B. Murdoch, Tossell opened the score for our opponents.

Bart.'s played up hard, and Stone and Whitaker scored, putting Bart.'s ahead. Before half-time, however, C. Murdoch had made matters equal. On restarting give-and-take play ensued, a *mêlée* in front of the Hospital goal resulting in one of the Bart.'s side heading the ball into his own goal, giving the Wells a lead of 3-2. Bart.'s did not allow this state of affairs long, and Stone soon equalised. The rest of the game was fast and exciting, but as the shooting fell off neither side could score, leaving the result a draw of 3 goals all— which fairly represented the game.

Team.—C. W. Ward made a very good first appearance in the Hospital team.

St. Bart.'s.—H. H. Butcher (goal); L. Orton, C. H. Turner (backs); E. H. Scholefield, C. G. Watson, R. Alderemith (half backs); V. G. Ward, G. W. Stone, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

Tunbridge Wells. R. H. Jones (goal); H. A. Barton and S. Lambert; J. Cowman, A. Macdonald, S. S. Weekes, B. Murdoch, C. Murdoch, F. S. Tossell, H. N. Haslam, and M. Nash.

The match v. Sittingbourne that should have been played December 8th has been postponed till March 9th.

ST. BART.'S v. NEWBURY.

December 11th, lost 2-4.

St. Bart.'s were very weakly represented, no less than five of the team being away; and to make matters worse Willett, owing to a mistake, did not turn up, a local substitute taking his place.

Bart.'s won the toss, and started with the wind; though Newbury pressed, Marrett soon broke away, and from a good run and centre Whitaker scored the first goal for the Hospital.

Play continued level, and shortly before the interval Whitaker intercepted a pass between the Newbury backs, and going right through, scored a second goal for Bart.'s. Although in this half Newbury pressed a good deal, Body safely negotiated their shots.

From the re-start Newbury went away, and soon scored their first goal, which was quickly followed by a second. More even play followed, and Whitaker on two occasions only just missed scoring;

but his efforts were not backed up, as Murdoch on the inside left had strained his leg early in the game.

A mistake by Orton resulted in a third goal for Newbury, and just on time their inside right added another.

Considering the strength—or rather the weakness—of our team, the result might have been much worse, and all the team played up well. Whitaker played splendidly at centre, and Marrett was good; of the back division Scholefield, Waterfield, and Orton bore the brunt of the work.

Team.—T. M. Body (goal); L. Orton and C. H. Turner (backs); R. Scholefield, C. G. Watson, and R. Waterfield (half-backs); A. S. Woodward, L. E. Whitaker, C. Murdoch, H. N. Marrett, and A. Substitute (forwards).

The match v. Pemberton, at Winchmore Hill for Saturday, December 18th, had to be scratched, as the Hospital could not raise a team.

The draw for the Inter-Hospital Cup first round is as follows:

Charing Cross ..... Guy's.  
London ..... Middlesex.  
St. Mary's ..... St. Bart's.  
St. Thomas's ..... University.

### Ibernetian Society.



MEETING of the above Society was held on Thursday, December 18th, 1897, Mr. Horder, Vice-President, in the Chair. Mr. Paterson gave a demonstration of the apparatus used in his administration of gas and oxygen. He held that with this a patient could be kept anaesthetised for half an hour and over, with a minimum of danger and practically no distress to the patient; another advantage claimed being that there were very few of the after effects which are so common in ether and chloroform; if a patient were sick at all after the administration, he rarely was so more than once.

The Vice-President then introduced Mr. Wallis, and said how pleased the Society was to welcome him back into its midst again.

Mr. Wallis, after a few preliminary remarks about the pleasure it afforded him to be back once again in "the old Abernetian vaults," and the happy times that he had spent there, read a paper entitled "Some Points in the Diagnosis and Treatment of Pott's Disease of the Spine." He pointed out how that very frequently the very first symptoms of Pott's disease were mistaken for ordinary lateral curvature, and treated accordingly, the result being disastrous to the welfare of the patient. Two cases of this description were cited.

Then, how great a necessity there is for clearly distinguishing between hip and spinal disease; and this is most likely to occur when the lumbar spine is affected.

With regard to treatment:

*Aspiration.*—Aspiration with injection of iodoform emulsion and opening and draining, the speaker did not regard as good treatment, except in special circumstances. Mr. Treves' operation of an opening in the loin he did not adopt, because in the first place he considered the abscess very difficult to find that way, there being so little room, and also

because of the rarity of the presence of a sequestrum, for which this operation was originally performed. The method recommended is as follows:

The skin being scrupulously prepared, the abscess is opened above Poupart's ligament by an oblique incision, avoiding the peritoneum; and a counter opening made in the loin by cutting on a pair of curved forceps introduced through the abdominal incision. The sac is thoroughly scraped with a Volkmann's spoon, mopped out with cotton wool, and flushed with 1 in 2000 perchloride. Then a preparation of iodoform paste made by mixing the powder with 5 per cent. solution of carbolic acid is rubbed into the sac wall. The anterior incision is then closed by a continuous suture, and smeared over with iodoform paste, followed by collodion. A long strip of iodoform gauze is pushed into the lumbar wound to act as a pack and drain for about twenty-four hours; it is then removed and the wound sewn up. This treatment Mr. Wallis has adopted for some time, and found it answer extremely well.

### The Bahere Lodge, No. 2546.

AN Ordinary Meeting of the Bahere Lodge was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, December 14th, 1897, Bro. W. G. Walsham, W.M., in the chair.

Bros. Hampton and Miles were raised to the third degree in Freemasonry by the W.M. Bros. Auden, Marshall, Bill, Cripps-Lawrence, Adams, Westbrook, Trechmann, and Surgeon Folliott, R.N., were passed to the second degree by W. Bro. Gilbertson. Dr. J. B. Christopherson was elected a member of the Lodge, and was afterwards initiated into the mysteries and privileges of Ancient Freemasonry by W. Bro. E. C. Cripps. Bro. Arnold W. Izard, of the Isaac Newton University Lodge, No. 859, was elected a joining member.

The W.M. Bro. Walsham was appointed to represent the Lodge at the forthcoming Centenary Festival of the Royal Masonic Institution for Boys, and W. Bro. Ashton Godwin offered to serve as a steward on the same occasion. The Lodge granted a sum of £21 to the British Medical Benevolent Fund, and afterwards appointed as the trustees of its own Funds W. Bro. Clement Godson, W. Bro. Gripper, Bro. the Rev. Sir Dorradaile Savory, Dart, and Bro. W. H. Cross.

The members of the Lodge with their guests afterwards dined together, to the number of forty. The evening was enlivened with unusually good music; the singing of Bros. Cripps, McCann, and Valérie, and the pianoforte and violin recitations of W. Bro. Burns and Bro. Trechmann receiving especial applause.

### Dinner to Dr. W. J. Collins.



HE Complimentary Dinner to Dr. Collins, given on December 16th at the Trocadero, was a great success in every way. Mr. Marsh was in the chair, and no less than 128 old Bart.'s men assembled in honour of the guest of the evening, amongst them being Sir R. Craven (Hull), Mr. Henry Power, Mr. Willett, Sir Richard Thorne Thorne, Dr. Griffith, Mr. Bowlby, Mr. Lockwood, Dr. Clay Shaw, Mr. Jessop, Mr. Berry, Mr. D'Arcy Power, Dr. Shore, Dr. Calvert, Mr. Womack, Mr. Waring, Mr. Leonard Mark, Dr. Robert Jones (Claybury Asylum), and Mr. Reginald Harrison. Letters expressing regret at being unable to be present were received from Dr. Church, Mr. Vernon, Dr. West, Dr. Alexander Hill (Cambridge), Mr. Barling (Birmingham), Surgeon-Captain Rayner, and others.

The dinner was good, and the band played an excellent selection. Mr. Marsh's genial spirit infected the whole company, and everyone thoroughly enjoyed themselves. Mr. Leonard Mark had designed a most appropriate and much admired menu card, the framed original for which, together with an album containing the names of those present, was presented to Dr. Collins during the evening. The Secretaries were Mr. Bruce Clarke, Mr. R. W. Lloyd, and Mr. Ernest Clarke, to whose energetic organisation all who were present are indebted.

After dinner Mr. Marsh rose, amid cheers, and said: "I have now to propose the health of our guest this evening, Dr. Collins, formerly a student of our medical school, and now chairman of the L.C.C. This is the toast of the evening, but I shall extend its range and term it also the toast of the Medical School of St. Bartholomew's Hospital and of the L.C.C. itself. It is obviously the toast of the evening, for it is the very thing we have come here to drink in bumpers. It is in a certain sense the toast of our Medical School, for amongst the men who have been distinguished there Dr. Collins has achieved a highly distinguished, and in fact a remarkable position. And I will call it the toast of the L.C.C. The L.C.C. is a somewhat heterogeneous body, composed of a number of groups that can very seldom be unanimous. The Council would not be unanimous, I suspect, if the question were what changes should be made in the arrangement and method of working of the Solar System; or, again, what course should be pursued in relation to Mrs. Ormiston Chant and her propaganda. But I believe there is one thing that would bring these different groups into complete harmony, and that would be an opportunity of drinking Dr. Collins's health, and acknowledging the heavy debt of gratitude under which he has laid the Council by the services he has rendered them as their Chairman.

"It seems obvious that so large and divided a body as the L.C.C. could do no useful work at all except under the guidance of a strong chairman, and as to what sort of a chairman Dr. Collins has been I have some information which I will give you presently.

"We all remember Dr. Collins as one of the most brilliant students we have ever had at St. Bartholomew's Hospital, and how he cut the record at the University of London. But it is not enough that a man should take a handful of prizes. Many can do this, and are good for nothing else. They are instances of irregular hypertrophy, with atrophy in other directions. But we all know that Job Collins was not a man of this kind. His performances in what I will call the prize ring, where he was such a notable bruiser, were only on a level with his other achievements, and an index of his general mental equipment. Now in what a striking manner has his medical diagnosis (and medical diagnoses have not always turned out to be correct) been confirmed by Dr. Collins's work in the wider arena in which he is at present occupied.

"The position he has achieved I may term without any exaggeration a really remarkable one. Only a few years ago he was merely a medical student with no connection with, or specially favorable introduction to public life. Now he is one of some six or seven positions in the largest, the richest, the most complex and the most powerful city that the world has ever seen; and let me remind you that Dr. Collins has attained this position although he is only just thirty-eight.

"Now, such immortals as Byron, Keats, and Shelley attained, or shall I say disclosed their immortality, before they were thirty; but these and their competers must be left in a group by themselves; when, however, we come down from the immortals to men who are only remarkable, what do we find? Pitt was Prime Minister before he was twenty-four, but he had exceptional advantages, and circum-

stances were altogether in his favour. Now, setting him aside and keeping to the present century, I do not remember anyone who has reached such a position at his age, and considering his antecedents, as that which Dr. Collins now occupies.

"But now let me ask how he has discharged the duties of his office? As chairman of the L.C.C. is he a failure, or is he a success? Must we regard him as the fly in amber, and "wonder how the devil he got there?" Well, I have some information as to the manner in which he has acquitted himself, and this comes not from his own side, but from those who, if they could, would have prevented his election; and more than that, it comes from three men who occupy a high position in the Council. One told me that Dr. Collins was a very able chairman, level-headed, a thorough master of the constitution and working of the Council, dignified, judicious, and judicial. Another said that he was, in his opinion, the best chairman they had ever had, not excepting Lord Rosebery. A third—and this seemed to me the strongest praise of all—that Dr. Collins had done what he could to discredit the influence of party spirit in the Council, and to secure the consideration of the different questions that were brought forward on their merits, instead of on the lines of party politics.

"There are three chief types of men who are concerned in the affairs of a state. The first, who is devoured by personal ambition and a desire to make himself a master of the world, and who is by no means scrupulous as to the measures he adopts—such was Julius Cæsar. Well, let us congratulate Dr. Collins and ourselves that he is not a new Julius Cæsar. Then there is the man who, however splendid his abilities, sees affairs in so many aspects that he is unable to concentrate his efforts on a single line of action, and thus he fails. Cicero well illustrates this type. From this point of view our guest is no Cicero. But yet in another aspect, that is in regard to his oratory, there is much of the Cicero in him. The third type is that of the man who makes his own personal advancement and everything else subservient to the welfare of the state. This type is represented by Cato. Now let us remember that Cato was the only one of these three who died in his bed. He reached a ripe old age, and at the end of it was able to say that he only regretted three things; first, that he had once gone by water when he might have travelled by land; the second, that he had spent an idle day; the third, that he had told a secret to his wife. And Cicero held him in such regard that he introduced him as his main character in his treatise *De Senectute*. Well, from what I have said there is reason to believe that Dr. Collins will become a second Cato. Let us, therefore, very heartily drink to the health of Cicero, Cato, Collins—names the initials of which, I am reminded by Dr. Godson, correspond with the two C's in the title of the body over which he presides. Let me remind him that this meeting is a meeting of those who know him best, and are therefore best qualified to judge of his character and work. I will ask him to accept this album containing the names of those who are here this evening, and also this design by his old friend Leonard Mark—which represents on the one hand the Chairman of the County Council on his judgment seat, and on the other a view of St. Bartholomew's Hospital; and let me hope, Dr. Collins, that as you look around you upon this scene and on this company, and as you glance at these small presents, we may anticipate that "*forsan et hæc olim meminisse juvabit.*"

Dr. Collins then said, "Mr. Marsh and gentlemen, one would indeed be a numskull and a heartless person if one were not profoundly touched by this expression of your good-will. The whole conception organised, the kind words spoken by yourself, and the way this toast has been received, almost overwhelm me. I might well remain silent, as I can hardly find adequate language in which to express my feelings. Presiding at the London County Council, so far from encouraging oratory, tends to suppress it. I found the Abernetian Society a far more suitable atmosphere for the practice of oratory. At the London County Council the fifteen minutes rule tends to discourage eloquence; it suffices for remarks, but scarcely allows the delivery of speeches. Moreover, the exigencies of office have during this year prevented me from taking part in the debates. Well, Mr. Marsh, I must at once discount the too generous praise in which you have indulged; I must attribute these classical references to your superabundant generosity, and when I have abstracted from your words such epithets as are due to this cause, I am still compelled to conclude that the charge of megalomania made against the County Council must include other persons as well; further, I must add that my friend Dr. Clay Shaw has evidently not the complete control of those people who entertain large delusions in reference to the capacities of their fellows.

"Gentlemen, I find great difficulty in knowing what I am to say on this occasion, being in a sense the objective of this banquet. I must



not talk shop; that would ill requite your hospitality. I must not talk politics; Mr. Henry Clarke, representing the side to which when not in office I have not the honour to belong, is present, and would very properly resent such reference. I can hardly talk about myself; that would be a very unengaging topic, and practically everyone in this room has known me for more than half my life. I asked myself as I was coming here to-night, however it was I came to be connected with St. Bartholomew's Hospital at all. I went to University College School; the site of that edifice was formerly the receptacle of the dead dogs and cats of London, and rejoiced in the appellation of "Stinkomake," on that site arose the now famous school, whose object was to give the rudiments of liberal education to Jews, Turks, infidels, and heretics. If its atmosphere were somewhat liberal and progressive, on the other hand that of St. Bartholomew's is perhaps somewhat conservative and moderate, but, sir, I shall ever look back upon that decade of student, resident, and teacher life at St. Bart's as perhaps the happiest years I can remember. It is associated with undying memories of friendships. I also was brought in contact with city life, that life of which Mr. Henry Clarke is so worthily a representative, "the old city," as it is irreverently termed in a Royal Commission, because known to me, and its history was traced out in my daily walks in the old walls, and gates, and churches, and the historic memories of Smithfield. No one acquainted with these old buildings about St. Bart's could fail to wish that even in the hurly-burly of politics no irreverent hand should lightly hurl the contumelious stone against a body which in its day withstood kings, princes, and barons, and in the darkest days of English history stood out for enlightenment, liberty, and progress.

Many of us here remember October 1st, 1876. Very green and fresh we were, and when we found ourselves at St. Bart's we must have felt indeed like the flies in amber. Well, sir, if I had to determine what it was that finally induced me to enter St. Bart's, I should have to attribute it to the seductive fascination of the then Warden of the School. I had not a single friend in the place; the first man I spoke to, or rather who spoke to me, was Hocken, whose romantic courtship, marriage, and untimely death far from these shores is known to all. "I believe we have to walk the Hospital," he said to me, and we forthwith peeped into one of the wards, but the black looks of the Sister, who pursued us like a Gorgon, frightened us away, and that was our only experience of walking the Hospital for at least another two years. St. Bart's twenty-one years ago was very different to what it is now. Sir James Paget, I believe, once lectured on St. Bartholomew's Hospital fifty years ago; great changes have taken place even since 1876, which we recall vividly. The old room of the Abernethian Society is gone; the Society for a while occupied a temporary iron shed called the "kettle," where I remember many speeches and debates, and where the subsequent refreshment was served by Mr. Pickering. There was to me always somewhat of a pathological flavour about the tea, probably owing to the manner in which that worthy official was engaged during the earlier part of the day. It is not for me to fight again those old Homeric battles. I will, however, take some credit for one thing; it was proposed that the nurses should be allowed to attend some of the meetings of the Abernethian Society; this was looked upon as revolutionary, and the first time it was mooted I was the only one who voted for it, I believe. It has now, however, become a well-established, and I understand a very successful custom, Matron and nurses attending in all their glory; apparently in this instance, at any rate, I was a reformer in advance of his time. Mr. Bruce Clarke I remember well as house surgeon, and I owe much to his encouragement; he was always most kind to me, and seemed to have a regard for me quite out of proportion to the facts of the case. Many of those with us then have now passed away; I must mention one of them—one to whom I owe a great deal—my old chief James Matthews Duncan. The fiery rectitude and the wholesome scepticism which he brought to bear on his work were, I venture to say, very valuable additions to St. Bart's.

"Well, Mr. Chairman, I have heard it said outside that it is unwise for a medical man to mix in public life; I do not think this is so, at any rate as regards the kind of work performed by the body over which I have the honour to preside; it is largely concerned, as you know, in ministering to the public health. In the latter part of the last century the chief political considerations seem to have been in regard to the "wealth of nations," at the end of this century, I venture to think, our politicians are as much if not more concerned with the "health of nations." I cannot help thinking that the participation of medical men in municipal administration is most valuable, and that doctors are at least as great a necessity there as any other profession,

"A wise physician skilled our wounds to heal,  
Is more than armies to the public weal;"

and I, at any rate, maintain that in administrative public work, medical men are greatly needed. What are some of the duties that the London County Council has to perform? We have to deal with sewage, and to dispose of 78,000,000 gallons from more than 4,000,000 persons; we have to deal with the housing of the poor, a branch of work in which Dr. Young and Dr. Hamer, who are here to-night—both of them Bartholomew's men—have rendered valuable services; then we have 1300 lunatics under our control, and Bart's has helped us again in this respect by giving us Dr. Claye Shaw and Dr. Robert Jones, who are among the great authorities in alienist medicine; then we have the water-supply, the regulation of coroners' duties, in all of which medical knowledge is involved or at least desirable. But I go further, sir, and I claim that the training of medical men should specially qualify them for the public service. Why should other professions have the monopoly of it? In France the engineers take an active part. What is the difference between a surgeon and an engineer? The surgeon operates on man, and the engineer operates on nature. Why should public work be so much given up to the lawyers? Why have they such a disproportionate representation? I claim that a medical training marks men for a public life. For what is diagnosis in its ultimate analysis but the prompt apprehension of minute differences? What is prognosis but judgment in provision based upon accurate past experience; and what is treatment in its final essence but resourcefulness in case of emergency,—all qualities I maintain in the highest degree valuable in public life. As for myself, I hope it is unnecessary before this audience to plead an apology for my life; to those who put forward the myth that my public duties have made me give up my profession, of which I am proud, I would say that I utterly repudiate any such notion. Many of us have grateful recollections of Mr. Marsh's lectures on practical surgery, and even to-day I took down my note-book and read again some of his well-remembered tips, with which he literally covered the body from top to bottom; he began with Pott's puffy swelling, and concluded with the fundamental distinctions between blind internal and external fistule. Lastly, let me say that it was no desire of mine that ended my career at St. Bartholomew's Hospital. I completed my period of two years as assistant demonstrator of anatomy, and my application to serve for another year was refused. The result was conveyed to me by Mr. Willett, and this he did in so delicate a manner that I verily believe I should have been satisfied under his genial kindness and direction even if I had been led to execution or to the stake. My first experience in residence as house surgeon was under Mr. Henry Power, and I have the most grateful recollection of his exemplary courtesy and kindness. That year in residence was a delightful one, though the delight did not exactly arise out of the quarters in which we lived. The arrangements were somewhat odd; into the room where I lived as midwifery assistant the light of heaven was never capable of entering, and at night I was lulled to sleep by the discordant noises of Smithfield Market carts.

"In those days, however, I learnt the geography of the city, and my experience in going about to cases of placenta previa stood me in good stead the other day at the Cripplegate fire, as it enabled me to thread my way with the Chairman of the Fire Brigade Committee to the spot.

"Mr. Marsh and gentlemen, I am afraid I am indulging in rather egotistical recollections, with which I promised at the outset not to bore you, so I will draw my remarks to a close. I am profoundly grateful for your hospitality, and I can only say that while in my work as Chairman of the London County Council, a post of importance and responsibility unsurpassed by any of the kind in the kingdom, I have often felt the anxieties well-nigh overwhelming, I have been and shall be greatly supported and inspired by evidences such as those I have received to-night, and which seem to indicate that I retain the esteem of my professional brethren.

"The sketch so kindly made by Mr. Leonard Mark, and the album of autographs you have handed to me, will remain with me among my most precious possessions as long as life lasts."

We regret that lack of space prevents our reporting the other speeches in full.

Sir R. Thorne Thorne proposed the health of the Chairman in a felicitous speech, and Mr. Marsh responded. Mr. Willett then proposed the toast of the Honorary Secretaries.

Mr. Duce Clarke, Mr. Ernest Clarke, and Mr. Lloyd each replied in suitable terms, and thus a highly successful evening was brought to a close.

## Christmas in the Wards.



GREAT deal of energy and originality was displayed over the Christmas celebrations in the wards this year.

The decorations everywhere were quite up to their usual standard—fairly lights, Chinese lanterns, and ivy trails forming the most salient features. In one or two wards notably, Paget and Martha, a less distinctively Christmas, though undoubtedly elegant character was achieved by graceful draperies and colour schemes.

Though the time-honoured Christmas tree was represented on a sumptuous scale in Faith and Lucas, a new departure was successfully carried out in Elizabeth and Paget, in the form of erections purporting to be fancy fairs or stalls, on which presents for the patients were arranged, and a mimic sale was conducted in a spirited manner by the respective Sisters.

In Luke a very effective animal, natural order vague, but representing impartially a Polar bear or a lamb, was filled with presents, and led round the ward on wheels to the delight of the patients. In Darker yet another new departure was to be met with. The old-fashioned bran-pie was superseded here by the counterfeit presentment of a real pie with crust, the presents coming out of a hole in the top. Placed on a table with a real tablecloth, knife, fork, and spoon, the illusion was complete. "A slice of Sister's bran-pie" was in great demand by the patients throughout the evening.

Presents of warm clothing and useful things were mostly distributed early in the day, leaving the rest of the day free for the various entertainments.

A seasonable spirit of pantomime seemed to have taken possession of the "Entertainment Committee" this year; Stanley boasted a very pretty little boy dressed as a Pierrot; in Elizabeth two tiny gauzy-winged fairies representing holly and mistletoe flitted about in great enjoyment of the bright scene, and certainly well deserved the admiration bestowed on them. Sweets were distributed by a little "Japanese lady," who in a real "kimono" looked remarkably quaint and picturesque.

Extremely amusing and carried out with much skill were the "monkey" and the "donkey," the latter drawing a cart containing presents for Silwell patients; much admiration was excited by their simian and asinine antics, performed with untiring energy and good nature, under somewhat trying conditions probably.

Music, professional and amateur, was varied and much appreciated everywhere, but of the latter first place must without doubt be given to the twelve "doughtie men" who performed in the "Bigophone" band, and "played" in such an exhilarating style to most varied audiences.

Some charming glees were given by Messrs. Drury Hussey, Douglas, and S. F. Smith; the latter accompanying on the banjo. As with the bigophone, each ward where they sang would have gladly retained their services for the whole evening.

A Pierrot and Pierrette troupe, consisting of Messrs. Grace, Horder, Coleman, Dyer, Walker, Miss Pritchard and Miss Coleman, played and sang, and provided a delightfully novel entertainment to both eye and ear. Their "get up" was particularly successful.

A professional quartette of glee singers most kindly gave their services towards the amusement of the patients, and needless to say were greatly applauded. Other entertainments, e.g. a phonograph, magic lanterns, conjuring, fish-ponds, &c., were all much enjoyed by the patients, and helped once more to make Christmas Day in the Hospital a thoroughly happy one.

## The Christmas Entertainment.



HOSE who were responsible for the Annual Performance are to be heartily congratulated on the very excellent entertainment they provided last week. We should be inclined to criticise the choice of the second piece—

"Weak Woman"—for a performance of this sort, as the play depends so much on its effect on the female interest, which makes it a very bold one for men to attempt. However, having been chosen, we have nothing but praise for the performance.

The evening began after the overture to "Rosamunde" had been played by the Hospital orchestra—with "The Duchess of Bayswater and Co." which went exceedingly well on the whole.

The very amusing part of Sir Jeremy Joles was in the safe hands of Mr. Brownlow, who, although he undertook the part on short notice, succeeded in giving a most admirable and humorous interpretation of the character; his appearance and make-up were most effective, and he made his many points with the greatest success. Mr. Hobday, as the trades-smiter Duke, played excellently, although it was a little difficult to hear him from the back of the hall. His matter-of-fact proposal was especially funny. Mr. Tweedie, both in this piece and in "Weak Woman," kept up a most trying falsetto voice with really commendable energy and success. Of the rest Mr. Meakin was responsible for Caryl Stubbs, and, though a little cold in his love-making, acted very well. Mr. Hawes made a very stately and effective Jenkyns, and Mr. Slade looked admirable as Kathleen. The play generally went with a smoothness and vigour that reflected the greatest credit on the stage management and coaching.

The second part began with two glees—"Gipsy Life" and "Three Doughtie Men"—by the Hospital Choral Society, who, in spite of a most uncomfortable crowding on the small stage, sang with vigour and accuracy. Our thanks are due to Nurse Carson, who accompanied on Thursday night at very short notice, owing to the pardonable absence of the accompanist. On this evening Mr. S. F. Smith sang "A May Morning" very well, and Nurse Ball charmed us again with "Butterflies," for which she gained a well-merited encore. On Friday the feature of the evening was the singing of Madame Giulia Ravogli. She most kindly sang four songs in response to repeated demands; one each from "Faust," "Carmen," and "Lucrezia Borgia" respectively, and "Kathleen Mavourneen," and it is hard to say which was the most delightful. Mr. P. Wood presented her with a bouquet on behalf of the Musical Society. His own singing of "The Golden Vanity" calls for the highest praise; and this we give in saying that he excelled all his previous efforts.

The third part followed a brief interval for refreshments. The Dramatic Society came out triumphantly from the ordeal of playing "Weak Woman." The play opened in a most charming out-of-door scene, in which we are introduced to two supposed heiresses—Helen and Lilian Gaythorne—who labour under the disadvantage of an unknown will. The various adventures of the several suitors for the hand and fortune of the fortunate owner of the property furnishes the motive of the comedy. Mr. Whitaker as Arthur Medwyn, a gentleman farmer, opened the play, and was successful throughout, though he had, perhaps, a tendency to underact the part. Mr. Meade made an excellent character of the fatuous Tootal, and Mr. Gibson played the Doctor with becoming decorum and dignity. The very difficult parts of the two young ladies were taken respectively by Mr. Slade and Mr. Grenfell, and they are to be heartily congratulated on their appearance and performance. Mr. Slade was especially good, acting throughout with ease and humour. Mr. Grenfell was inclined to be too stiff and monotonous, but his appearance was most successful. Mr. Tweedie was again excellent as the impressionable Mrs. Gunn; his management of the various mysteries of the female costume was most skillful, and his disposition of his skirt on sitting down a liberal education to the ordinary male spectator. Mr. Everington was very much in earnest as Frederick Fanshaw; his scene with Mr. Grenfell was especially good. Much of the fun of the play is given in the part of Captain Ginger, and Mr. Valerie, in a splendid make-up and an entirely new voice, succeeded in keeping the house in a continuous roar of laughter. He played splendidly throughout the piece, making his many points with a certainty and ease that were most delightful to witness. His entrance in his new uniform and his succeeding love scene with Mrs. Gunn were really splendid; considering, too, that he had had all the trouble and anxiety of stage-managing, his performance was a really remarkable one, and he fully deserved the applause he gained. A word of especial praise must be given to the scenery, which was charming in both pieces. Between the acts the Hospital orchestra played various well-chosen pieces, under the capable direction of Mr. Folland, which added much to the pleasure of the evening.

## New Productions.

"SOLID" COMPRESSED DRUGS FOR GYNECOPATHIC USE. (London, Burroughs, Wellcome and Co.)—Of the convenience and utility of compressed drugs we are being constantly reminded by the efforts of Messrs. Burroughs and Wellcome to meet the requirements of both physician and patient. Almost every practitioner must be aware by now of the value of their "emergency case" from practical experience. And now they have prepared a series of

"solids" for the instantaneous preparation of irrigations, which should be of considerable convenience. The formulae are as follows:—(a) the most sedative preparation consists of sodium bicarbonate 20 grs., tincture of opium 10 minims—one to four solids to be dissolved in a pint of water; (b) both sedative and astringent—zinc sulphate 5 grs., lead acetate 10 grains, extract of opium 2 grs., tannin 1 gr.—one or more to be dissolved in sufficient warm water; (c) astringent—zinc sulphate 15 grs., alum 15 grs.—two or four to be used to the pint of lukewarm water. The price is very reasonable, (a) and (c) being supplied to the profession at 8d. a bottle of 25, and (b) at 1s. 3d.

"TABLET" CHEMICAL FOOD (PHOSPHATES COMPOUND) (LONDON, Burroughs, Wellcome and Co.)—This seems a portable and convenient form of a well-established drug, which has the decided advantage over the other preparations in that it does not stain the teeth. We should doubt, however, if children would take them if they could not be induced to swallow fluid medicines. These "Tablets" (a word, by the way, which is the property of Messrs. Burroughs and Wellcome) are sugar-coated, in two sizes, representing half and one drachm doses respectively.

### The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

JANUARY, 1898.	
Sat.	15th.—A.F.C. v. Cheshunt, at Winchmore Hill. R.U.F.C. 2nd XV v. Guy's Hospital 2nd XV, at Winchmore Hill.
Mon.	17th.—Preliminary Scientific and Intermediate M.B. (Lond.) Examinations begin.
Tues.	18th.—Sir Dyce Duckworth's and Mr. Langton's duty.
Wed.	19th.—Sir Thomas Smith's Clinical Lecture, 2.45 p.m. A.F.C. v. Clapham Rovers, at Winchmore Hill.
Thurs.	20th.—Abernethian Society at 8 p.m. Dr. Milne Bramwell on "Hypnotism."
Fri.	21st.—Dr. Hensley's and Mr. Marsh's duty. Dr. Gee's Clinical Lecture, 1 p.m.
Sat.	22nd.—A.F.C. v. Barnes, at Winchmore Hill. A.F.C. Reserves v. Old Foresters.
Mon.	24th.—Volunteer Medical Staff Corps (Bart.'s Company). Second Annual Ball at King's Hall, Holborn Restaurant, at 8.20 p.m.; Hon. Secs., J. C. S. Dunn and E. A. May.
Tues.	25th.—Dr. Brunton's and Mr. Marsh's duty.
Wed.	26th.—Mr. Butlin's Clinical Lecture, 2.45 p.m. R.U.F.C. 2nd XV v. University College School. A.F.C. v. Eastbourne, at Eastbourne. A.F.C. Reserves v. St. Mary's Hospital II.
Thurs.	27th.—Abernethian Society, at 8 p.m. Dr. W. H. R. Rivers on "Fatigue."
Fri.	28th.—Dr. Church's and Sir Thomas Smith's duty. Sir Dyce Duckworth's Clinical Lecture, 1 p.m.
Sat.	29th.—A.F.C. v. Old Brightonians, at Winchmore Hill.
FEBRUARY.	
TUES.	1st.—Dr. Gee's and Mr. Willett's duty.
Wed.	2nd.—Mr. Butlin's Clinical Lecture, 2.45 p.m. A.F.C. v. Casuals, at Trafalgar Park. R.U.F.C. 2nd XV v. Merchant Taylors' School, at Willesden Green. A.F.C. Reserves v. Holloway Sanatorium.
Thurs.	3rd.—Abernethian Society, at 8 p.m. Mr. Gladstone Clark on "Extra-uterine Gestation."
Fri.	4th.—Sir Dyce Duckworth's and Mr. Langton's duty. Dr. Hensley's Clinical Lecture, 1 p.m.
Sat.	5th.—A.F.C. v. Beckenham, at Winchmore Hill. R.U.F.C. 2nd XV v. St. Thomas's Hospital II, at Winchmore Hill. A.F.C. Reserves v. Beckenham II, at Beckenham.
Tues.	8th.—Dr. Hensley's and Mr. Marsh's duty. Meeting of Rahere Lodge at Frascati's.
Wed.	9th.—Mr. Langton's Clinical Lecture, 2.45 p.m. A.F.C. v. Royal Engineers, at Chatham. A.F.C. Reserves v. City of London School, at Winchmore Hill.
Thurs.	10th.—Abernethian Society at 8 p.m. Discussions, Clinical and Pathological.

Fri.	11th.—Dr. Brunton's and Mr. Butlin's duty. Dr. Brunton's Clinical Lecture, 1 p.m.
Sat.	12th.—A.F.C. v. Reigate Priory, at Reigate. R.U.F.C. 2nd XV v. Marlborough Nomads II, at Surbiton. A.F.C. Reserves v. Crouch End II, at Winchmore Hill. Hockey v. Epsum College, at Epsum.
Tues.	15th.—Dr. Church's and Sir Thomas Smith's duty.

### Some Books by Bart.'s Men.\*

**S**T. BARTHOLOMEW'S Hospital has generally been able to hold its own in the output of medical literature. The present is no exception to the rule, and we propose to notice here a few of the books published lately by members of this Hospital.

The place of honour must be conceded to Dr. Lauder Brunton's work on *The Action of Medicines* (1). Though we can add nothing to the chorus of praise with which this book has been hailed by the press, it is not fitting that the *JOURNAL* of the Hospital, in which these lectures were delivered, should be silent. We shall not attempt to analyse their contents, as they must be familiar to many of our readers, but merely add our appreciations. The keynote of the book is struck in the preface, where Dr. Brunton tells us of the method he had in view. He thought of Solon's answer in regard the laws which he had given to the Athenians—"Are those the best laws you can frame?" said his questioner, "No," said Solon, "but they are the best laws that the Athenians can keep." Dr. Brunton could have, in fact he has, written a more learned treatise on the action of drugs, but it is hard to believe that any book on the subject could impress itself more vividly and permanently on the minds of those for whom it was written.

In a word, the great merit of this work lies in its suggestiveness. The student is made to think for himself, to regard drugs not as so many uninteresting substances in bottles and boxes which he must perforce remember before he can enter through the ivory gate of qualification, but rather as the weapons with which he will have to fight disease throughout his professional life. None of the facts here chronicled belong to that large class which the student looks forward to forgetting as soon as possible; full of practical guidance, each point is driven home by an anecdote culled from a large experience.

Some authors have the faculty of impressing their individuality on their work, and this is eminently true of the book before us; both by dictation and diagrams we are constantly reminded of its origin. Dr. Brunton tells us that he has now lectured for twenty-seven years on Pharmacology and Therapeutics, which makes the freshness, interest, and buoyancy of these pages all the more impressive.

We had hoped to notice Mr. D'Arcy Power's *Life of Harvey* on this occasion; and we regret the accidental but unavoidable delay. We have, however, received a copy of this author's *Hunterian Lectures on Intussusception* (2), which bear evidence of much careful work and observation on the anatomy, histology, pathology, and treatment of a very important disease. Of the anatomical points, a new one to which he has called attention is that at birth the large and small intestines are of about the same diameter, but the former rapidly increases in width while the latter is increasing in length, it is easy to understand how just at this period irregular peristalsis is most likely to precipitate the smaller into the rapidly growing larger tube. An interesting histological point is that the stress of the disease falls on the submucous and circular muscular coats, leaving the longitudinal muscular and serous coats but little affected. As to pathology, valuable experimental evidence is adduced as to the effect of irritants (such as turpith mineral and purgatives) in producing a series of contractions separated by relaxed portions of intestine, while substances producing orderly contractions (such as

\* (1) *The Action of Medicines*, by T. Lauder Brunton, M.D., D.Sc., LL.D., F.R.S. (Macmillan and Co., 1897; Price 10s. 6d.)

(2) *Some Points in the Anatomy, Pathology, and Surgery of Intussusception*, by D'Arcy Power, M.A., M.B., F.R.C.S. (London, The Keegan Publishing Company, 1897; Price 4s.)

(3) *John Hunter, Man of Science and Surgeon*, by Stephen Paget. (London, T. Fisher Unwin; Price 3s. 6d.)

(4) *Ambroise Paré and his Times, 1510-1590*, by Stephen Paget. (O. P. Putnam's Sons, London and New York, 1897; Price 10s. 6d.)

(5) *Aneurysms of the Aorta*, by Oswald A. Browne, M.A., M.D. (London, H. K. Lewis, 1897; Price 2s. 6d.)

(6) *District Nursing on a Provident Basis*, by Jameson B. Hurry, M.D. (The Scientific Press, Limited, 1898.)

eserine or barium chloride) render intussusception impossible. As to treatment, Mr. Power sums up in favour of hydrostatic pressure with hot salt solution of not more than three feet, except in enteric cases or those with very acute symptoms; the fluid is to be allowed to remain in at least ten minutes. After two unsuccessful attempts, or after three recurrences following reductions, laparotomy must be performed. Should enterotomy be necessary, a button or hobbin is recommended for enteric invaginations, while Maunsell's operation appears to be best adapted for the cure of the ileocolic and colocolic forms.

It is interesting to note that John Hunter's pathological material was so well preserved that Mr. Power found it more suitable for microscopical examination than many specimens of much more recent date. And this leads by a natural sequence to speak of John Hunter himself; Mr. Stephen Paget's recent life of that worthy being the text (3). This is the first of a series of biographies of *Masters of Medicine*, each by a different author. We welcome the series, since it helps to bring before the notice of the present upgrowing generation the pillars which have raised our profession to its present status.

In these days, when so much is known, there is of necessity much to learn before one reaches the "front" and can take one's place in the fighting line of advance. There is little time to consider the methods and temperaments of men who have added large links to the chain of knowledge which leads to our starting-point, and yet their lives are full of interest for us. It is therefore with much pleasure that one finds to one's hand the clear picture that Mr. Stephen Paget has drawn of John Hunter.

Not the least conspicuous merits of the book are its arrangement, the clear and pleasant style of its English, and the warmth and vitality that Mr. Paget has infused into his picture. To these the publishers have added good paper and a clear type, so that one feels that nothing has been omitted that could have added to the pleasure of reading the book. The value of the book is further enhanced by an introduction by Sir James Paget, and of this, having named the writer, there can be no more need of praise. We content ourselves with the statement that once having taken up the book few people will care to leave it so long as any part of it remains unread.

Mr. Paget concludes his preface with these words:—"The praise of John Hunter, and the long list of his achievements, are known to all of us; I have only tried to draw a plain sketch of him as he was seen by the men of his own days."

To these lines Mr. Paget has kept throughout, but the book is full of small details of Hunter's life which add a charm and reality to the story, and which would, many of them, have escaped a less sympathetic writer than Mr. Paget. They give an insight into the every-day life of John Hunter which without them would be impossible. One feels that one is at John Hunter's elbow, watching him work and hearing him lecture, and there is none of the heavy reading that one generally associates in one's mind with the word "biography."

The entry into surgical practice in London seems to have been little easier in Hunter's day than now. After he returned from the Peninsula at the age of thirty-five he "started practice in Golden Square. . . . First came the days of waiting for practice, that rise from the river of Time like the lean kine in Pharaoh's dream—'poor and ill-favoured and lean-fleshed, such as I never saw in all the land of Egypt for badness.' There were many difficulties in his way. He was only one more surgeon in London, against men of greater experience; and the good things of practice were in the hands of the leaders. . . . He had no hospital appointment; he had already lived twelve years in London, but in all that time had not published one word of writing; then for two more years he had disappeared out of England, his place in the school had been filled by Mr. Hewson, and things had gone on well without him. He had not the art of making patients; and his age was not altogether in his favour, for people would ask what he had been doing all this time."

To the people round Golden Square, Mr. Paget tells us, "John Hunter was known as a zealous student of the human body, who might or might not restore you to health, but would certainly wish to anatomise you if he failed."

Many of John Hunter's letters are reproduced, and those to Jenner in particular show well his keen, restless desire for facts—more facts,—however trifling their importance might seem, and the energy with which he pursued his quarry.

All these characteristics of John Hunter are brought out in the picturesque story that Mr. Paget tells, with the details of his youth, of his unhappy quarrel with William Hunter, of his tragic death at St. George's Hospital. These and many more make up a book full of interest, and one's only regret on reaching the end is that it is all too short. One has lived a little while with John Hunter, and

one seems to know something of his friends, his enemies, and his times, and much of himself and the way he worked and thought. And the time occupied in gaining this knowledge has been most pleasantly spent.

All who are interested in the history of medicine and surgery owe a debt of gratitude to Mr. Stephen Paget for his interesting *Life of Ambroise Paré* (4). It is impressed upon us at the outset that although Paré was a man who thought for himself in matters surgical, he was no rebel against authority like Paracelsus. His discovery that emollient dressings for wounds were preferable to the barbarous applications of boiling oil, resulted from a failure in the supply of oil on the battle-field, and no one was more fearful of the results of the experiment than Paré himself. His use of the ligature in amputation wounds was an application of the method already employed in wounds elsewhere.

The character of the man comes out clearly in Mr. Paget's pages. Energetic, fascinated with his profession, and delighting in his own skill, Ambroise Paré stands for all time an example of the practical man, testing all things, in conflict with the already musty tenets of the mediæval schoolmen. John Hunter himself was not a more ardent advocate for putting all to the test of experience; many are the points of resemblance to be traced between Mr. Paget's two heroes. His work was learnt in two stern and excellent schools—as resident surgeon to the Hotel Dieu at Paris for three years, and then on the field of battle. He shows, says the author, that "character in the long run avails more than circumstances. Ambroise Paré's methods are antiquated, his theories were all wrong, his books are the forgotten treasures of a few great libraries. Our methods, our explanations, will also be superseded; our books, many of them, will not even be treasured. He has kept his hold for three centuries upon men by force of character, and by that alone."

The workmanship of this book, which is dedicated to Sir Thomas Smith, is admirable. It is copiously illustrated with portraits, plans, figures of surgical instruments of the age, and many other matters to delight the heart of the antiquarian. Incidentally we learn many things of that time; that the conflict as to the respective provinces of physicians and surgeons was fought then even more fiercely than to-day; that the expression "feeding on ambrosia" was jocularly applied to Paré's methods of treatment, so careful was he of his patient's general condition; and lastly, that our hero was probably "ploughed" the first time he was examined for the diploma of Master Surgeon. Wherefore, O oft-rejected, take heart of grace!

Dr. Oswald Browne's thesis on *Aneurysms of the Aorta* (5) is a valuable piece of clinical work, embodying the observations on all the cases of this disease within the Hospital for the last thirty years. The course and termination usual in each situation is thoroughly discussed, but fanciful deductions and explanations are studiously avoided. To abstract his conclusions would be impossible in the space at our disposal, and we would refer all interested in the subject to this paper.

Dr. Hurry, of Reading, has a very practical scheme to advocate in his *District Nursing on a Provident Basis* (6). There is a large class of patients who cannot afford a private trained nurse, and who are quite above the need of charity. For such a plan is suggested by which trained nurses can be provided by a similar arrangement which obtains at present for dispensary medical attendance or sick clubs. We have often felt the need of some such scheme, and Dr. Hurry shows conclusively that it is not only possible but has in places been actually carried out.

### Correspondence.

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

THE INDIAN MEDICAL SERVICE.

DEAR MR. EDITOR,—Last year when at Netley I promised a member of the *JOURNAL* committee that I would write an account of the life there. Unfortunately for my promise I was too much occupied that summer to finish my letter. However, I now venture to make amends for my remissness. Perhaps a few words about the Indian Medical Service may be of more interest to your readers. There are probably many good men at the Hospital passing their time as *locum*s who have not made up their minds what to do ultimately. It is to them that this letter is addressed. I am not going to talk about the Army Medical Service. You all know that it is at present a most unpopular service, and its grievances are in every paper.

The Indian Medical Service is on quite a different footing, as over

half its members are in civil employ. The senior members in military employ sometimes feel the want of the proper recognition of their rank, but that will all come in time. The real disadvantages of the Indian Medical Service are those which it has in common with the Indian Civil Service, the Staff Corps, and, to some extent, all Indian Services—insufficient leave, the great expense of double establishments if married, and the frequent separation from wife and children. Leave has now been closed to us for nine months. But if you do not marry you can avoid most of this, as you can afford short leave. What I want to point out is that if men do not much care for private practice, and can stand a hot climate, they had better try to enter the Indian Medical Service, for there is no comparison between the life of the average G. P. or his assistant and the life out here. Another point not shown in the papers supplied by the India Office concerns the amount of pay drawn in allowances. This must be qualified by drawing attention to the rule about passing the Lower Standard in Hindustani. No military allowance can be drawn until that decidedly stiff examination is passed. You may easily draw only Rs. 350 per month for a year, unless you have luck. Plague allowances are excepted. Personally I have drawn about Rs. 600 a month for the last nine months; of course, this is unusual luck in so young a member of the service. I leave your readers to work that out at 1s. 3d., the exchange rate of the rupee to-day.

If you mean to come out, go up for the examination at once; the younger you are the better. Though, of course, good qualifications and good appointments help, it is not always these which tell for the best posts. Besides, if you wait you may become too old for promotion; whereas if you join young you may be able to come home later on and take your F.R.C.S. or M.D. It is not always pleasing to find a man who was your junior at hospital—perhaps one of your own dressers—senior to you in the service. There is every variety of opening out here for all tastes, and an energetic man is never at a loss as to how to get on a post where you can get all the material you want. The number of operations done by men out here puts even Bart.'s into the shade. Surely it is better to draw comfortable pay for a few years and do work that is not quite what you want in order to get posts like those in the Presidency towns and some of the native states, than to spend six to ten years in the dissecting room, perhaps to be passed over after all. As to general practice, in my opinion it is not to be compared with the Indian Medical Service.

To return to pay, you will probably find that after you pass the Lower Standard you will generally be drawing rather more than the pay of your rank plus the Rs. 100 for regimental allowances. In other words, this difficulty over, you generally get a little more than you have expected, as you obtain extra work. On the other hand, full charge appointments are slow in coming. In Madras at present you have to wait five years to get your regiment pucca. There is a good opening in Madras for specialists, as so many of the best men go to Bengal. And also every one in our service has military duty, whatever Presidency he comes from. However, if you are particularly keen on active service try for Bengal. Bombay has advantages too; it has more variety of climate than Madras in its military stations, and is nearer home.

If any one wants advice as to kit I shall be very glad to write to him. I got "let in" badly myself, and am in a position to talk on that subject. One good rule is to get the very least you can do with at Netley, and the rest out here. This is far cheaper, and some one on the spot will show you what you really want. You always stop long enough in Bombay to have a kurkee and white kit made for models, and after that the up-country durrice is cheaper, and can copy anything. Of course, if you are going to the frontier you may want a full kit from Bombay. Begin to learn Hindustani from the day you hear that you have passed, while you are yet young and energetic. I hope if any Bart.'s men are in the next batch to come out they will let me know, as I probably shall be in Bombay. Tell them to write care of W. Watson and Co., Bombay. I hear Stevenson is at the front in a field hospital. Walton is at Kalyan Junction in charge of the medical inspection of passengers. He just missed the Momand expedition, had a month's roughing it for nothing, and was then rushed back for plague work. That is the one thing you may count on here, general uncertainty as to where you will be to-morrow. So do not bring a wife with you when you come out. That must be left till later. I hope this long-winded prolix letter will bring me an answer from some one at Bart.'s,—there are one or two who owe me letters. Trusting part of this, at any rate, may interest some of your readers.

I am, sir, yours, &c.,

BOMBAY, Nov. 10th, 1897.

W. G. RICHARDS.

### Appointments.

BROCK, J., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the Uganda Railway.

DICKSON, A. W., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Infirmary, Halifax.

GRANVILLE, A., M.R.C.S., L.R.C.P., appointed House Physician to the West London Hospital.

SHUTER, G. P., M.B., B.C. (Cantab.), D.P.H., appointed Anaesthetist to the West London Hospital.

### Examinations.

UNIVERSITY OF CAMBRIDGE.—2ND M.B.—*Anatomy and Physiology*.—F. C. H. Home, N. Maclaren, J. C. Newman, G. H. Orton, J. S. Hamilton.

3RD M.B., Part i.—*Surgery and Midwifery*.—A. E. Carsberg, C. S. Myers, J. S. Sandilands. Part ii.—*Medicine*.—H. Boulton, W. L. H. Duckworth, I. G. Forbes, M. E. Hardy, A. E. Jeaffreson, T. H. Molesworth, C. S. Myers, H. D. O'Sullivan, S. Verdon-Roe, H. B. Shewell, R. A. Yeld.

LONDON UNIVERSITY.—M.D. EXAMINATION.—F. M. Burnett, R. H. Dickinson, W. d'Este Emery, S. Gillies, F. S. Locke.

B.S. EXAMINATION.—1st Division.—F. W. Robertson, E. J. Toye, 2nd Division.—J. E. G. Calverley, S. Cornish.

HONOURS LIST.—First Class.—E. J. Toye (qualified for Gold Medal).

M.B. HONOURS LIST.—*Medicine 3rd Class*.—F. W. Robertson, E. J. Toye. *Obstetric Medicine*.—1st Class.—E. J. Toye (Scholarship and Gold Medal); 2nd Class.—F. W. Robertson. *Forensic Medicine*.—2nd Class.—F. W. Robertson.

### Births.

GARROD.—December 29th, at 9, Chandos Street, Cavendish Square, the wife of Archibald E. Garrod, M.D., of a son.

LAWRENCE.—December 25th, at 37, Belsize Avenue, N.W., the wife of Laurie A. Lawrence, F.R.C.S., of a son.

RICE.—December 1st, at 5, Clarence Terrace, Leamington, the wife of Bernard Rice, M.D. (Lond.), of a son.

STEEDMAN.—On November 30th, at High Road, Streatham, S.W., the wife of J. F. Steedman, F.R.C.S., of a son.

TUNNICLIFFE.—December 13th, at North Finchley, the wife of E. T. M. Tunnicliffe, of a son.

### Marriage.

FORD—CRANE.—On December 28th, at St. John's, Notting Hill, by the Rev. Leonard Joyce, Frank Chubb Ford, M.B., of 47, Ladbroke Square, youngest son of the late Rev. John Chubb Ford, British Chaplain, Buenos Ayres, to Isabel Ellen, eldest daughter of the late Edward Crane, of Monte Video, and Mrs. Crane, of 14, Lansdowne Crescent.

ACKNOWLEDGMENTS.—*St. Mary's Hospital Gazette*, *The Student* (Christmas Number and McEwen Hall Special Number), *London Hospital Gazette*, *The Therapist*, *The Nursing Record*, *Guy's Hospital Gazette*, *The Gynoscope*, *Middlesex Hospital Journal*, *St. Thomas's Hospital Gazette*, *St. George's Hospital Gazette*, *The Sphygmograph*, *Giornale della Reale Societa Italiana d'Igiene*.

# St. Bartholomew's Hospital



## JOURNAL.

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[PRICE SIXPENCE.]

### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C., BEFORE THE 1ST OF EVERY MONTH.

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### St. Bartholomew's Hospital Journal,

FEBRUARY 14th, 1898.

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

NO one will dispute that the compulsory notification of infectious diseases was a step in the right direction. Most of the objections urged against it have been proved nugatory by experience. But we wish here to draw attention to a defect in the working of the Act, a side issue, accidental and not essential, and one for which its framers can hardly be held responsible. We allude to the question of the fees.

As everyone knows, the medical man who notifies is entitled to a fee of half a crown for each case in private practice, and one shilling for each case in hospital practice. Whatever the conditions may be in private practice, in hospital work it appears that these fees are by no means

invariably forthcoming. Some will be inclined to retort that this is a very trivial matter,—a shilling is surely not worth troubling about. Perhaps; but let us remember that a medical man who fails to notify a case is liable to a fine of £2 10s. for each such failure. The responsibility of notifying in private is even more trying, as actions for libel have been commenced before now against an unfortunate practitioner for wrongly notifying a case as infectious. Considering, then, the risks which every medical man runs both in purse and reputation in connection with this Act, it behoves him to rigidly exact his fees. We have taken the trouble to analyse the notifications returned from this Hospital for the quarter ending January 1st, 1898. In that time 136 notifications were made by twenty-four different persons, and so far fees have been received for only 69 of these. We venture to assert that nearly all these have been received from four vestries, and that certain other vestries, who are earning for themselves an unenviable notoriety in the matter, have not sent a single fee.

The Public Health (London) Act, 1891, which regulates these matters, states, with admirable simplicity, that the Sanitary Authority "shall pay" the practitioner who forwards the notification. Two vestries at least, Whitechapel and St. Luke's, adopting the common-sense interpretation of this, forward the fees to some responsible person at the Hospital for distribution. Clerkenwell Vestry sends the fees to each individual; the Vestry of St. Mary's, Islington, improves on this by enclosing a stamped envelope for the receipt, but rather damages this generosity by sending the fee as a crossed postal order, a most tiresome form of payment. Some other vestries, among them being Lambeth, adopt the curious plan of sending a note to the effect that the fees will be forwarded on returning a receipt to them. But none of these methods are objectionable. The method we must distinctly protest against is the demand for an account from the medical man "that it may be examined and passed for payment." When he has gone through the counterfoils, how can he tell what are the boundaries of each particular vestry's jurisdiction? By sending such a demand they admit their liability. It is a piece of red tape

which is entirely uncalled for. As for the vestries who adopt none of these methods, but "keep on saying nuffin'," we do not profess to understand the principle on which they act.

Complaint without a suggestion for reform is valueless. We advocate, then, that the Resident Staff of this and other hospitals should insist that the fees be paid to some person at the Hospital responsible for their distribution. To the objection, *non possumus*, which may be raised by devotees of red tape, a simple and effective answer is ready to hand in the fact that this plan is already followed by at least two vestries. The present degree of subdivision, where twenty-four persons have each to deal with nearly a dozen vestries, is ridiculous. If our suggestion be followed, the game of "bilking" the medical man as played so merrily by Bumble at present, would come to a speedy termination.

### A Few Remarks upon Adherent Pericardium.\*

By SAMUEL WEST, M.D., F.R.C.P.

THE diagnosis of adherent pericardium presents many difficulties. In many cases there may be no symptoms whatever, and then of course the diagnosis cannot be made, unless from the previous history.

It is not at all uncommon in the post-mortem room to find the pericardium completely adherent in patients who have lived to a good old age, and who have never presented at any time symptoms of such a lesion, and in whom there is no history of any cause which could have produced it.

In the same way, in a patient who has passed through an attack of acute rheumatic fever, in the course of which severe pericarditis had occurred, all the symptoms may gradually disappear, and the physical signs return to the normal, and the patient remain in good health for years without any cardiac symptoms. The question in such a case would arise whether the pericardium was adherent or not.

How far complete recovery can take place after an acute attack of pericarditis must remain a question of opinion, but on the whole the chances of it are much less than in the case of pleurisy, and we know well how frequently a slight attack of pleurisy leaves adhesion behind. I suppose we may, at any rate, assume that in cases where there has been suppuration in the pericardium, the two layers of the pericardium will subsequently adhere, although I do not know that this necessarily follows as a matter of course. Yet in the case of suppurative pericarditis that I recorded, now

\* Made in the course of a debate upon this subject at the Medical Society, in January, 1898.

many years ago (nearly eighteen), after the sac had been incised and drained, the cavity of the pericardium was completely obliterated in the course of a week. The patient got quite well. I have frequently seen him since, the last time about a year ago. He had grown a big man, and was in perfect health; there were no physical signs whatever, except the scar over the seat of incision, which would show that there had ever been anything whatever the matter with his heart. He was apparently in perfect health, yet I can hardly suppose that the pericardial sac has not been completely obliterated.

Usually the diagnosis of adherent pericardium is made in some such way as follows:

The patient, who has some symptoms of cardiac disease and some physical signs of a lesion—let us suppose those of mitral disease following rheumatic fever, presents certain other peculiarities, especially in the shape of the heart, and possibly in some other physical signs, which show that the case is not one of simple mitral disease alone. Something else is required to completely explain the condition, and that something very often turns out to be an adherent pericardium,—at any rate, the diagnosis thus made is often confirmed subsequently if an opportunity for post-mortem examination presents itself.

Systolic recession of the apex-beat is given as a pathognomonic sign very frequently in descriptions of adherent pericardium. I think it is pathognomonic when present, but it is far more often absent. It requires for its production certain peculiarities which are not likely always to concur; for the pericardium must not only be adherent, but it must have formed adhesions both to the chest walls in the region of the apex, as well as to the mediastinum behind. This latter lesion is an essential part in the production of the phenomenon; for the apex-beat in health is due to the elastic recoil or spring of the aorta when the blood is driven into it during systole; if, however, the base of the heart be fixed, so that this recoil of the aorta cannot make itself effective, as the heart shortens on systole the apex will be drawn up and in, and thus the phenomenon produced.

In adherent pericardium it is not the obliteration of the serous sac which is the only, or indeed the most important lesion. The fibrous part of the pericardium is in direct continuation on the outside with the fibrous tissues of the mediastinum, and over the heart with the intermuscular connective tissue.

If the two layers are adherent, but the inflammation has not spread in either direction, then it really makes very little difference whether there is a real pericardial sac or not; for a pseudo-pericardium, as it may be called, is established in the loose mediastinal tissues, so that the action of the heart is not impeded. If, however, the mediastinal tissues are thickened, and the heart closely bound down to the sternum and chest walls, the movement of the heart must necessarily be very greatly impeded; the heart will be prevented to a

great extent from emptying itself; it will rapidly fail, and present the signs, after death, of dilatation.

In a similar way, if the inflammation spreads from the pericardium along the fibrous intermuscular bundles into the substance of the heart itself, a condition will be produced very similar, for example, to that of cirrhosis in the liver; the effect upon the soft muscle bundles will be the same as that upon the soft liver cells, and they will degenerate and atrophy. In such a case symptoms of cardiac failure appear very early.

In chronic cases a considerable amount of thickening and induration may take place in the heart substance, which may give the appearance of hypertrophy, but in some of these cases the hypertrophy, as it is often called, is not a real muscular hypertrophy at all, but a spurious hypertrophy largely due to the increase of the interstitial connective tissue.

Partial or irregular lesions of the pericardium sometimes give rise to very puzzling and difficult physical signs when a second effusion takes place; thus there are some strange cases recorded, in which pockets containing pus or serous fluid have been found in a partly obliterated pericardium.

Adherent pericardium is no doubt, in the great majority of cases, of rheumatic origin. Sometimes it may arise in the course of other infectious or septic fevers, or be the result of the spreading of the inflammation to the pericardium from the neighbourhood,—as, for example, after pneumonia or pleurisy.

Irregular adhesions at the base of the heart may produce very odd symptoms sometimes; thus I have seen, as the result of a pleurisy, the vena cava almost completely occluded and symptoms of venous obstruction produced, of which the cause was very obscure during life, and undiagnosable.

Tubercle and gumma seem to be the cause occasionally of pericarditis, and so, of course, may be also malignant disease in the mediastinum, but these affections partly belong to the same category.

To account for some of the cases in which no cause can be ascertained for an adherent pericardium, it must be borne in mind that acute or subacute pericarditis may be observed without any symptoms at all pointing to it; it may be discovered by accident, as it were. This occurs most frequently with granular kidney or gout. I have seen several instances of this, and if a careful routine examination of the patient had not been made, the condition would have been overlooked. In granular kidney, post-mortem examination shows that adherent pericardium is by no means very rare.

It is remarkable that in some cases of chronic pericarditis the friction may continue to be heard for a great length of time—weeks or months—long after all symptoms have passed off. I have observed this myself in a few instances.

### Some Rectal Diseases.

By F. C. WALLIS, M.B., F.R.C.S., Assistant Surgeon  
Charing Cross Hospital and St. Mark's Hospital.

#### I.

ANAL PRURITUS, ANAL FISSURE, SIMPLE RECTAL ULCER.

FISSURES or ulcers are so often the exciting cause of pruritus ani (more especially ulcers), that I have thought it better to consider these three disorders in a group.

*Anal pruritus* is one of the most persistent and wearying of the various disorders which afflict the lower end of the alimentary canal.

The main feature of the disorder is the intense itching of the parts, which is most marked at night-time, when the patient is in bed. The results of the constant scratching are very soon made apparent on the tissues, which become inflamed, raw, and unusually moist, especially where the buttocks are in apposition.

In chronic cases the epidermis is thickened and sodden, and frequent cracks occur in the skin surface, particularly in the post-anal line, or at any part of the anal circumference on the muco-cutaneous margin.

A certain amount of stress has been laid on the fact that in old-standing cases patches of skin become changed in appearance to a dead white colour, and to the touch more like scar tissue than normal skin.

This is the ordinary pathological sequence of chronic inflammation, the effect of which is to replace most of the elements of the true skin with fibrous tissue. It may be seen in the skin in any other part of the body where chronic inflammation has been, or is existing.

The condition of the parts may vary considerably from the above, and the variation depends upon the particular cause of the pruritus, or upon some co-existent local trouble, such as *eczema*, *eczema marginatum*, *pediculi*, &c.

*Causes.*—The causes of pruritus are constitutional and local, and not infrequently a slight local cause will lead to a bad condition of pruritus, because of some predisposing constitutional condition. It is always well to bear this in mind in treatment, and I quite agree with Allingham in what he says on this point.

*Errors of diet*, especially in gouty people, or in those who are prone to secrete an excessive quantity of uric acid, are the commonest causes of the *persistence* of cases of pruritus.

At St. Mark's Hospital I invariably ask three questions—(1) How much beer? (2) When do you have supper? (3) When do you go to bed?

The answer to the first question is, of course, vague, but it is usually found that beer, in the abstract, is drunk during the evening, particularly at supper, and that the supper is often a late and a hearty one. The patient retires to bed

within an hour. Washing in general is rather rare, and locally almost unknown.

In patients of a better class it will be found that some particular article of diet is apt to produce pruritus, and when this is discontinued the pruritus, if treated with some local application, will soon cease.

As examples of this I may quote two instances. The one, a patient who was a most careful liver, came to see me about a condition of quite bad pruritus. Knowing him to be careful, I could not find out any dietetic indiscretion until when dining with him I noticed he drank a quantity (three tumblers full) of ordinary claret, and I elicited from him that he usually took almost as much at luncheon. This was discontinued, and the trouble disappeared in a very short time.

The other case was somewhat similar, in that the patient, who was gouty, indulged in an imperial pint of champagne every night at dinner. After much persuasion this was discontinued, and a rapid cure was the result. Coffee, tea, tobacco, various forms of shellfish, &c., are all possible causes of pruritus.

The difficulty in dealing with general causes is to get the patient to do what he is told. More often than not the offending article of diet is one to which the patient is particularly attached, and which he consequently gives up only after a struggle.

Strumous people with delicate skins and a great deal of hair locally are apt to suffer from pruritus, especially when somewhat "run down."

The neurotic element must not be forgotten in these cases. People of sedentary occupations, who are overworked and are of this temperament, are liable to attacks which are sometimes most difficult to cure.

Local causes of pruritus are fairly numerous. Constipation, hæmorrhoidal congestion, hæmorrhoids, polypi, fissures, fistule, oxyuris vermicularis, and simple ulcers are causes inside the bowel.

Causes outside are eczema, eczema marginalis, pediculi, excessive sweating; lastly, and amongst hospital patients mainly, want of washing.

Most of the local internal causes speak for themselves, producing from congestion or discharge a condition of local irritation, which if not attended to soon produces a well-marked condition of pruritus ani.

There is one of these causes, viz. the local solitary ulcer, to which I wish to draw particular attention.

A few months ago we had quite a number of pruritus cases hanging on in the Out-patient Department, and in spite of all sorts of treatment they remained much as they originally were. I carefully explored the rectum in each case with the finger, and then with the speculum and a small electric lamp which I could introduce into the rectum. In more than 25 per cent. a small ulcer could be felt situated dorsally between the two sphincters or a little

higher. This condition was confirmed by the speculum and electric light.

Since then, Mr. Cudmore—the house surgeon—and I have examined each case of pruritus by this method, and the percentage of these ulcers continues certainly as high, if not higher than that mentioned above.

It is curious that the frequency of this cause should have been overlooked by other observers, but I hope now attention has been drawn to the fact that the experience of others will be forthcoming.

*Treatment.*—Treatment in these cases must be local and general, and will vary greatly according to the social position of the patient.

In Charles Dickens's "Little Dorrit," an Italian, out of gratitude to some Englishman for having saved his child's life, asked what he could do to prove his thankfulness, and the Englishman's answer was "wash a little more." This might with profit be repeated as a sort of litany to most hospital patients suffering from pruritus; perhaps "wash a great deal more" would be better still.

This sanitary measure, combined with a strict diet, discontinuance of beer drinking, and some saline purgative, will go a great way towards curing most cases, which are, or were originally, constitutional in origin. I find that bran baths, especially at night-time, are most beneficial. A large double handful of bran put in a gauze bag and placed in the bath ten minutes before the patient sits in it is the simplest way of procuring this. A small amount of pearl-ash may be added to the bath water, which should be as warm as can comfortably be borne by the patient. The bath should last for twenty minutes, the buttocks should be separated as far as possible, and this is best done by placing the bran bag between them. Afterwards the parts should be carefully dried, and dusted with a powder containing equal parts of oxide of zinc, starch, and boric powder; the buttocks are well separated by a firm pad of cotton wool, which should be kept applied closely by means of a T-bandage, and should be worn at night-time. The bath may with advantage be repeated in the morning, and a strip of lint, spread with boric ointment, should be kept in position during the day by a pad and bandage.

If some parasite is the cause, the treatment will be to get rid of it by the usual well-known methods.

Hæmorrhoids, fissure, fistule, &c., causing pruritus must be dealt with before a cure can be hoped for.

If none of these exist, look for the solitary ulcer mentioned above; if this is overlooked, a cure will not be brought about. If this is present, the best and most rapid method of dealing with it is to stretch well the sphincters under an anæsthetic, scraping the ulcer at the time if it is thought necessary to do so.

Two cases where this was done are related in Cooper and Edwards' book, but the presence or absence of the ulcer is not stated.

It will be seen from the above remarks that although pruritus ani is easily diagnosed, the cause may be quite difficult to ascertain, and the cure still more difficult to obtain.

A careful examination is most essential, and if this is made, and the patient given to understand that it is only by strictly adhering to the treatment for possibly quite a length of time that a cure can be effected, success will be met with in nearly every case. But it is necessary that the patient should be made to fully appreciate that the disorder does not always yield readily to any form of treatment.

*Anal fissure*, although a very slight local lesion, is one of the most distressing complaints that a medical man has to deal with. Against this, however, may be set the fact that the treatment is a certain cure, and usually permanent.

The cause of the unusual and continuous daily pain of a fissure is really its locality. Muco-cutaneous margins are all extremely sensitive and plentifully supplied with nerves, and the anus is no exception to this. It is quite curious what a difference there is in the painful symptoms in various cases; and it depends entirely upon whether the ulcer or fissure is actually on the sphincter or just inside it. Fissures which are on the sphincter, and can be readily seen upon separating the buttocks, are those which cause the most pain, amounting in some cases to real agony, lasting for many hours. Those which are situated a little higher, and can only be seen when the muco-cutaneous margin is put on the stretch, do not give rise to the same amount of pain, and the paroxysms are not so long-lasting.

Fissures are produced in the first place by the contents of the bowel causing some lesion during the act of evacuation. This lesion is generally situated in the mid-line posteriorly, but may occur at any other part of the anal circumference.

When the fissure is due to a simple crack in the muco-cutaneous margin its appearance is very much like that seen in a badly "cracked lip," but when the lesion is due to one of the small anal valves being torn down the appearance is quite different. In these cases the first thing that presents itself is a small tag of oedematous skin, which Van Buren has called the "sentinel pile;" if this tag is pulled back a shallow ulcer is seen immediately on the other side of it, and in these cases the floor of the ulcer is generally unhealthy in appearance.

This is one of the very few surgical troubles where a patient willingly submits to—almost asks for an operation. The reason, of course, is the daily bitter pain that has to be gone through.

Before I deal with the treatment, which is quite simple, I wish to urge that *no delay is permissible*. The two following cases tell their own tale, and confirm my statement.

E. G., a girl *æt.* 18, came to my out patients at St. Mark's on September 16th, 1896. She had pruritus ani and a fissure, for which she was given some medicine and ointment, and her name was put down to come in as soon as possible. She

attended once after that, and then her mother came up asking for medicine, saying the girl was too ill to move. On inquiry it was considered advisable to get the patient to the hospital, and she was brought in a cab in the course of an hour. It was at once evident that the girl was extremely ill. Temp. 103°, quick pulse, furred tongue, and anxious expression.

On examination a large bilateral ischio-rectal abscess was found with wide-spread inflammation of skin. Pus of the most foul odour escaped from the bowel. The abscess was opened on one side and the tension relieved there and then, and the girl came into the hospital, where two days later the abscess was very freely opened, and a complete rectal examination made under an anæsthetic. A large internal opening was discovered well above the internal sphincter.

The patient was discharged on November 23rd, 1896; readmitted in February, 1897, for a fistula—the remains of the large abscess,—and was discharged cured on April 3rd, 1897, the whole treatment going over a period of six months.

The other case was that of a man *æt.* 49, who attended the out-patients' department for a fissure for about three weeks previous to his admission on February 20th, 1897, when he came to the out-patient's department with an enormous ischio-rectal abscess, which was at once freely opened; a sinus ran up alongside the bowel for nearly six inches. The patient was sent to the wards. Temperature on admission was 101°6', but normal next day. On February 26th temperature began to rise, until March 1st, when it reached 103°. On this date a collection of pus at the upper end of the sinus burst into the rectum. The temperature came down gradually to normal. On March 8th I operated on him, laying the whole sinus and track freely open from the outside. There was a large internal opening high up. The wound was packed for a few days and then fomented.

From now, on, the man made a steady recovery, the internal opening healing up with the gradual contraction of the wide external operation wound. He was discharged well on June 5th, 1897, having been in hospital four and a half months, and has remained well ever since.

These two cases well illustrate that there is serious danger, over and above that of the daily pain, in allowing these fissures to go unrelieved.

The sequence of events in these two cases I take to be as follows:

On account of the pain which follows the daily evacuation, patients put off the evil moment as long as possible. The lower bowel becomes loaded with most septic material, which starts by infecting the fissure and so getting into the subcutaneous tissue. Very soon the ischio-rectal fossa falls a victim, and here, owing to the peculiar conformation of the fossa, a large amount of pus may accumulate before

any signs of tension make the patient feel that it is necessary to "see some one." By the time that point is arrived at the whole of one or both fossæ may be tense pus sacs, and, as happened in both the cases related above, the bowel may give way high up. In the cases quoted both these internal openings closed, but it is not the fortune of most cases to have such a good result.

Now, as regards treatment of fissure, there is only one which can be relied upon as curative, and that is division of the whole, or better still, part of the external sphincter. This may or may not be accompanied with stretching of the sphincter, but I do not consider it necessary. Merely stretching the sphincter alone may cure it, but it may not. The reason of this is that although sphincter paralysis is produced by the stretching, it does not exist long enough to allow the fissure to heal; therefore, although there is temporary relief, after a time all the old symptoms may recur, to the great exasperation of all parties concerned.

During the last few months I have adopted the following method in the out-patients' department at St. Mark's:

The patient being in the knee-elbow position, the buttocks are separated, and the fissure and surrounding parts are well washed with 1 : 500 perchloride solution; then a 4 per cent. solution of eucaine is injected in the manner I suggested in a former paper. An incision is now made commencing at the external limit of the fissure, and going straight back for three quarters of an inch to an inch, completely dividing whatever part of the sphincter is underneath it. By this incision spasm of the sphincter disappears, and the contraction of the muscular coat of the bowel—particularly the internal sphincter—draws the ulcer into the bowel out of harm's way, so to speak.

The incision is plugged for twenty-four to thirty-six hours, and the patient is given strict injunctions with regard to cleanliness and the application of 1 : 500 perchloride solution locally. Some slight laxative is ordered, and the patient is seen on the fourth or fifth day. Nearly twenty cases of fissure have been so treated now by Mr. Cudmore and myself. No bad results have occurred, and I have not heard of any case so treated which has not ultimately got well.

This treatment may be considered somewhat risky. My reason for trying it was because of the number of men who were waiting for admission and had to go on, week in, week out, with no relief, or only the slight relief which palliative treatment affords.

If a patient carries out the instructions given him there are no risks; all pain is relieved, the fissure gradually heals, and—Saturday being the day for the treatment—he is able to lie up until Monday and resume work on Tuesday. This last fact is an important one to busy men in all stations of life.

Simple ulcer of the rectum I have found to be quite a common complaint. It is usually associated with pruritus

ani, and when this is not present the patient complains of a dull aching or dragging pain, and a burning sensation lasting for some time after evacuation. These are usually the symptoms complained of. The cause is the same as that mentioned for fissure.

These ulcers are usually single, and nearly always situated dorsally, between the sphincters, not interfering, at all events, with the external one. They are not easy to discover by examination unless one's finger has had some practice, but after a few examinations have been made there is no difficulty. They can be seen with the speculum, and look livid in colour as compared with the pink colour of healthy mucous membrane. When seen by this means they appear to be much higher up the bowel than they really are, because the tissues are pushed up by the speculum.

Patients go on with these ulcers for a very long time without seeking relief. The ulcers remain stationary, and show no inclination to either heal, spread, or multiply.

Women suffering from this are often treated for uterine or ovarian troubles, and men have been treated for prostatic disease, and a calculus has been diagnosed.

These ulcers are difficult to cure by any palliative treatment,—in fact, I think one may say the majority of them are not to be cured by these measures. Mercurial ointments, nitrate of silver in solution or applied in the solid form, may be tried, but disappointment is more often the result than not.

The best treatment is to dilate the sphincter well, and to scrape the surface of the ulcer, which rapidly heals after this, provided that here, as in all cases of rectal surgery, scrupulous surgical cleanliness is maintained.

(To be continued.)

## On Appendicitis.

A Paper read before the Abernethian Society on  
November 4th, 1897.

By T. P. LEGG, M.B., F.R.C.S.

(Continued from page 51.)

**DIAGNOSIS.**—Nothing may be more easy, and nothing may be more difficult to diagnose than appendicitis. It is those cases where the history points to rapid onset and development of the symptoms in which the difficulty arises. Cases where the patient is obviously very ill, with distended abdomen and nothing much to be made out on examination, are the ones which give rise to grave mistakes and fatal results. In all such cases remember two things, the value of an examination under chloroform, and "in all cases of doubt, think of the appendix." Under chloroform a definite mass or induration may be felt in the right iliac fossa, which before was not evident, leading to a correct diagnosis, and saving the patient's life, or at least giving him a chance. Moreover, this may prevent the discovery post mortem of a localised abscess, which if drained would have saved him. The history is of importance,—a history of previous

attacks or pain with constipation which may have only lasted a few days, and scarcely caused inconvenience. The age of the patient is of some value, more especially in helping the diagnosis from mechanical obstruction, though the appendix may here be at fault, causing the obstruction by bands of adhesions. From acute intestinal obstruction due to other causes the diagnosis may be impossible till the abdomen is opened. In these cases, however, the vomiting is more profuse and stereotyped, the constipation both of feces and flatus more absolute, and localised tenderness usually not present. But, even so, when the abdomen is opened in the middle line, examine the iliac regions carefully for induration, and still think of the appendix.

In intussusception we have the passage of bloody motions, tenesmus, and the characteristic tumour.

Perforated gastric ulcer has been diagnosed for appendicitis, and the abdomen opened, and nothing found wrong with the stomach. Such a case is reported by Mr. Page in the *Lancet*, 1895, vol. 1. At the post-mortem a circumscribed abscess due to perforation of the appendix was found, and no general peritonitis. The patient was twenty-one years old, and had been ill fourteen days.

Tuberculous peritonitis and tuberculous ulceration of the cæcum have been mistaken for appendicitis. Such cases have been reported by Mr. Lockwood in the *Clinical Journal*, and Mr. Page in the *Lancet*, July 3rd, 1897. In the early stages renal colic has been diagnosed for appendicitis; the symptoms being frequent micturition, pain on micturition, and along the course of the ureter, as well as localised tenderness, most marked in the loin and kidney region.

Typhoid fever is another disease which not infrequently has led to error. There was such a case in the hospital this summer, and it was only at the post-mortem that the true nature of the illness was found out. It was then found to be a case of general peritonitis due to a sloughing appendix, with multiple abscesses throughout the whole body—in fact, general pyæmia.

Other diseases to be borne in mind are gall-stone colic, perinephric abscess, pelvic abscess, psoas abscess, cancer of the cæcum, constipation, and the hysterical appendicitis of French surgeons (*Lancet*, 1896).

In women, abscess due to the appendix has been diagnosed as due to disease of the ovary or Fallopian tube, and in children hip disease on the right side has been diagnosed when the appendix was the cause of the symptoms. Finally, it must not be forgotten that all the symptoms of acute general peritonitis may be simulated by a localised abscess.

**Prognosis.**—The prognosis of appendicitis is not easy to determine, and it has to be considered in relation to the chance of recovery and chance of relapse.

In any given case it is not only difficult, but often impossible, to say whether the patient will die or recover. For those cases in which the onset is gradual may and do end in general peritonitis and death; and those cases in which the onset is acute, and the patient desperately ill, end in complete recovery.

As far as I can make out, the general mortality in hospitals is 14 or 15 per cent. Treves says, taking all cases together, the mild and most serious, the mortality is about 5 per cent. In connection with hospital statistics many of the cases, it must be remembered, are hopeless on admission.

The most rapidly fatal cases are those where the signs of general peritonitis are the first symptoms of the illness.

As to relapses, Hawkins says that of 250 cases admitted to St. Thomas's, 23·6 per cent. gave a history of one or more previous attacks. Fitz put it as high as 44 per cent., and Greig Smith from attacks. Fitz put it as high as 44 per cent., and Greig Smith from attacks. Fitz put it as high as 44 per cent., and Greig Smith from attacks. Fitz put it as high as 44 per cent., and Greig Smith from attacks.

**Complications.**—As to complications, one has only time to mention one or two of the most important, and which give rise to after trouble. The first is fecal fistula; the opening of the fistula is usually in the right iliac region, over and communicating with the cæcum; in other cases it opens in the loin or at the umbilicus, or, if the abscess has burst internally, into the organ affected. They last a very long time in many cases, but in the majority they show a disposition to close spontaneously under careful dieting and attention to the bowels. In other cases they heal up rapidly as soon as the abscess heals. They are very difficult to cure by operation.

The second complication is ventral hernia. Treves says they occur in less than 5 per cent., and most commonly in abscess cases

where a large incision was made and not partially sewn up. The best way to prevent their formation is to sew up the wound layer by layer, keep the patient on his back till it is soundly healed, and give a slight support or truss if necessary.

Other important complications are intestinal obstruction due to kinking of the intestines by adhesions, or adherence of the inflamed and sloughing appendix to the intestine, two or three such cases have been in the hospital during the last five years.

Abscesses of the liver, subphrenic abscess, and pyelophlebitis have not unfrequently been found, and in most of the cases a fatal result has occurred; they are obviously pyæmic.

**Treatment.**—Absolute rest in bed is most essential till all the acute symptoms have disappeared and the local signs subsided. Every case, however mild, should be so treated, as one cannot foretell what course will be taken.

The diet should be of such a kind as to leave little debris. Whey alone is given by some physicians; milk should be given boiled, and well diluted with barley or plain water. If it causes sickness it should be given peptonised, and always at definite intervals and in stated quantities; if necessary, rectal feeding should be used; beef tea, broths, and eggs may be given. Locally the weight of the bed-clothes should be removed, and hot fomentations with or without belladonna or opium applied; leeches relieve the very acute pain.

Internally opium should not be given as a routine thing, and if possible avoided; when necessary it should be given in the smallest doses required to produce the desired effect, viz. to relieve pain and put the bowel at rest; morphia hypodermically may be required, and belladonna is recommended by many. Evacuation of the bowels is best obtained by enemata.

**The prevention of relapses.**—(1) Correct all digestive disorders; take food at regular hours, and such food as is easily digested; eat it slowly, and have the teeth attended to if not in good condition.

(2) Have the bowels open daily, using an aperient or enema if necessary.

(3) Treves recommends massage of the abdomen, and some intestinal antiseptic such as salol night and morning.

(4) Violent physical exertion and exposure to cold are to be avoided; gentle exercise is beneficial.

**The question of operation.**—First, as regards relapsing cases. This operation was first proposed by Treves in his paper read before the Royal Medical and Chirurgical Society in 1888. He there describes his first case, in which the appendix was not removed but freed of adhesions, the patient recovering completely. In the same paper he recommends removal of the appendix in the majority of cases.

The questions then arise—in what cases, and when, should the operation be done?

The time when the operation is to be done is, without doubt, during the quiescent stage, when all acute symptoms have subsided, for if not, troublesome and severe hæmorrhage may occur; besides, the appendix may not be found, and the risk of infecting the peritoneum is increased.

Each case must be separately considered. Most surgeons advocate removal after two well-marked attacks, and probably this may be right considering all cases; but the facts of the case should be pointed out to the patient, and the risks he undergoes by not having the organ removed. It should be pointed out to him that at any time he may get a very severe attack, and death result. But even so one must consider his station of life—whether he is able to spare the time, and nurse each attack properly. Next, the age of the patient should be taken into account; the younger, the more the operation should be urged, for the attacks are likely to go on, and the risk is less than in adults.

Operation should be urged in all cases where the attacks are frequent or have been numerous, when the last attack was severe, when the patient has to lead an invalid's life or is prevented from following his employment, and when the local signs are persistent during the quiescent period.

**Method of operating.**—Most surgeons use an oblique incision, about two inches long, parallel to the outer part of Poupart's ligament, about two inches from the anterior superior iliac spine; the objection that is made against this incision is that much muscular tissue is divided, and a ventral hernia liable to result. In certain cases this does happen, but the risk can be reduced to a minimum if the muscular fibres are separated rather than divided, and the layers

\* This method of sewing up the wound refers to those cases operated on for removal of the appendix in relapsing cases. Where the wound is not quite aseptic, buried sutures are not advisable; but even in such cases all the layers can be approximated by single sutures.

of the abdomen be sewed up separately, and rest in bed enforced till the scar is firm. Besides, this incision is the one placed nearest to the appendix. Two other incisions are made by some—one in the middle line below the umbilicus, and the other obliquely, parallel to the linea semilunaris and midway between the umbilicus and anterior superior iliac spine; the rectus is exposed, and pushed to one side. In sewing up the wound, special care is taken to reapply the rectus to its natural position and in stitching the separate layers of the abdomen and the margins of the cut aponeurosis. It is said that the appendix is more readily reached than would seem likely, and the risk of hernia practically none.

All adhesions, except very recent ones, must be cut and not separated by tearing. The cæcum being found, the longitudinal hand on its surface is looked for and traced downwards; the gut is drawn out of the abdomen with the appendix, and the general peritoneal cavity shut off by sponges, and the general peritoneum to the cæcum as necessary, usually about half an inch away, and the mesentery transfixed by two or more silk ligatures, which are tied; then the appendix is cut away from the mesentery, and its peritoneal coat divided circularly as well as the muscular; the mucous membrane is drawn out and cut off. This procedure cannot always be carried out, on account of previous inflammation. In such cases divide it right across. The stump is then disinfected by touching it with the actual cautery or applying pure carbolic acid; dust on iodiform, close the mucous membrane by two or three fine silk sutures, and then stitch the peritoneum up over the mucous membrane, so as to give the stump a complete peritoneal investment, using Lambert's suture. If the peritoneum cannot be closed over, make a graft of peritoneum from an adjacent piece. After irrigation the wound is closed as described, and no drain is necessary.

The operation may be very difficult owing to the adhesions, which may be so dense as to prevent the appendix being found, or that organ may be very closely adherent to the cæcum.

Treves recommends that the incision should not be placed directly over the dull part or the line of the appendix, as here the adhesions are densest.

The mortality of the operation is very small. Treves has done 150 cases with one death. Last year it was removed eight times with no deaths in the hospital.

As regards operation in acute cases, widely different opinions are held as to when it is to be done: one class of surgeons operate quite early, and the other class wait, watching symptoms. Many surgeons say that if the signs of pus are present, operation should be done at once; others, in the absence of specially urgent symptoms, wait from day to day on the ground that the pus is at first not well localised, and may be deeply situated so as not to be found without infecting the general peritoneal cavity, or at any rate breaking down existing adhesions and increasing the risk to the patient. It has already been mentioned how difficult it is to diagnose the presence of pus, and some American surgeons strongly advocate the use of the exploring syringe in such cases; one of them, Weir, advocating its use in several places, "particularly a deep hypogastric puncture into the pelvis." This is a practice not to be recommended in any case. A very much safer and better plan is an incision.

If the symptoms point to general peritonitis, immediate operation should be done, the incision being first made in the middle line, and the cavity examined; if no peritonitis is found, the wound is closed before operating on the appendix.

Now, suppose an abscess is present, the first and main thing to be done is to open it and let out the pus. The incision is best made parallel to and slightly above Poupart's ligament, and below the anterior-superior iliac spine. This is the best and most direct way of draining the abscess. An incision in the right linea semilunaris is bad, inasmuch as the pus is not directly reached and evacuated; further, the risk of opening and draining the abscess through the general peritoneal cavity is increased. For similar reasons a median incision is much less satisfactory.

Having let out the pus, I think all the surgeons here do nothing more in most cases. From my own experience washing out is not necessary, as the discharge will be sweet in twenty-four hours, or at any rate plain water at low pressure is all that is necessary; further washing out is not without risk, and it is impossible to make the abscess cavity aseptic, and in no case must the walls be scraped.

The incision should be free—it may be easily sewn up afterwards. Some surgeons advise examination of the abscess cavity to note whether the appendix can be seen, and if so whether it can be removed; of course, if it lies loose, or nearly separated, and can be removed without breaking down adhesions, remove it by simply placing a ligature round it and cutting it off; nothing further in the way of an elaborate operation can be done; persistent attempts to

find it by breaking down adhesions are not advisable. This, however, is the point on which surgeons widely disagree. American surgeons deliberately break down the adhesions, pack sponges in the wound, and remove the appendix. Mayo Robson says, "if the adhesions be broken and the general peritoneal cavity opened, no harm will result if the parts be isolated by sponges; on no account should a prolonged search be made." Last year at this hospital, in thirteen cases of limited incision and no removal of appendix (all acute cases), ten recoveries were the result; and in two cases the appendix was found easily and removed, and both recovered.

If on opening the abdomen pus is found but not localised, should the appendix be sought for and removed, or should a drain be put in and nothing further done? Last year seven cases were operated on in which the peritoneal cavity was opened and washed out, and the appendix sought for and removed; three lived and four died, in all there was general peritonitis, and the question arises whether this resulted from or was present prior to the operation? In some it was apparently present at the operation, and in others it appears to have been absent.

As regards washing out, the length of time for which it can be done depends on the condition of the patient; some improve under it, but rarely is prolonged irrigation borne well. Many surgeons sponge out the cavity, and do not wash out at all, particularly the lumbar regions and pelvis; into each of these a drainage-tube is afterwards placed and left in twenty-four to seventy-two hours, according to circumstances; this is, perhaps, the better method. Of chronic appendicitis with suppuration, six cases were operated on last year by limited incision through the adhesions. In no case was the appendix sought for, and all recovered.

It is not possible to lay down any definite time when operation should be done, but the longer it can be delayed, probably the better; in most cases it would not be called for before the third day at the earliest, and generally not earlier than the fifth day. Cases which end fatally in thirty-six to forty-eight hours are rare, and most of them hopeless from the outset; still, if the diagnosis be made their only chance is operation.

Then it is also argued that the abscess is liable to burst into the general peritoneal cavity, as a matter of fact, eight out of sixty-seven cases (Dr. Dull) took this course. A small collection of pus may be deeply placed and not found, whilst the general peritoneal cavity becomes infected in the manipulations necessary at the operation.

The more the abscess is localised, the better the chance of recovery.

To sum up, all the symptoms of general peritonitis may be simulated by a localised abscess, and the onset of a non-suppurative case may be most acute, so that early operation should not be considered necessary in such cases—each must be considered separately. There is one set of cases, however, where an abscess has been known to exist and burst internally; in these cases immediate operation is essential. In all cases the appendix should not be sought for by a dissection or the adhesions broken down.

TABLE SHOWING NUMBER OF CASES ADMITTED TO THE WARDS OF ST. BARTHOLOMEWS HOSPITAL DURING THE YEARS 1892-6.

Year.	Medical Wards.	Surgical Wards.
1892 .....	34	5
1893 .....	23	7
1894 .....	30	11
1895* .....	19	15
1896* .....	23	53
Totals ...	129	91

Totals for 5 Years.	Males.	Females.
Medical Wards, 129 .....	99	30
Surgical " 91 .....	76	15
Total ...	220	45

Proportion of males to females attacked, 3·8 to 1, i.e. nearly 4 males to 1 female.

Percentages.—Males, 79·5; females, 20·4.

\* In these years several cases of abscess were admitted to the Medical Wards, which I have here included in the Surgical Wards as they were transferred and operated on.

TABLES SHOWING THE FREQUENCY OF APPENDICITIS AT DIFFERENT AGES OF CASES ADMITTED TO ST. BARTHOLOMEWS HOSPITAL DURING THE YEARS 1892-6.

Age.	Cases admitted to the Medical Wards.					Totals.
	1892	1893	1894	1895	1896	
0-5 .....	2	3	3	2	—	10
5-10 .....	8	5	5	4	—	27
10-15 .....	9	2	8	5	6	30
15-20 .....	9	9	11	4	—	37
20-30 .....	4	—	2	3	4	14
30-40 .....	—	3	—	1	—	8
40-50 .....	—	—	1	—	—	3
50-60 .....	—	—	—	—	—	—
Totals ...	34	23	30	19	23	129

Age.	Cases admitted to the Surgical Wards.					Totals.
	1892	1893	1894	1895	1896	
0-5 .....	—	1	—	—	—	1
5-10 .....	—	—	2	1	—	3
10-15 .....	1	—	3	1	—	5
15-20 .....	2	1	—	7	14	24
20-30 .....	1	2	3	4	18	28
30-40 .....	—	1	2	2	7	12
40-50 .....	—	2	1	—	—	3
50-60 .....	—	—	—	—	1	1
Totals ...	5	7	11	15	53	91

TABLE SHOWING FREQUENCY OF ATTACK AT THE DIFFERENT AGES OF CASES ADMITTED TO ST. BARTHOLOMEWS HOSPITAL, 1892-6.

Age.	Medical Wards.		Total.	Percentages.
	Medical Wards.	Surgical Wards.		
0-5 .....	—	1	1	·45
5-10 .....	10	11	21	·95
10-15 .....	27	19	37	16·8
15-20 .....	30	24	54	24·5
20-30 .....	37	28	65	29·5
30-40 .....	14	12	26	11·8
40-50 .....	8	4	12	5·4
50-60 .....	3	1	4	1·8
Totals ...	129	91	220	

The following table is taken from Treves' article on Perityphlitis in vol. iii of Clifford Allbutt's *System of Medicine*, and is placed here for comparison of the percentage of cases at the different ages. It was compiled from a total of 452 cases.

Age.	Proportion of Cases per cent.
5-10 years .....	10·8
10-20 " .....	40·7
20-30 " .....	29·0
30-40 " .....	11·5
40-50 " .....	4·6
Over 50 " .....	3·4

### A Case of Tubal Pregnancy.

By T. STRANGEWAYS PIGG,

Demonstrator of Pathology in the University of Cambridge.

THE following notes on a case of tubal pregnancy speak for themselves. That the case is an unusual one there can be no doubt. It will be noticed that the patient was under twenty, and with the exception of the changes due to the presence of the ovum, the uterus, the Fallopian tubes, and ovaries were quite normal.

I have been unable to find a similar case recorded, but no doubt a more careful search would be successful.

The patient, an unmarried girl *æt.* 19 years, "in perfect health," was seized one evening after returning from a short walk by a sudden desire to go to stool. Nothing was passed, but feeling faint

and unwell the patient went to bed. A medical man was called in the next day. He found the patient in bed with a quiet pulse—abnormal temperature, but complaining of an uneasy feeling in abdomen. On examination the patient screamed at the slightest touch over the abdomen, though firm pressure gave no pain when her attention was distracted. She had always been regular at her periods, and suffered no pain at these dates. The next period was due that day.

No further symptoms were noticed, and a simple purgative was prescribed and the patient ordered to remain in bed. During the afternoon and evening she fainted repeatedly, especially in turning on her right side, and early the next morning died, without having again been seen by her medical adviser.

I was asked to make a post-mortem examination, and the following is an abstract of my notes at the time:—The body was well nourished, but appeared very anæmic. On opening the abdomen a large quantity of blood and clot welled out, which had evidently been retained at considerable pressure. The whole peritoneal cavity was found to be full of blood and clot.

A careful examination was then made of the contents of the abdomen, and all the viscera were found to be healthy until the uterus was reached. It was then seen that the right Fallopian tube was distended by an oval swelling about the size of a walnut; this was situated one and a half inches from the uterus. At the upper and free border of the sac a small rupture was found, and this proved to be the source of the hæmorrhage which led to the patient's death. The sac was that of an extra-uterine pregnancy, and contained an ovum of about five weeks. The uterus and Fallopian tube presented the usual appearances of a tubal pregnancy of this age, but otherwise they were quite normal. They were carefully examined microscopically, and no evidence of any past or present inflammation could be discovered.

The right ovary contained a corpus luteum. All the other viscera were perfectly healthy.

### Notes.

NEARLY one hundred past and present members of the Junior Staff, dressers, and "Fellowship" men have joined together to present a testimonial to Mr. James Berry on his retirement from the post of Surgical Registrar, as some slight acknowledgment of their high appreciation of all that he has done on their behalf during his tenure of that office. Mr. Berry has chosen an oil painting of the interior of St. Bartholomew the Great as the form which the presentation is to take.

It appears that the list of Bart's men decorated with the V.C. is likely to receive yet another addition. According to the *British Medical Journal*, Surgeon-Captain William Selby, of the 1st Battalion 2nd Goorkhas, is to be recommended for this honour. He displayed great gallantry, standing over a wounded Goorkha and saving him when the enemy were almost upon him.

DR. COLLINS' old schoolfellows soon followed the example of his Hospital companions. He was entertained at dinner by former members of University College School at Frascati's on January 13th, Mr. Wolf Defries in the chair.

MR. W. E. N. DUNN has been appointed Junior Resident Anæsthetist in succession to Mr. F. H. Lewis, resigned.

IN connection with the paragraph in our last number

concerning the Gold Medal for Obstetrics at the London M.B., it is worth noting that this honour has fallen to Bart.'s fourteen times in the last seventeen years.

At the suggestion of Dr. Waldo, Medical Officer of Health for Southwark, the Vestry have opened a receiving-house for the temporary reception of those whose houses are being disinfected for infectious disease. The families are accommodated for eight hours, and everything is found for them except food, which they, of course, have to provide. They are given baths and clean clothes while their own clothes are being disinfected. The idea is excellent, and might well be followed elsewhere.

THE *Guyoscope* is not dead after all; a second series has appeared, containing the obituary notices published by its contemporaries on its supposed demise! Some have referred to its Bob Sawyer-like character; but in this respect it has followed the example of Tom Sawyer, who had, we believe, the almost unique privilege of listening to his own funeral sermon.

The ranks of our contemporaries has been still further recruited by *The Stethoscope*, being the Bristol Medical Students' Journal. With such a title it is rather a happy idea to head the column of hospital news with the words "On auscultation we hear."

ACCUSTOMED as we are to the curious forms of enterprise, shall we call it, of the East End practitioner, it was a slight surprise to see recently a baby's feeding bottle with the name and address of a medical man stamped indelibly in the glass. Of course his name bore the prefix Dr., though the Medical Directory omits to credit him with the degree. The mother stated she bought the bottle at a "chemist's shop;" apparently her words were wiser than she knew.

THE next Examination for the Charles Murchison Scholarship in Clinical Medicine will be held at the Royal College of Physicians of London, on Monday, the 18th day of April, 1898, and following days. The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than four and not more than six years at a Hospital in London or Edinburgh recognised by the Royal College of Physicians of London or by the Medical Faculty of the University of Edinburgh, and whether holding a Medical qualification or not. The Examination will be conducted both orally and in writing, and will include—(a) examination of patients, with reports on their cases; (b) questions on pathology and treatment; and (c) examination on specimens. The Scholarship is of the value of Twenty Guineas, and is tenable for one year. Intending Candidates are required to send in their names to the Registrar of the Royal College

of Physicians, Pall Mall East, London, not later than April 4th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

SIR DYCE DUCKWORTH has been appointed Harveian Orator to the Royal College of Physicians.

DR. E. J. CAVE has been admitted a Member of the Royal College of Physicians.

MR. S. L. BOX and Mr. D. R. ROWLANDS have been granted the D.P.H. of the Royal College of Physicians and Surgeons.

MR. D. P. THOMAS, of Market Bosworth, has been placed on the Commission of Peace for the county of Leicester.

THE QUEEN'S SPEECH contains two references of interest to the profession. Many will be curious to see the proposed amendment of the Vaccination Law which will be recommended for the "earnest attention" of Parliament. We are glad to note that mention is made of legislation for a teaching University for London, even though qualified by the cautious remark "in case the time at your disposal should permit you to proceed" with it.

### Amalgamated Clubs.

#### ASSOCIATION FOOTBALL CLUB.

##### BART.'S v. PEMBERTON.

Played at Winchmore on January 8th, and resulted in a defeat for the Hospital by 5 goals to 3. The ground was very slippery. At first Bart.'s played one short, and Pemberton quickly scored a goal. Bart.'s soon replied with one by Dawson; and again in the first half Ward scored for the Hospital, who crossed over with a lead of 2-1. In the second half Pemberton played a much better game and pressed continuously, the Hospital team showing signs of want of condition after the Christmas vacation. So Pemberton scored 4 more goals, and Dawson did the only scoring for Bart.'s in the second half.

For Bart.'s Ward played a capital game, and Whitaker and Dawson were good, but the back division was decidedly weak.

Team.—C. Dix (goal); L. Orton, C. H. Turner (backs); E. H. Scholefield, C. G. Watson, N. E. Waterfield (halves); C. Dawson, V. G. Ward, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

##### ST. BART.'S v. CHESHUNT.

Played at Cheshunt on January 15th. From the start Cheshunt pressed, and Barwell running through opened the scoring for Cheshunt, this proving to be their only point. The Hospital made a determined attack, but failed to score through weak shooting. The game continued even, and just before half-time Ward equalised with a good shot. From the re-start Cheshunt suddenly a complete change came over the game, the Bart.'s forwards getting together and playing a magnificent game. And to the end of the game a continual bombardment of the Cheshunt goal was kept up, Bart.'s adding 5 more goals. Whitaker got the second, and Watchouse the next two. A penalty resulted in a fifth from a shot by Whitaker, who later on added the sixth. Thus the Hospital won handsomely by 6 goals to 1.

This was by far the best game the Hospital have played this season, the forwards playing magnificently, and by their scoring in the second half fully atoning for weak shooting in the first.

At half Scholefield was very good, his tackling being quite first-rate; and at back Stone played a good game, while in goal Butcher was safe as usual.

Team.—H. H. Butcher, G. W. Stone, L. Orton, E. H. Scholefield, C. G. Watson, N. E. Waterfield, R. Waterhouse, J. A. Willett, L. E. Whitaker, V. G. Ward, H. N. Marrett.

##### ST. BART.'S v. BARNES.

Despite the fact that Whitaker, Willett, and Butcher were representing the United Hospitals at Cambridge, and Ward, Talbot, and Bostock were unable to play, the Hospital were able to bring off a victory against Barnes at Winchmore Hill on Saturday, January 22nd, by 2 goals to 1. Bart.'s were the first to score through O'Brien, but then though they pressed they failed to score through the bad shooting. Before half-time Barnes equalised, and early in the second half Marrett scored the second goal for Bart.'s. The game remained unaltered to the end, when Bart.'s were left with a hard-earned victory.

Waterhouse, Murdoch, and O'Brien played well, and Scholefield was the best of the back division.

Team.—G. Harland, G. W. Stone, L. Orton, E. H. Scholefield, C. G. Watson, N. E. Waterfield, M. G. Winder, R. Waterhouse, C. O'Brien, C. Murdoch, H. N. Marrett.

##### ST. BART.'S v. EASTBOURNE.

Played on the "Saffrons" ground at Eastbourne on Wednesday, January 26th, resulting in a win for the Hospital by 3 goals to 1. At the start Eastbourne pressed, and after a short time scored a goal in a rather unsatisfactory manner; one of their forwards pushing the ball through the goal with his hands. After this reverse, the Hospital quickly settling down attacked vigorously, and were soon rewarded with a goal, Willett scoring after a good shot from Pickering had struck the cross-bar and rebounded into play. Fast and even play was the order of the day, each goal being in danger several times until a penalty was given against Eastbourne, which Whitaker had no difficulty in negotiating, and half-time arrived with Bart.'s leading by 2 goals to 1. In the second half the Hospital had much the best of the game, never being seriously pressed, although Stanborough made some good runs, and sent in two or three good chances were missed, as their shooting was not deadly. Just at the end Eastbourne made strenuous efforts to break through the Hospital defence, but were unsuccessful, and had to retire defeated by 3 to 1. For the Hospital Whitaker, Willett, and Pickering combined very well and did a lot of work, while Scholefield played his usual sound game at half, and Butcher was very safe in goal.

Team.—H. H. Butcher (goal); L. Orton and G. W. Stone (backs); E. H. Scholefield, A. N. Other and N. E. Waterfield (halves); H. N. Marrett, H. J. Pickering, L. E. Whitaker, J. Willett, and A. B. Artsman (forwards).

#### INTER-HOSPITAL SENIOR CUP 11E.

##### FIRST ROUND.—ST. BART.'S v. ST. MARY'S.

Played at Wimbledon on Friday, 28th January. The ground was in excellent condition, and no wind or sun to affect the game. Bart.'s won the toss; St. Mary's kicking off and quickly getting together began with the best of the game, and made some brilliant attempts to score, which Bart.'s, who had started raggedly, only just managed to avert. Ward soon got away with a good run, unfortunately failing to score when close to goal. Mary's continued to press hard, but Bart.'s warmed to their work, and settling down to a steady defence very soon succeeded in shifting the play to their opponents' end. The game continued very equal, both sides putting in some hard shots and both defending well. At half-time, after some very vigorous play, neither side had scored; and although in this half Mary's had started so well, Bart.'s were gradually gaining the upper hand. From the kick-off Bart.'s, who were combining well, kept Mary's hard at work, and Marrett taking a neat pass from Ward made a dash down the line and put in a splendid shot from the corner, which Mary's goal-keeper failed to stop. However, after a nasty fall Marrett succumbed to cramp and had to leave the field, which gave Mary's a decided advantage. Bart.'s had once more to assume a strictly defensive game, and were only able to make a few more unsuccessful attacks, in which Ward was chiefly conspicuous. The game all through was very fast and equal, and played in the usual cup tie form, though it was noticeable only one foul was given. No other scoring was done, and at the whistle the result stood Bart.'s 1, Mary's 0.

For Mary's, Vickers at back, Matthews at half, Leaming and

Farquharson amongst the forwards played excellently. Altogether their team looked very fit, though Matthews and Gonin had bandaged hands.

For Bart.'s Orton, making no mistakes, was the backbone of the defence, and played a very steady and safe game, while too much cannot be said of the way Butcher kept goal and helped the backs. Scholefield, Ward, Marrett, and Talbot worked hard all through, but the rest of the team were certainly not up to their usual form. The teams were—

St. Mary's.—G. E. Paschall (goal); H. Vickers, R. Cruise, (backs); A. Sedgewick, H. Matthews, G. R. Cox (half-backs); H. E. Clarke, C. H. Farquharson, B. W. Gonin, J. Sharples, R. C. Leaming (captain) (forwards).

St. Bart.'s.—H. H. Butcher (goal); G. W. Stone, L. Orton (backs); A. H. Bostock, C. G. Watson, E. H. Scholefield (half-backs); H. N. Marrett, V. G. Ward, L. E. Whitaker (captain), J. A. Willett, J. H. Talbot (forwards).

##### RESERVES.

	Played at	For	Agst.
Wed. 8th Dec.	Holloway Sanatorium	Holloway	2 ... 5
Sat. 11th "	Rubens Club	Winchmore Hill	5 ... 2
Wed. 15th "	Royal Coll. of Science	Away	0 ... 4
Sat. 22nd Jan.	Old Foresters	Forest School	1 ... 4

#### INTER-HOSPITAL JUNIOR COMPETITION.

At a Committee meeting it was decided to enter for the Junior Inter-hospital Cup started this year, for which the following are the rules:

1. That there be a Cup for competition among the 2nd XI's of the Metropolitan Hospitals.
2. That the first round for the 2nd Cup be played after the first round of the Senior Competition.
3. A "second eleven man" is one who is in his year, and as soon as he has played in the Senior Competition, he shall be ineligible for the Junior in that year.
4. The subscription shall be 10s.
5. The affairs shall be entirely under the management of the General Committee.
6. Only hospitals entering for the Senior Competition are allowed to enter for the Junior.

The following are the draws:

- A. Guy's v. London.
- B. St. Bart.'s v. St. Mary's.
- St. Thomas's a bye.
- B. v. A. St. Thomas's a bye.
- D. or A. v. St. Thomas's.

A meeting was held at St. Mary's Hospital on January 14th to select a team to represent the United Hospitals v. Cambridge on Saturday, January 22nd. The following team was selected:

Goal: H. H. Butcher (St. Bart.'s), backs: J. Sharples (St. Mary's), P. A. Greene (London), half-backs: H. J. Dickering (St. Bart.'s), J. MacAlpine (Guy's), H. Fletcher (London); left wing: A. Hay (St. Bart.'s), L. E. Whitaker (St. Bart.'s); centre: G. P. Wilson (London); right wing: J. Willett (St. Bart.'s), L. Humphrey (Guy's). Reserves: L. Orton (St. Bart.'s), back: H. N. Matthews (St. Mary's), half-back: R. C. Leaming (St. Mary's), H. A. Upward (London).

Owing to Cup Ties several men were unable to play, H. Vickers (St. Mary's), H. N. Matthews (St. Mary's), H. A. Upward (London), and R. C. Leaming (St. Mary's) playing for Pickering, MacAlpine, Hay, and Humphrey. The result was a defeat for the Hospitals by 7 goals to 2. Willett and Wilson scored for the Hospitals, and, despite the score, Butcher gave a good display in goal.

#### RUGBY UNION FOOTBALL CLUB.

We have received no news of the Club this month.

#### HOCKEY CLUB.

##### ST. BART.'S v. FINGHLEY 3RD.

Played at Winchmore Hill on October 23rd.

This resulted in the first win for the Hospital since hockey was started last year.

In the first half Butcher scored from a scrimmage in front of goal, and Edwards sent the ball through just before half-time.

In the second half the ball was nearly always down their end; but



we could only beat their goal-keeper three times, Butler (twice) and Hallowes scoring with smart shots. Their goal was scored by one of our own men putting the ball through by mistake, the final score reading 5-1 in our favour.

**Team.**—A. Blank (goal); Nicholson, Jeaffreson (backs); Grenfell, Pollock, Parker (halves); Roberts, Butler, Muirhead, Edwards, Hallowes (forwards).

#### ST. BART'S v. SOUTHGATE 2ND XI.

Played at Southgate on October 30th.

Soon after the start Southgate scored from a corner, but Muirhead equalised shortly afterwards. Another goal to them was cancelled by Butler, and at half-time the score read 2 all.

The second half was very even. Butler gave us the lead, which was kept till the last five minutes, when Southgate scored again from a corner, making a draw of a well-contested game. Score: 3-3.

**Team.**—Nicholson, Jeaffreson (backs); Grenfell, Parker, Boyd (halves); Johnson, Butler, Muirhead, Hallowes, Edwards (forwards).

#### ST. BART'S v. EPPING.

Played at Epping on Saturday, November 6th

Epping started off at a great pace, and during the first quarter of an hour scored 3 goals.

The second half was more keenly contested, and plenty of good opportunities were thrown away by bad shooting. Savill scored once for our opponents by a clever single-handed run, the result being 4-2 in their favour.

**Team.**—Nicholson, Jeaffreson (backs); Grenfell, Pollock, Parker (halves); Muirhead, Boyd, Johnson, Hallowes, Edwards (forwards).

### Abernethian Society.

THE mid-session address was delivered on January 13th in the Medical Theatre by Dr. Lovell Drage. Mr. W. Langdon Brown, President, took the Chair at 8 o'clock.

In the course of a few introductory remarks he welcomed Dr. Lovell Drage—an old house surgeon of Sir Thomas

Smith's, and now coroner for the county of Hertford—on behalf of the Society, and called upon him to read a paper entitled "The Coroner's Court." The first part of the paper was taken up with interesting details of the historical side of the coroner's office, tracing its origin previous to A.D. 1194. He urged upon all members of the medical profession the importance of a knowledge of the working of the court, the coroner's office being one which provides protection for those signing death certificates and exonerating medical men from all blame if properly used. He thought that greater pains should be taken with regard to making post-mortems, and considered that the subject should receive greater attention in the training of medical schools. The question of juries almost always bringing in the verdict of temporary insanity in cases of suicide was discussed, the speaker thinking that the matter of insanity required some explanation, and that if a medical man is prepared to advance this theory he should likewise be prepared to back that statement up with facts.

A vote of thanks was proposed by Mr. Phillips and seconded by Mr. Tucker. This was carried with acclamation. The meeting then adjourned to the Library.

We regret the absence of the Nursing Staff on this occasion, which was as all the more unexpected as the secretaries received no intimation till the very morning of the meeting that such was to be the case. This was the first address, we believe, for at least two years from which they have been absent. Needless to say the success of the meeting suffered severely.

On January 20th the first ordinary meeting of the second half of the session was held in the Society's room; Mr. Hussey, President, in the Chair. Mr. Horder read a short paper on "Hypnotism," looking at the subject both from a medical and scientific point of view. An animated discussion followed, in which a visitor, Dr. Milne Bramwell, took a leading part.

On January 27th Mr. Langdon Brown, President, in the Chair, Dr. W. H. R. Rivers, Lecturer on Experimental Psychology at Cambridge, gave an address upon "Fatigue."

He spoke of the subject as it affected the individual, drawing a distinction between subjective and objective fatigue. He then

explained and commented upon Professor Mosso's work in this department of science, describing the methods of examination employed, and pointed out the desirability of new methods. The experimental psychologists have lately been repeating and extending Mosso's experiments; but some of them, notably Professor Krepaline, have invented and largely used a method of numerical notation. This the speaker had employed himself; analysis of many work curves made out on the results of employing it had revealed the fact that besides fatigue there were many other factors to be taken into account in drawing up any satisfactory theory. Dr. Rivers then passed on to consider the relations of fatigue and medical therapeutics, touching on the action of drugs, the theories of immunisation and of resistance to disease, pointing out that this last observation was a contribution to the long-neglected study of temperament and constitution.

On February 3rd, Mr. Langdon Brown, President, in the Chair, Mr. Gladstone Clark read a paper on "Extra-uterine Gestation."

The speaker first dealt with the pathology of the disease, saying that it was now practically certain that the pregnancy was always tubal in the first place, and not peritoneal, discussing the various theories in relation to it. He then passed to the primary rupture and the cases in which the secondary rupture occurred, giving the reasons for believing that nature may cure the accident in such cases. The clinical features of the subject were then dealt with, the speaker dwelling for some time upon the question of the previous sterility in the majority of cases, and the value of a history of amenorrhoea, and the character of the pain. This last symptom probably was due to three causes:

- (1) Mechanical distension of the tube.
- (2) Irregular contraction of the tube.
- (3) Perimetritis.

Attention was given to the importance of not accepting the unsupported statement that a patient had miscarried. As this history is by no means infrequent in such cases, a bad mistake may sometimes be avoided by observing this precaution. Occasionally before rupture the enlarged tube may be felt in one or other posterior quarter of the pelvis, and the condition diagnosed with difficulty.

The importance of obtaining the certain signs of pregnancy before diagnosing an extra-uterine gestation was insisted upon; and sound should then only be used after consultation, and where it is absolutely necessary for diagnosis. The treatment was next discussed, the most favorable cases for operation, of course, being those in which the condition is diagnosed before rupture. Mr. Clark thought that the shock due to rupture is no contra indication for laparotomy. Waiting was advised in those cases where after rupture the hæmorrhoea did not enlarge rapidly, but the medical attendant should always be prepared to operate on the shortest notice. The careful sponging away of all the old blood-clot was not advocated, the speaker believing that the general plastic peritonitis which sometimes supervened, not being septic, was due to irritation of an anæmic peritoneum by mechanical means.

### The Rahere Lodge, No. 2546.

AN Ordinary Meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, on Tuesday, January 11th, 1898, Bro. W. J. Walsham, F.R.C.S., the W.M., in the chair.

Bro. A. R. Kay, B.A. Oxon., of the Apollo University Lodge, No. 357, was elected a joining Member. Messrs. James Morrison and Edward Carnall were elected Members of the Lodge, and Dr. Morrison being present, was duly initiated into Freemasonry by the W.M.

Bros. Auden, Bill, Cripps-Lawrence, John Adams, Westbrook, and Trechmann, were raised to the third degree by the W.M. and W. Bro. Trollope.

A grant of £21 from the Lodge funds was made to the British Medical Benevolent Fund.

The brethren and their guests afterwards dined together.

An Ordinary Meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on the 8th inst., the W.M. Bro. W. J. Walsham in the chair. Bro. Morrison was passed to the second degree by W. Bro. Cripps; and Messrs. Edward Carnall and S. S. Hoyland having been elected members of the Lodge, were initiated into Masonry. Bro. G. W. Micklethwaite, of the Isaac Newton University Lodge, No. 859, was elected a joining member.

A vote of thirty guineas was made towards the forthcoming festival of the Masonic Institute for Boys.

Thirty-five members and their guests afterwards dined together, and the evening was enlivened by the music and recitations of Bros. F. W. Gale, Burns, Cripps, Robinson, and Tyard.

### The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

#### FEBRUARY.

Wed. 10th.—R.U.F.C. v. East Sheen, at Richmond. Mr. Langton's Clinical Lecture at 2.45.  
Thurs. 17th.—Abernethian Society at 8 p.m. Mr. Douglas on "Lymphadenoma."  
Fri. 18th.—Dr. Gee's and Mr. Willett's duty. Dr. Church's Clinical Lecture at 1 p.m.  
Sat. 19th.—R.U.F.C. v. Leicester. A.F.C. v. Salisbury, at Salisbury. R.U.F.C. 2nd XV v. Upper Clapton, at Clapton.  
Tues. 22nd.—Sir Dyce Duckworth's and Mr. Langton's duty. Semi-Final Inter-Hospital Rugby Cup Tie.  
Wed. 23rd.—Mr. Langton's Clinical Lecture. R.U.F.C. v. Hampstead at Winchmore Hill.  
Thurs. 24th.—Abernethian Society at 8 p.m. Dr. Emery on "The Action of Tobacco."  
Fri. 25th.—Dr. Gee's Clinical Lecture. Dr. Hensley's and Mr. Marsh's duty.  
Sat. 26th.—R.U.F.C. v. Kosslyn Park, at Old Deer Park. R.U.F.C. 2nd XV v. Templars.

#### MARCH.

Tues. 1st.—Dr. Branton's and Mr. Butlin's duty. R.U.F.C. 2nd XV v. Forest School.  
Wed. 2nd.—Mr. Marsh's Clinical Lecture.  
Thurs. 3rd.—Abernethian Society at 8 p.m. Dr. Robinson on "Some points of interest concerning Gonorrhoea in Women."  
Fri. 4th.—Dr. Church's and Sir Thomas Smith's duty. Sir Dyce Duckworth's Clinical Lecture. Final Inter-Hospital Cup Tie.  
Sat. 5th.—R.U.F.C. 2nd XV v. Guy's Hospital 2nd XV, at Winchmore Hill.  
Tues. 8th.—Dr. Gee's and Mr. Willett's duty.  
Wed. 9th.—Mr. Marsh's Clinical Lecture. R.U.F.C. 2nd XV v. Royal School of Science, at Winchmore Hill.  
Thurs. 10th.—Abernethian Society at 8 p.m. Mr. J. P. Maxwell on "Pyuria."  
Fri. 11th.—Sir Dyce Duckworth's and Mr. Langton's duty. Dr. Hensley's Clinical Lecture.  
Sat. 12th.—R.U.F.C. 2nd XV v. Ealing 2nd XV, at Winchmore Hill.  
Tues. 15th.—Dr. Hensley's and Mr. Marsh's duty.

### Volunteer Medical Staff Corps Ball.

THE members of the St. Bartholomew's Hospital Half-Company of the V.M.S.C. held their Second Annual Ball at the King's Hall, Holborn Restaurant, on Monday, January 24th, which seemed to be thoroughly enjoyed by over 200 subscribers and their friends.

The actual numbers present fell short of those attending last year, a fact which is to be regretted, as showing that the more general support by members of the Hospital anticipated was not forthcoming. In addition to the refreshment arrangements made for the previous occasion, a light supper was added, and it would appear that the alteration met with universal approval. Mrs. Walsham most kindly again officiated as the President of the Ladies' Committee, and received the guests.

The Committee were delighted to see so many of the Hospital Staff present, among whom may be mentioned Dr. Church, Sir

Thomas Smith, Mr. Howard Marsh, Mr. Walsham, Dr. Herringham, and Dr. Calvert.

The band of the Royal Artillery furnished most charming music throughout the evening. So far as the ball itself was concerned, an unqualified success was obtained, but the financial aspect of the entertainment did not prove so encouraging. For this reason the Committee publish the balance-sheet, showing a considerable deficit entirely due to the small number of tickets sold among the students of the Hospital. In the face of such financial difficulties, it will be impossible for the Committee to again repeat their venture unless there are good reasons for believing that a more general and extended support will be afforded by the students themselves. At the same time the Committee will be only too pleased to receive suggestions in regard to the formation of a Committee which might have a wider field of influence among the various sects of students interested in recreation.

#### BALANCE-SHEET.

ST. BARTHOLOMEW'S HOSPITAL (V.M.S.C.) SECOND ANNUAL BALL, JANUARY 24TH, 1898.

Receipts.		Payments.	
	£ s. d.		£ s. d.
Subscriptions	from	Holborn Restaurant,	
sale of tickets	... 74 9 0	supper, &c.	... 71 5 8
Donations	... 3 13 6	Band	... 9 19 6
Deficit	... 15 9 10	Programmes, tickets,	
		and printing	... 5 18 6
		Bouquets	... 1 15 6
		Tip to head waiter	... 1 0 0
		Badges, postage, tele-	
		grams, &c.	... 2 18 2
		Committee expenses	... 0 15 0
			£93 12 4

Audited and found correct,

A. J. W. Wells, } Hon. Auditors.  
H. G. McKinney, }

### Reviews.

ROUGH NOTES ON REMEDIES, by Wm. Murray, M.D., F.R.C.P. Lond., 2nd edition. (London, H. K. Lewis, 1897, price 3s. 6d.)

Dr. Murray's main thesis is stated clearly in his preface: "We have stood almost still too long, bewildered by the profusion of new remedies presented to us by the pharmacutists, and striking almost blindly with new-tangled remedies, while the old tried swords of our ancient armory lie rusting on the shelf." He therefore urges a more systematic observation of the effects of well-known drugs. A glance at his table of contents shows that he sticks to his text—arsenic, belladonna, mercury, and nitrate of silver being the drugs of which he treats.

The book is most refreshing. Dr. Murray is an enthusiast, and he refers the modern scepticism concerning the efficacy of drugs to the use of the right remedy under unsuitable conditions, in inadequate doses, or in unfortunate combinations. "I for my own part," says he, "have an undying, nay, an increasing vital faith in the virtue of medicines." He certainly has the courage of his convictions, for we read of 15 minims of Liquor Arsenicalis three times a day, 40 minims of tincture of belladonna every two hours, and 80 grains of calomel for a single dose. Assuredly if these heroic doses be necessary for success, we moderns are but trifling with the weapons of the ancient armory. We shrink from wielding the sword of Ulysses. It has been said that it is never worth a man's while to give a dose which will imperil his night's rest, and person ally we should sleep but ill after prescribing such. Nightmare visions of arsenical neuritis, of belladonna delirium, of acute mercurial poisoning, would haunt us, and we should arise determined to confine our therapeutical enterprise to Haustus Flavus.

But, seriously, these notes are well worth reading; they are thoroughly suggestive even where entire acquiescence cannot be given; they bear the marks of clinical experience; they force us to reconsider our position in many particulars. It is only too true that the many modern text-books relegate treatment to a few lines at the end of a chapter, while devoting pages to points of pathology often obscure. But our patients expect to be cured; they do not care merely to be regarded as interesting cases; and it is a melancholy

fact that an old-fashioned practitioner who employs only a few drugs, but knows them and their combinations practically, will succeed in effecting a cure where a man well versed in modern points and counteracting will cut but a sorry figure.

SCHOOL HYGIENE IN ITS MENTAL, MORAL, AND PHYSICAL ASPECTS, by J. KERR, M.A., M.D., D.P.H. Cantab. This excellent little book is a reprint from the *Journal of the Royal Statistical Society* of Dr. Kerr's Prize Essay for the Howard Medal of the Society. In his position of Medical Superintendent to the Bradford School Board, Dr. Kerr has had exceptional opportunities for the study of his subject, and has collected some valuable facts and statistics. After giving a general historical account of the origin of the present educational system, Dr. Kerr plunges boldly into the consideration of the effects of the aggregation of large numbers of children in Board schools, and deals in a masterly way with the elaborate and extensive precautions necessary to preserve the individual health, and to prevent the spread of disease accidentally introduced. From statistics of death-rates at school ages before and since the Education Acts dealing with accidents, measles, whooping-cough, scarlatina, diphtheria, smallpox, and phthisis, the general conclusion is arrived at that increasing school attendance does not act harmfully. In the case of phthisis, however, an increased death-rate appears to be associated with increased school attendance. From statistics of notifications of infectious disease, there does not appear to be any evidence for England and Wales that school attendance is any considerable factor in disseminating diphtheria. The importance of proper organisation of the schools is insisted upon, and particularly that of warming and ventilation, which is described as "the most urgent and pressing question at present in school hygiene." Many valuable statistics and much useful information are given by Dr. Kerr on this point. Lighting of schools is next dealt with, after which Dr. Kerr treats of the growth, hearing, and vision of school children, in an elaborate system of statistics, and several interesting results are arrived at: thus it is found that the percentage of defective vision "diminishes from year to year with age, and from class to class as we ascend in the school." The importance of such details as the height and character of the seats and desks is gone into. Finally, the vexed and important question of how to deal with special cases of intellectually defective children and the deaf and blind is discussed. Altogether we congratulate Dr. Kerr on his book.

WILLIAM HARVEY, by D'Arcy Power, F.S.A., F.R.C.S. ("Masters of Medicine" Series, London, Fisher, Unwin, and Co., 1897, price 3s. 6d.)

In this excellent biography Mr. D'Arcy Power has evidently closely followed Boswell's maxims with admirable results. By copious use of contemporary documents he has drawn a vivid picture of our Hospital's greatest physician and his surroundings. Born in 1578 and dying in 1657, William Harvey lived through some stirring years of our national history; associated in turn with the Universities of Cambridge, Padua, and Oxford, he was provided with the best available academic training. At Cambridge Caius had just founded the study of anatomy on a sure basis; at Padua the science had been greatly developed by Vesalius and his successor Fabricius; while at Oxford, in his maturer years, Harvey was enabled to escape from the turmoil of the Civil Wars, and quietly trace the development of the egg with Bathurst at Trinity. Long may the ancient universities continue thus to afford a secure retreat for the scholar. But the scholar can seldom entirely escape from strife that rends the state; Aristides paid the penalty with his life, and Harvey was not scatheless. The mob broke into his rooms at Whitehall, scattering his notes on post-mortem examinations, embryology, and comparative anatomy. The imagination conjures up the losses that Science has sustained from the destruction of her sibylline leaves, whether by the vandalism of the mob, by the gambols of a pet dog, or by the impious hand of Sir Everard Home. What discoveries, we wonder, are hidden in those lost papers of Harvey, Newton, and Hunter? There is reason to hope, however, that some of Harvey's writings may be found again; so lately as 1888 Dr. Norman Moore discovered a fragment.

To the Bart's man the chief interest of the book lies in the narration of Harvey's association with this ancient Hospital, to which he became physician in 1609. The former relative status of the physician and surgeon is impressed upon us by the fact that even till Abernethy's day no surgeon could prescribe anything beyond a blue pill or a black draught, unless the prescription was counter signed by a physician. Even in surgical matters they had not a free

hand, for it was ordained in Harvey's time "that no chirurgion or his man do trepan the head, pierce the body, dismember or do any great operation on the body of any, but with the approbation and by the direction of the doctor." A side-light is thrown upon these humiliating restrictions by the application of a certain surgeon to be excused from attending "anatomies" on the plea that he now confined his attention to shaving and selling silk! But the Barber-Surgeons' Company possessed some power, as Harvey discovered to his cost when he failed to diagnose a fractured skull, and did not call in a surgeon. This error of his should be a consolation to a house surgeon pilloried in the *Star*, or riddled by the questions of an "intelligent" juror.

Arduous as the duties of the Censors of the Royal College of Physicians may be to-day, they are at least spared the task that then fell on them of visiting the various apothecaries' shops and investigating their stores. The report on the Dioscordium and the Venice treacle supplied in several shops is very unflattering; but doubtless their therapeutic activity was quite as great as that of approved samples.

Space fails us to comment on the many points of interest raised by Mr. Power's book, but we must notice, in conclusion, the essential modernity (to use a cant phrase) of the researches which led to Harvey's great discovery of the circulation of the blood. The clear logic, the direct appeal to experiment, the arguments derived from comparative anatomy and embryology, mark him out as a true father of many of our modern methods, and for all time as a man of commanding genius.

CATECHISM SERIES, Surgery, Part VI. (Edinburgh, E. and S. Livingstone, price 1s.)

If a work of this type is really needed, it is the strongest possible argument for the necessity of a severe entrance examination for medical students. We always like to say anything that can be said in praise of a book, and must therefore bring this review to a hasty conclusion.

### Obituary.

HENRY GOVERNION SELBY, M.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P.

We much regret to announce the sudden death of H. C. Selby at the Napier Hotel, Poona, on January 2nd, from heart disease. He had only just reached India for special plague duty, and his serious condition was apparently unsuspected; the fact remains that he had aortic regurgitation. The night before he was seen by his Bart's colleagues shortly before midnight in his usual health; Mr. Littler Jones was called at a quarter to seven in the morning to see him, as he had become alarmingly ill, and in spite of all that could be done he died at half past eight.

At his funeral there were present two Bart's nurses and no less than four Bart's men. His cousin, Prof. Governion, the only relative he had in the country, arrived from Bombay in time to be present. Among the flowers placed on his grave were wreaths from the Bart's men now on plague duty, the Poona Plague Committee, the nurses at Valentine Lodge, and other friends.

The deceased entered Downing College, Cambridge, in 1890, of which foundation he became a Scholar; he graduated in the First Class of the Natural Sciences Tripos in 1893, and subsequently joined this Hospital. He took his Diploma and M.B. in due course, but was soon after laid aside for a time with typhoid fever. This was said to have left him with a dilated heart, and he went for a voyage

to America, from which he returned apparently in good health. The fact that he had a serious organic lesion of the heart was, as we have already said, unknown till the last few minutes of his life. And thus is cut short a career from which past performances had led us to expect much.

DRUCE JOHN SLATER, M.D. Lond.

On Saturday, the 29th of January last, occurred the untimely death of an old St. Bartholomew's man, popular in his time as an athlete and as a trusty comrade—Druce John Slater. He was out shooting when, through some accident, his gun discharged and lodged the contents of both barrels in his chest. His death was almost instantaneous.

Druce Slater was born in November, 1856, and was consequently in his forty-second year. He entered the Hospital in 1878, became M.B. Lond. and M.R.C.S. in 1883, and held in succession the posts of Obstetric House Physician to the late Dr. Matthews Duncan; Clinical Assistant to the Hospital for Consumption, Brompton; and House Surgeon to the East London Hospital for Children, Shadwell. After travelling abroad with a shooting party he finally settled down to general practice in South Kensington, where he very soon made for himself a large circle of acquaintances, both friends and clients; for Slater was not only a sound doctor, he was also a genial and entertaining companion. In 1888 he passed the examination for the M.D. Lond. His practice went on increasing until Christmas, 1896, when he fell a victim to influenza, after successfully withstanding its attacks since 1889. But though stoutly built and possessed of energy, which seemed to many of his friends inexhaustible, the prolonged and arduous work immediately preceding his illness left him in a condition not the most favorable to resist what we are all now well acquainted with as one of the worst after-effects of influenza, profound nervous depression. And in order to recover from this he was advised abroad. He visited Jersey and the Canary Islands, and was greatly benefited by a tour through South Africa. On his return to England in September of last year he rested at the sea-side for a month, and in October resumed his practice. Friends and patients all were delighted to see the marked improvement in his state, for his buoyancy of spirits and his untiring zeal for the welfare of others had made him a general favourite. But not only did he win the affection of his friends and the confidence of his brother practitioners, he gained also the esteem and respect of his patients by his assiduous attention to their well-being in time of illness. When work was to be done he never spared himself, nor did he ever grudge his night's rest spent at the bedside of the sick. As I have heard it remarked by one of his grateful patients, "never did anyone spare himself so little when anxious and critical work was to be done in his profession as Dr. Slater." And this feeling in which he was affectionately held found itself a vent

in the great number of sorrowing inquiries at the first rumour of his sudden death, and the numerous and beautiful wreaths that attended him to his last resting-place. Druce Slater's temperament was peculiarly sensitive; he loved to be always doing, and was full of generous self-sacrifice for others' good. His memory will not fade amidst his friends, and he will be remembered at St. Bartholomew's as being one of the first, if not the first, to fight the battles of the Junior Staff.

### New Productions.

D. C. L. MALT EXTRACT.—MESSRS. T. B. BROWNE, Limited, have forwarded to us a highly palatable Malt Extract prepared by the Distillers' Company, Limited, Edinburgh, which we should think could hardly disagree with the most delicate digestions.

### St. Bartholomew's Hospital Christian Association.

MEETINGS have been arranged for the months of February and March in the Inquest Room at 5 p.m. The following speakers have promised to be present:

Feb. 3rd.—T. Tatlow, Esq.  
" 10th.—H. W. M. Munn, Esq.  
" 17th.—A. Mercer, Esq.  
" 24th.—W. R. Moore, Esq., B.A.  
March 3rd.—A. E. W. Gwyn, Esq.  
" 10th.—Rev. A. Rouse, M.A.  
" 17th.—Bible Reading.

A prayer meeting is held daily (Saturdays excepted) in the vestry of the church at 1.0 to 1.10 p.m.

C. A. S. RIDOUT, Hon. Sec.

### Appointments.

BUMSTED, H. J., B.A. (Cantab.), M.R.C.S., L.R.C.P., appointed House Surgeon to the Beckett Hospital, Barnsley.

CALVERLEY, J. E. G., M.D., B.S. (Lond.), M.R.C.S., L.R.C.P., appointed Surgeon to P. & O. ss. Valatta.

HALL, A. J., M.B., B.C. (Cantab.), M.R.C.P. (Lond.), M.R.C.S., has been reappointed an Honorary Physician to the Sheffield Royal Hospital.

### Examinations.

CONJOINT BOARD.—M.R.C.S., L.R.C.P.—The following have completed their examinations and taken their diplomas.—J. W. Milne, J. L. Morris, A. G. Tolpitt, W. B. Parsons, C. L. Fort, W. A. Bramson, R. N. Geach, E. A. Weber, R. Harfield, E. S. E. Hewer, N. H. Joy, R. H. Lloyd, H. G. Tymms, A. O. Way, C. V. Knight, B. J. Collyer. *Chemistry and Physics*.—T. H. Fowler, G. Hughes, J. K. N. Marsh, H. M. H. Melhuish, G. W. Miller, A. C. Young. *Practical Pharmacy*.—F. H. Ellis, R. J. Hanbury, F. G. Richards, G. A. W. Spear. *Elementary Biology*.—J. G. de G.

Best, E. S. Ellis, L. U. Geraty. *Anatomy and Physiology*.—E. B. D. Adams, G. E. Cathcart, D. C. O'C. Finigan, E. C. Hepper, J. W. Robertson, E. D. Smith, F. E. Taylor.  
SOCIETY OF APOTHECARIES.—*Medicine (Section 1) and Forensic Medicine*.—J. B. Cautley.

### Correspondence.

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

#### THE ROUTINE DOUCHING OF THE PUERPERAL UTERUS.

SIR,—Since reading Dr. James Morrison's paper in the *JOURNAL* of June last, I have scanned each succeeding issue for some criticism of his advocacy of routine douching of the puerperal uterus. I am glad to see that in the December issue Dr. Robinson has opened the ball.

Dr. Robinson deals so skilfully with the question from a scientific point of view that I cannot hope to add anything of value to what he has said from that standpoint.

My first comment on reading Dr. Morrison's paper was that in existing conditions of general practice, a routine douching of confinement cases on the third or fourth day would be so unusual that but few patients would consent to it, and of these still fewer would give the practitioner an opportunity of attending them in future confinements. I make this comment with bated breath; it is, I fear, too utilitarian to carry weight with those whose present happy aim is science apart from shakels. However, to any Bart.'s man who intends to douche all and sundry of his confinement cases willy-nilly on the third or fourth day, I respectfully say, "for the sake of your practice, don't!" Why, on the third day they "negotiate their last fence," take their dose of oil, and take the doctor's future visits as mere milestones on the road to recovery. Why, beside the man who disturbs them from their comfort at this time in order that (to quote Dr. Morrison) "an intra-uterine douche may be given, and the uterus thoroughly washed out."

If, then, one is imbued with Dr. Morrison's views, and must for conscience sake carry them out, one risks becoming a martyr in the cause; all the more reason for making certain that the cause is a good one, and I for one am grateful to Dr. Robinson for showing that it is not. I can speak only from my own knowledge of between two and three hundred cases occurring in general practice in the country. Of these many were "B.B.A.'s" (owing to distance) attended by well-meaning but terribly septic country women, and in many more the sanitary conditions were of the worst, the cesspools about here being generally under the bedroom window and next door to the well.

I cannot pretend to any exact notes of the cases that have run a normal course, and it may be that of these (to quote Dr. Morrison) "every woman was at about the end of the first week slightly septic or septic," but I doubt it. That it was so in a few cases I know, but I also know that a judicious purge rendered the temperature normal for good. With the four abnormal cases I can claim a more intimate acquaintance, and these, of course, involved the use of the douche.

By abnormal cases I mean, of course, those which were abnormal during the puerperal period, not those abnormal during labour. To give brief details:

1. Primipara set. 17 (B. B. A.). I examined placenta and suspected retained membranes. On the fourth day temperature 101°. Quinine prescribed. On morning of fifth day temperature 102°. On evening of fifth day temperature 104°. I gave perchloride douche and removed decomposing membranes. The temperature dropped to normal, and subsequent recovery was uninterrupted.

2. Multipara. When first called to the case the os was practically undilated, and the distended cervix protruded from the vagina into a particularly septic bed (exactly as described by a correspondent writing from Jamaica to the *British Medical Journal* in June, 1896). Delivery was afterwards effected naturally, during my short absence from the house. The patient afterwards developed general septicaemia and died. Douches were given regularly from the time of the first rise of temperature.

3. Multipara with continually raised temperature from fourth day. In spite of constant douches she developed pelvic abscess, which ended in complete convalescence under other hands.

4. Multipara. Good hygienic conditions, but a first-rate trained

nurse. Constant elevation of temperature at some period of the day from fourth to tenth day, scarcely ever above 100°. On tenth day, at midday, I gave a perchloride douche 1-4000, which would have been given earlier, but the patient was very much opposed to it. During the afternoon the patient had abdominal pain, which increased to the great alarm of both patient and nurse. I saw her at 8 p.m., and found her in intense abdominal pain, with the legs drawn up. The temperature was 102°. Fortunately twenty grains of antipyrin brought down the temperature to 99°, and next morning it was normal. The recovery was afterwards rapid and uninterrupted.

When one sees case after case run on to an uninterrupted recovery under the most adverse conditions, even when, as in cases B.B.A., such ordinary precautions as clean hands, let alone disinfected hands, have been absent, how can one possibly agree with Dr. Morrison that nature "probably" meant well, but that she is powerless to prevent the noxious germs from rushing up to happy hunting-grounds on the placental site?

I cannot recollect this spirit in the teaching of Dr. Matthews Duncan. I rather remember his maxim that "meddlesome midwifery is bad midwifery."

The value of the douche as a remedy rather than a routine is very great, of course, and one word in this connection respecting Case 4 mentioned above.

In this case the douche was distinctly indicated, and eventually completely successful, but it caused some of those alarming symptoms which Dr. Morrison says "are mentioned in books as having occurred," and of which Dr. Robinson gives such timely warning.

I would submit that the puerperal state is a natural state, and that the douche is one of our many means of assisting nature when she requires assistance; but that as a routine treatment in every case on the third or fourth day it is unnecessary and risky.

Yours faithfully,

LAURENCE A. WINTER, M.R.C.S., L.R.C.P.  
Chartham, Kent; Dec. 15th, 1897.

### Births.

HENSTOCK.—On December 24th, 1897, at Viña del Mar, Chile, the wife of J. L. Henstock, M.R.C.S., L.R.C.P., of a son.

ROBINSON.—On January 25th, at Killieser Avenue, Streatham Hill, the wife of Louis Robinson, M.D., of a daughter.

SKIPWORTH.—On January 28th, at the Terrace, Gravesend, the wife of P. L. G. Skipworth, M.R.C.S.(Eng.), of a son.

### Marriages.

GILLIES—WILLIES.—On January 12th, at St. Augustine's, Flint-ham, by the Rev. J. H. Heath, M.A., Sinclair Gillies, M.A., M.D., son of the late Mr. Justice Gillies, of Auckland, N.Z., to Annie, younger daughter of John Willies, Flintham, Notts, late of Ossington Grange, Newark.

MAUND—NODING.—January 26th, at the Pro-Cathedral, Kensington, by the Rev. Septimus Andrews, M.A., O.S.C., assisted by the Rev. Michael Fanning, John, eldest son of the late John Maund, Esq., J.P., D.L., of Ty Mawr, Brecon, to Clare, only daughter of the late Thomas Henry Noding, Esq., of Trinidad, W.I.

### Deaths.

SELBY.—On January 2nd, at the Napier Hotel, Poona, Henry Covernton Selby, M.A., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P., aged 30.

SLATER.—On January 29th, at Temsworth, Bedfordshire, Druce John Slater, M.D.(Lond.), M.R.C.S., L.R.C.P., of Courtfield Road, South Kensington, aged 41.

ACKNOWLEDGMENTS.—*St. Thomas's Hospital Gazette, Guy's Hospital Gazette, London Hospital Gazette, The Stethoscope, The Sphygmograph, The Dentist, The Student, The Nursing Record, St. Mary's Hospital Gazette, The Guyoscope, The Hospital, St. George's Hospital Gazette.*



Thomas Smith

# St. Bartholomew's Hospital



## JOURNAL.

VOL. V.—No. 6.]

MARCH, 1898.

[PRICE SIXPENCE.]

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MARCH 14th, 1898.

*"Equan memento rebus in arduis  
Servare mentem."—Horace, Book II. Ode iii.*

WE have to announce with regret that Sir Thomas Smith has resigned his position as Senior Surgeon to the Hospital. This is, of course, not unexpected; the recent changes in the Orthopaedic Department and elsewhere have been but shadows of an event which was known to be inevitable. Nevertheless all Bart's men will keenly regret the departure of one from our midst who has been closely associated with the Hospital for nearly half a century, during which time he has not only added conspicuously to its renown, but has endeared himself to everyone. It would be indeed hard to say whether Sir Thomas Smith is most admired by Bart's men in his professional or his personal capacity; nor is it necessary to decide. It is part of that conservatism with which Bart's is always

credited that we have, in Lowell's phrase, learnt "of old friends to be most miserly." And though we recognise the advisability of the superannuation rule, nay, its actual necessity, this does not lessen our sorrow at the loss of so tried and trusted a friend. Still it is gratifying to remember that Sir Thomas Smith does not leave us from failing health; his force is not abated, and our loss will be the gain of others. Freed from the exacting duties of the Hospital, he will be more at liberty to devote his time to private practice.

It was in October, 1850, that Mr. Smith (as he then was) began his student career at our Hospital. The minute books of the Abernethian Society still record his admission to the ranks of its members, and his subsequent election as President in 1857. After qualifying he was elected a Demonstrator in the "Rooms," and a little later Demonstrator of Operative Surgery. He became a Fellow of the Royal College of Surgeons in 1858, and published his textbook of operative surgery in the following year. When Senior Demonstrator of Anatomy his colleague was Mr. Morrart Baker, and the Assistant Demonstrators were Mr. Vernon and Mr. Langton. In 1864 he was elected Assistant Surgeon to the Hospital, and soon after took charge of the special Department for Diseases of the Ear. At the time of his election to the Staff the Surgeons were Mr. Skey, Mr. Wormald, Mr. (now Sir James) Paget, and Mr. Coote, and the other Assistant Surgeons Mr. Holden, Mr. (afterwards Sir William) Savory, and Mr. Callendar. In 1873 he became full surgeon, a post he has held for just a quarter of a century. On the death of Sir William Savory he was appointed Surgeon Extraordinary to the Queen.

Of the numerous other positions he has held we need only mention the Vice-Presidency of the College of Surgeons, the Honorary Secretaryship of the Royal Medical and Chirurgical Society; he is still Consulting Surgeon to the Hospital for Sick Children, Great Ormond Street. By his kindly consideration for all with whom he has had to deal in these various positions, he has won the affectionate esteem of his colleagues, the students, and the patients alike.

We have not spoken of his contributions to surgical literature, though these are by no means inconsiderable.



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His work on cleft palate is known to all, and the value of our Hospital Reports has been repeatedly enhanced by papers from his pen, rich in clinical experience.


Great was the delight of all Bart.'s men, past and present, when on the occasion of the Diamond Jubilee the Queen conferred a Baronetcy on our Senior Surgeon and her Surgeon Extraordinary. It is no secret that Sir Thomas Smith was less anxious for the honour than Bart.'s was to see that honour so worthily bestowed. The spontaneous nature of the reception accorded him at the Hospital on the day following this announcement was in itself a testimony to his unbounded popularity. The repetition of this reception next day at consultations will be long remembered by those present for the graceful speech with which Sir Thomas Smith made his acknowledgments.

We had hoped that in this number Sir Thomas might have been able to give some reminiscences of his long connection with the Hospital. These fifty years have seen great changes, and we should have been glad to have the opportunity of viewing them as they appeared to him. But stress of engagements forbade, or rather, shall we say, deferred the accomplishment of this. For Sir Thomas Smith has promised to think over it in a few months' time, and see if he can provide us with an article on the subject; and such a contribution we are sure will be eagerly anticipated. Meanwhile we are glad to have the opportunity of presenting our readers with an admirable likeness of one who will always be affectionately remembered, as he himself requested, by the familiar name of Tom Smith.

### Pathological Jottings.

By A. A. KANTHACK, M.D., F.R.C.P., Professor of Pathology in the University of Cambridge.

#### VII. THE PROCESS OF ACUTE INFLAMMATION (continued).

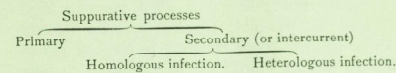
 FEW words must now be said regarding the action of the pyogenic micro-organisms. It is erroneous to imagine that these microbes are truly specific in their action, and thus capable of producing suppuration only. Suppuration is only the outward expression of certain inflammatory processes, and it is not even the most serious phase or variety of inflammation, and therefore, *a priori*, we should expect that the so-called pyogenic organisms can bring about various forms of inflammation according to the prevailing conditions. As a matter of fact we find that the same species of organisms may produce a slight local inflammation or an extensive spreading inflammation, a small local suppuration or a large acute abscess, an erysipelas or a cellulitis, a pneumonia, a septicæmia, an infective endocarditis, or a pyæmia. Thus a small acne pustule may contain one or more varieties of pyococci, it may grow into a boil, the latter into a carbuncle, which

again may be followed by septicæmia or pyæmia. The pneumococcus may be found in pneumonia, in suppurative otitis media, in angina Ludovici, in infective endocarditis, peritonitis, and pleurisy. Almost all vegetable micro-organisms possess the faculty of producing an inflammation, and those which are most frequently found in primary inflammatory processes are called pyogenic; but whether they produce a benign form of inflammation or a suppuration, an oedematous or necrotic inflammatory lesion, will depend chiefly on the virulence of the bacteria, the local conditions, the local or general resistance, on the quantity of bacteria introduced, and on the supply of micro-organisms, *i.e.* whether we have a single or a continued invasion of micro-organisms. Under favourable conditions, *i.e.* if the virulence of the bacteria is reduced or the resistance of the tissues exalted, we have an innocent local inflammation; as the virulence increases, or as the resistance decreases, suppuration makes its appearance, and if the virulence is excessive and the resistance slight, we have an oedematous, necrotic, or gangrenous inflammation. Septicæmia appears when the organisms enter the circulation and multiply in the blood. It is of the utmost importance to realise that suppuration is not a specific process, it is a clinical term for changes which can be recognised by the unaided eye.

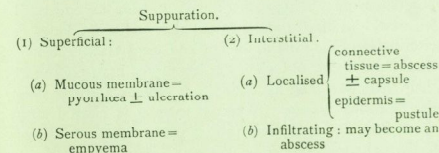
The character of pus varies considerably. (1) Thus it may be thick creamy, light yellowish or greenish in colour, possessing a characteristic faint odour (laudable pus), which is oftenest associated with staphylococci. (2) It may be serous and thin, when the streptococcus is not uncommon. (3) Its colour may be blue or green, which is due to the presence in pus of the *B. pyocyaneus*. (4) In suppuration, occurring during the course or as the result of enteric fever, we frequently find thick reddish pus, when the lesion is due to an infection with the *B. typhosus*; (5) while gangrenous pus is generally associated with a mixture of organisms (mixed infection). It must not be imagined, however, that we are in a position to recognise the nature of the bacterial infection from the appearance or character of the pus. In so-called laudable pus streptococci may be found alone or together with staphylococci, and again in serous pus staphylococci may occur, and the pus in typhoid suppuration may differ in no way from ordinary pus. At the present time the bacterial character of pus can be only gauged by means of the platinum needle and a test-tube, all the more since usually two or more species of pyogenic organisms occur together. Whatever we may be able to do in the future, at present we cannot distinguish with anything like certainty different specific forms of pus; all we can say is that in serous pus streptococci are likely to occur, and in ordinary laudable pus staphylococci, but we must not go further.

In the study of pyogenic lesions it is important to remember that a *suppurative process may be primary or secondary, i.e.* it may be the only lesion present or it

may appear in the course of or after the defervescence of an infective fever. Thus a patient may present himself with an abscess due to some injury associated with or followed by infection (primary suppuration), and another patient may develop an abscess during or after an attack of enteric fever (secondary suppuration). In the latter case the suppuration may be due to the same organism which caused the fever—in our example the *B. typhosus* (*homologous infection*), or it may be due to an altogether different organism, such as a streptococcus or a staphylococcus (*heterologous infection*).

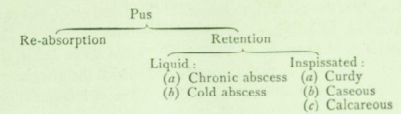


Anatomically suppuration may be (1) *superficial* or (2) *interstitial*; that is, pus may be either discharged from a free surface or it may collect in the depth. When the process is superficial it may appear (a) as a result of inflammation of a mucous or (b) serous membrane. In the former case we speak of *pyorrhœa*, and this may or may not be accompanied by superficial ulceration. In the other case we are dealing with an *empyema*, although this term is now generally applied to suppuration of the pleura. When the suppuration is interstitial the pus may remain (a) localised, forming an *abscess*, which may or may not be surrounded by a capsule; or (b) it may infiltrate the connective tissue. The *purulent infiltration*, by destroying the tissues bathed by the pus, may become converted into an abscess. If the pus infiltrates the epidermis the result is a *pustule*, which in reality is an epidermal abscess.



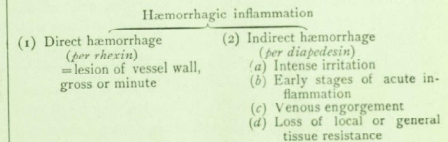
The pus which has been formed may be re-absorbed on cessation of the irritation or inflammation. This, however, can only take place when the collection of pus is but slight. This re-absorption is effected in part by phagocytosis, in part by the proliferation of the endothelial and connective-tissue cells. Proliferative changes there must be, because during suppuration there is histolysis, and the destroyed tissue must be replaced by fibrous tissue (*indirect repair*). If the pus does not disappear in this manner it remains behind as pus, and the result is generally a chronic abscess. The latter may have a distinct fibrous capsule, and if the inflammation abates or ceases the capsule becomes smooth, and forms the so-called *pyogenic membrane* of older writers. In most chronic abscesses inflammation and suppuration continue, micro-organisms flourish in the pus, and they with their poisons act as irri-

tants. In some, however, all inflammation ceases, the micro-organisms perish, and the symptoms due to pent-up pus may be entirely absent (*cold abscess*). On the other hand, the unabsorbed pus may become *curdy and inspissated, or caseous*, and even calcareous or cretaceous on account of a deposition of calcium salts; calcification is always preceded by inspissation or caseation.



*Hamorrhagic exudation.*—It has already been stated that, along with the leucocytes and fluid exudation, red blood corpuscles pass out of the vessels. Under certain conditions this passive diapedesis of the red corpuscles may be excessive, so that the exudation becomes hæmorrhagic. In such cases leucocytes are generally scarce, so that we obtain a *blood-stained serous exudation*; but occasionally the red corpuscles are mixed with the leucocytes and round cells which have been collected in large numbers at the inflammatory centre, so that we obtain a *blood-stained purulent exudation*.

The excessive diapedesis of the red corpuscle is due mainly to the severity of the irritant, or to lowering of the resisting powers of the tissues. Thus we find that virulent infections, such as smallpox, malignant pustules, and acute necrosis, are frequently accompanied by hæmorrhagic exudation; or that in a debilitated subject, such as one suffering from renal disease, inflammations readily become hæmorrhagic. In gangrene also, where the toxins are powerful, and are absorbed in large quantities, the vessels are injured, and hæmorrhages due to direct rupture or due indirectly to diapedesis are common. Again, in the early stages of acute inflammation hæmorrhagic exudations are not unusual; thus in acute nephritis, to begin with, the urine is often red from admixture of blood (nephritis hæmorrhagica). A mechanical injury may cause vascular lesions, gross or minute, by which the blood finds an outlet and mixes with the inflammatory exudation; this, however, is a true hæmorrhage, and very different from the hæmorrhagic inflammation where



the blood transudes by a process of passive diapedesis. The former is a hæmorrhage *per rhexin*, the latter a hæmorrhage *per diapedesin*. Again, inflammation may occur in a part of the venous circulation of which is laboured and obstructed,

*i. e.* in an engorged area. Here there is considerable slowing of the blood stream, marked fullness of the venous channels, and grave disturbance of nutrition. Inflammation under such conditions readily causes a transudation of blood, a hæmorrhage *per diapedesin*.

**Proliferative changes.**—We must now consider the proliferative changes of acute inflammation. These are best seen when the exudative changes are clearing away, but it is erroneous to imagine that in point of time they follow the exudative phenomena. They begin while those latter are progressing,—in fact, they may be observed at the margins of the affected area often at the earliest stage of inflammation, but they become more evident when with the disappearance of the leucocytes the veil is lifted and a clear view is obtained, and they persist, passing imperceptibly into the stages of repair. Repair is a termination of inflammation, but not even a necessary one, for it may often be absent. Proliferative changes are always present; at times, however, they are but slight in degree, at others extremely well marked. An injured tissue, which has any life left in it, is always ready to react by repair; if there is loss of substance the living cells will multiply and proliferate, but if there is no loss of substance, no necrosis, but merely damage to the cells, it may simply recover. We have, therefore, two processes by which an injury is made good; (a) repair by recovery, (b) repair by proliferation. The latter may or may not be accompanied by or preceded by inflammation. Thus an injury to a tissue may not be sufficient to rouse the connective tissue, and then *repair is direct*, the cells proliferating and producing homologous tissue, but if it is sufficient to rouse the connective tissue into an inflammatory reaction, repair is indirect; matter has to be cleared away, a gap has to be filled up, and this can only be done by fibrous tissue, *i. e.* by heterologous tissue. It is in the nature of things that reparative changes should appear in inflammation; the living tissue tends to repair an injury, that is a postulate of pathology; and we find that while the least injured cells recover, the more injured ones die, and their places are supplied by a new progeny. Now, since in inflammation there is always some necrosis, there must be proliferation, and therefore proliferative changes are a *sine quâ non* in inflammation. These changes are observed (1) in the connective-tissue cells, (2) the endothelial cells of the lymph spaces and capillaries. The connective-tissue cells enlarge, their nuclei become swollen, round or oval, and karyokinesis (mitosis) is active, which is certain evidence of proliferation. These changes occur while the leucocytes are still present, and the leucocytic infiltration may be so considerable as to hide the proliferative phenomena altogether from view. When, however, the leucocytic infiltration clears up, which it always does as the inflammation subsides, then we see clearly what has taken place. There are many large protoplasmic cells, rich in cell substance, with nuclei which stain but faintly, or are rich in chromatin, and resemble epi-

thelial cells, and are therefore often called epithelioid cells. Others are more fusiform in shape, with long darkly staining nuclei; these gradually become spindle-shaped. It is generally believed that the spindle-cells are merely a later stage of the epithelioid cells, *i. e.* that both are derived from the connective-tissue cells, although some observers believe that the spindle-cells are derived from the fixed connective-tissue cells, and the epithelioid cells from the endothelium. At this period, when the leucocytic infiltration has disappeared and the cells begin to proliferate, numbers of small uninuclear round cells appear, which possess a large round nucleus, and resemble lymph corpuscles (lymphocytes). These small cells are collected in irregular groups, or in distinct masses which may be compared to adenoid or lymphoid collections, and they constitute the *small round-cell infiltration* (lymphocytic infiltration). These small cells appear to be derived from rapidly proliferating connective-tissue cells, from the endothelium of the lymphatic spaces, and from the lymphocytes which are always present in the connective tissue, but many of these small wandering cells may have been attracted by so-called "chemiotactic" influences. The free connective-tissue cells, the lymphocytes, and the endothelium of the lymph spaces are all migrating, and may therefore be attracted to the seat of irritation.

The normal connective tissue possesses (a) fixed cells and (b) wandering cells, but normally while only the latter are free and under the spell of chemiotaxis, we find during inflammation that the fixed cells divide and proliferate, and then become free and migrating. They wander to the seat of inflammation, being at first mixed up with the emigrated leucocytes in the exudation, and they assist the latter in clearing away the irritant, foreign and dead matter, hæmorrhages and fibrin, and when the leucocytes have performed their share they take up their dead remains and complete the cleansing process. When everything is cleared away they either fall into their proper places, or they undergo further changes and form vascular cicatricial tissue. A croupous pneumonia, for instance, may clear up, the leucocytes disappearing, being in part discharged with the expectoration, in part taken up by the connective-tissue cells and the endothelium; these cells may then simply resume the places they ought to occupy, so that the result is a complete resolution without secondary thickening, or they may form vascular connective tissue which gradually becomes fibrous and leads to a chronic induration of the lung. In resolution, therefore, we have homologous repair, in induration heterologous repair (*cicatrisation*). When cicatrisation occurs the proliferated cells become spindle-shaped, arrange themselves in strands along the vessels, more and more interstitial substance appears between the cells, which have become still more fusiform and are now called fibroblasts. The latter become gradually less protoplasmic, while the interstitial substance increases, and gradually typical fibrous

tissue is formed, which in time becomes harder and less vascular.

It is during the stages of repair, especially during the earlier stages, that phagocytosis is well seen. The connective-tissue cells take up the dead tissues, the leucocytes, foreign bodies, &c., following the example set them by the leucocytes. If the material to be removed is copious or firm, giant-cells will appear, *i. e.* multinucleated cells with numerous nuclei, and often provided with branched processes. They are both phagocytic and histolytic, dissolving the substances with which they come in contact. It is a debated point whether the giant-cells are of endothelial or connective-tissue origin, whether they are plasmodial or formed by continued cell division. This matter will be discussed in a subsequent article.

During the process of heterologous repair new vessels appear. These are formed by the original capillaries which throw out endothelial buds into the inflammatory area occupied by the proliferated cells and by the small round cells forming the lymphocytic infiltration. At a given point the endothelial cells of the capillary divide and multiply, until we have a solid endothelial protrusion or offshoot. This becomes hollowed out by the blood forced into the bud from the old vessel, and in this manner the vessels are prolonged into the proliferating tissue. Examining these newly formed vessels more closely we find that they are surrounded by numerous small round cells, amongst which we find spindle-cells, epithelioid cells, and large protoplasmic cells, and if the suitable conditions exist, *i. e.* copious or firm foreign matter, also giant-cells. Such vascularised proliferating cellular tissue constitutes the so-called granulation tissue of the surgeon, which gradually becomes converted into cicatricial tissue, and as the cicatricial tissue becomes more fibrous the vessels gradually disappear, so that eventually we obtain a hard, dense, white or glistening fibrous tissue.

We may here take leave from acute inflammation, having traced its main features and followed it into resolution (homologous repair) and cicatrisation (heterologous repair). Other points might have been mentioned, such as the part played by the nervous system, and some matters might have been discussed more fully. Exigencies of space, however, a due regard for a sense of proportion, and the fear of being voted tiresome, compel me to leave this entrancing subject, the proverbial battle-ground of pathologists. For fuller information larger works on pathology must be consulted. The reader, however, should remember that as soon as resolution and repair set in inflammation is at an end, and further that cicatrisation may take place without preceding inflammation, as we have already seen while discussing Chronic Inflammation.\*

\* "Pathological Jottings," No. II, November, 1896.

## Perforating Gastric Ulcer.

A Paper read before the Abernethian Society on  
November 11th, 1897,

By R. DE S. STAWELL, B.A., M.B., B.C.



URING the last few years the subject of gastric and duodenal ulcers has been invested with new interest by the successful application of operative measures in the treatment of the deadly perforations, which they not infrequently cause; and it is this question which I here propose to consider. That we should now be able to meet this terrible lesion with a fair prospect of success, and rescue from practically certain death our patients, often young and, except for this localised spot of ulceration, probably perfectly sound, is an achievement which every one, I think, will admit marks a distinct advance in the range of practical surgery. Some years ago Senn predicted the extension of operative interference in this direction, but the credit of having first definitely suggested laparotomy and suture, or other suitable measures, in cases of gastric perforation, appears to be due to Dobson of Bristol, who in 1883 called attention to the subject in a paper published in the *Bristol Medical and Surgical Journal* for that year. Though Krieger in 1892 was able to report the first successful case, British surgeons appear to have played the principal part in the elaboration of the operation; and now each year brings an increasing number of successful cases, many which in former times might have been overlooked being treated with brilliant results. There still, however, appears to be in a certain proportion great difficulty of diagnosis, and the details of treatment are not yet fully agreed upon. This being so I thought it might not be unprofitable to study the cases which have been treated in this hospital, and I have examined our records for the past twenty-eight years with results which, I hope, may prove of some interest for discussion. Simple perforating ulcers of the duodenum appear to be so closely correlated to those which occur in the stomach that they may fitly be considered at the same time.

I wish first to touch on some general facts concerning gastric ulcer which, I think, are interesting, before paying special attention to perforations.

First as regards frequency. Most authorities place this at between 4 and 5 per cent. of all diseases, deducing the proportion from post-mortem statistics. From clinical observation, however, as Osler remarks, one would not suppose the affection to be of such common occurrence. In our records, out of 7700 post-mortems I found the presence of gastric ulcer noted in rather more than 1 per cent., while in 62,600 in-patients during the corresponding period it was diagnosed in only 7 per cent.; and in the last twelve years, while only thirty deaths from this cause appear in the statistical tables, which are compiled chiefly from the ward books, yet post mortem the fatal issue could be traced in thirty-seven, either directly or indirectly, to gastric ulcer.

Thus it would appear that a certain number of ulcers are not recognised during life, and to this class belong many of those which perforate. Giving rise to few and apparently trivial symptoms, they eat their way through the layers of the stomach wall undiagnosed, and sometimes even unsuspected, until perhaps, as actually occurred in one case, a merry laugh suddenly ruptures the thin film of peritoneum remaining between the patient and death.

Sex prevalence.—With regard to the relative prevalence in the sexes, the proportion from post-mortem statistics appears to be about three females to two males, but there is considerable discordance between the estimates of different observers. Lebert found fifty-seven cases in males to forty-one in females, and in those which Fagge quotes from the Guy's Hospital records fifty-nine were in men and forty-two in women. But in neither of these observations is it mentioned whether an equal number of bodies were examined of each sex, and this would be the only condition under which the relative sex frequency could thus be compared. At Bart's I find that though the total number of male and female patients admitted in each year was approximately the same, the number of males who died exceeded the females in the proportion of ten to seven. In addition to this, while autopsies were conducted on 71 per cent. of the males who died, only 62 per cent. of the females were seen on the post-mortem table. It is not unreasonable to expect that this may hold good for other large hospitals. Thus, though in ninety-six cases I was able to collect from the St. Bart's

post-mortem records there occurred fifty-five males to forty-one females, figures strikingly similar to those mentioned above, and appearing at first sight to indicate a preponderance of males, yet on comparing the numbers of necropsies of each sex in which these records were observed, I found the true ratio to be six females to five males. This involved going over separately the notes of nearly 8000 post-mortems; and, with all deference to the registrars, I would suggest that the value of our records might be enhanced if the numbers of male and female autopsies respectively were stated in the index to each volume.

*During life, however, the females appear greatly to preponderate, the ratio from our records being four to one, this corresponding with the observations of Sidney Martin and others. One is therefore not surprised to find that the mortality is stated to be much higher in men than in women, and our records give 25 per cent. as compared with 6 per cent. But I have been unable to find evidence of past or present ulceration noted in a greater number of females dying from other causes than of males, nor have I seen it stated that such an observation has been made; so that one is tempted to explain the discrepancy by supposing that a greater number of ulcers are overlooked in men during life. We shall presently see that the usual position of this lesion differs in the two sexes, and I thought that perhaps, therefore, some sign or symptom considered characteristic might often be absent in male patients; but it is a point difficult to investigate, and I have been unable to substantiate this hypothesis.*

*Site.*—A somewhat striking contrast between the sexes was observed on classifying the ulcers described in our post-mortem books, according to their occurrence in the duodenum and pyloric, middle, or cardiac third of the stomach respectively. In men the ulcers favour the duodenal end, while in women a reverse tendency is manifested. Thus in the former the pyloric third was much the most common site, the duodenum coming next, and the numbers rapidly diminished as the cardia was approached; but in women the middle third was the seat of election, the cardiac third being second, while very few were found near the pylorus or in the duodenum (see Table I).

This point seems of interest, and I am not aware that attention has been drawn to it before.

*Morbid anatomy.*—Every one is familiar with the text-book descriptions of the so-called "acute perforating" variety, a single small, circular "punched-out" ulcer, with congested edges; and the "chronic" form, more extensive, with thickened border and crateriform centre, forming a funnel which is often inclined obliquely to the coats of the stomach, or having a sloping or terraced margin, aptly compared by Sidney Martin to an oyster-shell.

From a study of the position of these ulcers one is inclined to believe that their ultimate result, *i.e.* whether they cause death by perforation, hæmorrhage, or protracted vomiting and exhaustion, may depend not so much upon the special form of ulcerative process as on their situation. Thus on the anterior surface of the stomach, owing to the mobility of that region, adhesions do not form, and perforation into the peritoneal cavity is the common result. I have seen perforation into the peritoneal cavity from an ulcer in this situation with no case of fatal hæmatemesis from an ulcer in this situation. On the more fixed posterior wall adhesions to the neighbouring viscera are quickly contracted round the base of the ulcer, and when the stomach wall is pierced extravasation of gastric contents is thus prevented; but ulceration continuing, the adherent viscus is attacked, and fatal hæmorrhage may ensue from the eroded pancreatic or splenic arteries. In the same way ulcers on the greater or lesser curvature, being near the coronary arteries, more readily cause profuse hæmatemesis than those placed where the arterioles are quickly sealed.

It would appear that all simple ulcers of the stomach tend to perforate its wall, either quickly or slowly, according as they are acute or chronic, and hence I think the name "acute perforating ulcer" may be misleading, for it might be taken to indicate that the danger of perforation was limited to cases of acute ulcer.

That chronic ulcers may cause sudden fatal perforation is well demonstrated by three cases, amongst others, which occurred in this hospital, in women aged forty-two, fifty-one, and fifty-eight years respectively. In all of them the ulceration was evidently of old standing, and partial cicatrization had led to hour-glass deformity of the stomach. They each had marked symptoms of perforation, and died in seven, eight, and twenty-four hours respectively from the onset. Post mortem the fatal apertures were found on the anterior wall, one the size of a pea, the other two measuring half an inch across.

Another case occurred this year in a man aged sixty-three, in whom the presence of a gastric ulcer was not suspected.

To come now to perforation, this is the most common cause of

death, occurring in about 6 to 7 per cent. of all cases of gastric ulcer, according to Welch; and this closely corresponds to the proportion obtained from our statistics.

*Sex.*—Comparing the sexes, from the post-mortem records it appears that it was the cause of death in 50 per cent. of the male fatalities due to gastric ulcer, and 45.5 per cent. of the female; the proportion of deaths from gastric perforation was eight males to nine females. If we include perforation of the duodenum, we find that the men predominate in the proportion of seven to six. I wish to lay stress on this point, and shall refer to it again when discussing the diagnosis.

*Age.*—In women perforation is most commonly met with between the ages of fifteen and thirty-five, the majority of cases occurring between eighteen and twenty-five. In men it is rare to find a simple perforation of the stomach under thirty-five, while it may occur at any time after that age up till about sixty-five. But in duodenal ulcers perforation takes place earlier, the average age of twelve male cases in our records being thirty-three, seven being under thirty-five years. In women, on the other hand, in which the affection is uncommon, the age would appear to be greater.

The most striking feature in the table (Table 2) is the great liability to perforation which seems to exist in young females who are the subjects of gastric ulcers. There is no need to lay stress on this point; so far as I can judge, it has already been too much impressed upon our minds, to the exclusion of the important fact that perforation is also of frequent occurrence in men, especially during and after the middle period of life, when it is the stomach itself which is affected; in earlier years the duodenum is more likely to be the seat of the lesion. I should, perhaps, mention that in these investigations it has been my endeavour to exclude all cases of malignant ulceration, and those doubtful lesions in which no microscopic examination was carried out have been omitted.

The site of perforation is naturally, from an operative point of view, of great importance. We shall see that in this, as in other details, a difference is observed in the two sexes. From our records it appears that in males the area where perforations are most commonly found is the pyloric end of the anterior surface and lesser curvature, while in women the middle and cardiac thirds of the anterior wall represent the dangerous region.

In fifty Bart's and fifty published cases the proportion of perforations on the anterior surface to those on the posterior wall was, in men, eight to one; in females about three to one.

The site of duodenal perforations appears to be very constant, being in all the St. Bart's cases within one inch of the pylorus, a single exception being two inches distant, and usually on the upper and anterior aspect, thus well placed for operative treatment.

*Number of perforations.*—In the great majority of instances there is a single aperture, but a few cases have been recorded in which perforations were sutured on the anterior wall to no purpose, for in a few days fatal rupture occurred on the posterior wall.

Perforation as a rule takes place into the general peritoneal cavity, and seems almost invariably to lead to death, generally in less than forty-eight hours. Cases have been recorded in which the shock of perforation was sufficient to cause immediate dissolution, while in others a circumscribed abscess has been formed, and the patient, after lingering for several months, has succumbed to subphrenic abscess or other septic complications.

There appear, however, to be a few undoubted cases of recovery after perforation without operation. In the majority of these cases either some inflammatory process has glued the stomach to the abdominal wall, diaphragm, or colon, and perforation has taken place through the adhesions; or a localised abscess formed by the extravasated gastric contents has burst externally or into some hollow viscus. Thus Murchison described a case of gastro-cutaneous fistula formed in this manner, and Habershon and others have reported cases where a communication has been formed with the colon or small intestine. Perforation has taken place several times into the gall-bladder, liver, spleen, pericardium, and in two cases reported by Finny\* into the left ventricle. In these instances, however, the patient did not recover. MacLaren† reports a case in which, after symptoms of perforation occurring in the morning before food had been taken, and all feeding by mouth being stopped, the patient developed signs of mischief at the base of the left lung, and after an illness lasting more than four months, coughed up a considerable amount of fetid pus, eventually recovering. This is probably a genuine case; but a number of instances are published in which perforation is supposed to have taken place, and, no operation being undertaken, the patient

\* *Brit. Med. Journ.*, 1886, vol. i, p. 1102.

† *Ibid.*, 1894, vol. ii, p. 863.

has recovered. I am unable to ascertain that in any of these cases the diagnosis was subsequently verified, but I do know that there are several instances in which perforation has been diagnosed by able and experienced men, and nothing found at the operation, the patients making a good recovery. I know of two cases who have reported several successful cases, was actually induced in one to reopen the abdomen a few days after the operation, the symptoms leading him to think that a second perforation had occurred.\* Such instances, as Dr. Alexis Thomson points out, justify us in taking a somewhat sceptical view of many of the so-called cases of spontaneous recovery after perforation.

The size of the aperture, the character of its edges, the presence or absence of surrounding thickening, and the question of the formation of protective adhesions, are all important points as regards operative procedure. In thirty-four St. Bart's cases the aperture varied from a pin's point to the size of a shilling, being most commonly not much larger than a threepenny piece. This appears to be a usual size.

In nearly all cases the edges were clean, having a punched-out appearance; and in only six was any surrounding thickening noted, which in no case appeared extensive. It was especially mentioned as not present in seven. As regards adhesions, in nine it was definitely stated there were none; in seven no mention was made of their presence; in seven there were adhesions to the liver, in five to the pancreas; and in three the intestines were generally matted together. In no instance did extravasation appear to have thus been limited. In only three cases was there any limited peritonitis or localised abscess formation, all of which had died, one within a week of the attack, another under two weeks; while in the third, where a kind of sinus was found amidst adhesions, no definite history could be obtained. Two subphrenic abscesses should perhaps be included, as in them there was a history suggestive of perforation, though post mortem no patent aperture was visible.

*General symptoms.*—I can add nothing to the general descriptions of the signs and symptoms of gastric ulcer which are to be found in the standard text-books. It appears impossible to diagnose the position of the lesion, though many points have been thought to indicate it, such as the site of the pain, the time after food at which it comes on, the posture in which the patient finds most relief, and others, all of which have been proved unreliable.

Hyperacidity of the gastric juice, due to excess of hydrochloric acid, has unfortunately now been found to be frequently absent in cases associated with dilatation of the stomach.

*HISTORY.—Hæmatemesis.*—One important point in the symptomatology of those ulcers which are likely to perforate is the rarity with which any history of hæmatemesis or melena can be obtained. This, I think, is not difficult to understand on the supposition that the position of the ulcer is the important factor in determining perforation or hæmorrhage, a point which I have already endeavoured to demonstrate. Of thirty-two cases in which a history appeared in the notes, in twelve it was stated that there had been no hæmatemesis or melena in sixteen; it was not mentioned; while in four did any hæmorrhage appear to have taken place; in one instance "slight," in another once or twice in seven years, and in the other two on one occasion only, four months and three years ago respectively.

This does not appear to have been recognised until quite lately, for in the *Obituary Journal* last year a man of such experience as Mr. Barker, of University College Hospital, remarks the absence of any history of hæmatemesis, in four cases upon which he operated, as an unusual fact. It is now, however, more generally accepted, I think, and not without reason, as the records of operation cases will show.

*Gastric trouble.*—In most cases of perforation some history of preceding gastric trouble is forthcoming, though it may be but slight. The usual and most important symptom seems to be pain coming on soon after the ingestion of food, generally localised, and felt either in the epigastrium or in the back, between the tenth dorsal and first lumbar vertebrae on the left side (Sidney Martin). It is relieved by vomiting, which generally occurs within one to two hours after the meal. Violent pains may come on, and during the paroxysm tenderness is sometimes grateful, though in the intervals epigastric tenderness, and perhaps hyperæsthesia, is observed. These pains may be caused by excessive or irregular movements of the stomach due to its irritable condition. Pressure might control the movements and thus give relief. Nothing, as a rule, is to be felt in the clinical variety I am now considering, but I might mention here that in some cases, together with evidence of a dilated stomach and emaciation, has led to an erroneous diagnosis of carcinoma.

\* *Lancet*, 1894, vol. i, p. 544.

*Pain after food.*—In thirty-one Bart's cases in which the history was given, pain after food was noted in twenty-four, during from three weeks to ten years before perforation; it was associated with vomiting in eighteen, but in only two is the absence of this sign recorded. Vomiting alone after food occurred in two cases, and "dyspepsia" was the sole symptom in another. In one case no history of any gastric trouble at all could be obtained. Of the rest, one man had experienced an attack of severe epigastric pain one year previously, and suffered from constipation, but in the others no definite history pointing to gastric disorder was mentioned, though two were anæmic and constipated.

Weir and Foote,\* in an exhaustive analysis of seventy-eight operation cases collected from the literature, found that though in only 37 per cent. of the patients was gastric ulcer suspected, 55 per cent. complained of symptoms described as "indigestion" or "gastritis." In only 8 per cent. was no previous indication obtained.

Constipation is very common; it was recorded in 57 per cent. of the St. Bart's cases, and regularity of the bowels noted only in twelve per cent.

*Anæmia.*—Eleven cases out of the thirty were anæmic; many of the others looked sallow, and only two were stated to have a healthy appearance. It must be remembered, however, that the description was written, in the majority of the cases, after the onset of the severe symptoms, so that these figures, I am afraid, cannot be depended upon.

*Symptoms of duodenal ulcer.*—These are often not to be distinguished from those of gastric ulcer, and frequently they do not appear to give rise to any. Of seventeen fatal cases in which the history was found in the notes, in three nothing in any way suggestive of trouble in the alimentary tract could be obtained; four complained only of pain after food during the previous few days or weeks; one suffered from obstinate constipation. The other seven gave a fairly definite history of pain after food, and vomiting, by which in one or two cases it is stated the discomfort was relieved.

*SIGNS AND SYMPTOMS OF PERFORATION.*—The historical case of Henrietta, Duchess of Orleans, as related by Dr. Gee in the *Bradshaw Lecture* for 1802, forms such an excellent clinical picture of gastric perforation that I will give it in his words. "She had ailed for some time from pain in the stomach and side, but seemed to be otherwise in good health. One day after dinner she complained several times of pain; she drank some succory water as a stomachic, and putting the cup down with one hand, with the other she pressed her side, and said in a voice which betokened much suffering, 'Ha! what a stitch in the side! what pain! I cannot bear it.' Speaking these words she flushed, and a moment afterwards turned pale, with a wan lividity which astonished everybody. She kept crying out, and begged to be carried away, for she could no longer hold up. Supported by the arms of others she managed to walk, but with difficulty, and bent double. Put to bed she cried out more than ever that the pain in the pit of her stomach was past belief; she turned from side to side. A physician was fetched, who pronounced her complaint to be colic, and who prescribed suitable remedies. But the pain continued; she said that her suffering was greater than could be conceived, and that she would die. All this occurred in less than half an hour. Whatever she swallowed made her retch; she brought up only a little mucus mixed with food. The efforts to vomit and the excessive pain threw her into a state of exhaustion which resembled repose, but she told the bystanders not to deceive themselves, that the pain was as great as ever, and that she had no strength left to cry out. She heard some one remark that she was easier, and she said, 'That is so far from being true, that were I not a Christian I would kill myself, so great are my sufferings. It is wrong to wish evil to any,' she added, 'yet I would that somebody could feel for a moment what I feel, so as to know what my pain is like.' Her pulse became imperceptible, her limbs cold, her friends anxiously asked if nothing more could be done; they suggested a score of remedies, and at last her physicians in sheer desperation made an attempt to bleed her, but the blood would not flow. They gave her some broth, for she had taken no food since dinner. She no sooner swallowed it than her sufferings increased; she complained that her stomach was filling up. Death was pointed on her face; the last struggle was short, and after two or three convulsive movements about her mouth she died—nine hours from the beginning of her illness."

This account, the original of which was written at the end of the seventeenth century by one of the Maids-in-waiting, is so graphic that it will serve without comment as an illustration of much that I shall presently have to say.

\* *New York Medical News*, April 23th, 1890.



We may now pass in review the cardinal points in a typical case of perforation.

**Onset.**—The final rupture appears to happen frequently about *two hours after a meal*, or is brought about by some quick movement or strain, such as coughing, laughing, or lifting a weight. In many cases it suddenly occurs without any obvious reason, and there are several instances of the ulcer perforating while the patient is in bed.

**Pain.**—Sudden excruciating pain in the epigastric region is almost invariable, and is probably caused by the extravasation of the hyper-acid gastric contents. The pain is often at first definitely localised, and this may be of great help in the diagnosis, but it usually soon becomes generalised. It is sometimes felt in the back between the scapulae, and in duodenal perforation may be marked in the right hypochondrium. Sometimes it appears to be referred to the inguinal or hypogastric region.

**Shock.**—The shock thus caused is very intense, and may prove instantly fatal, as in a case mentioned by Mr. Maurice of Reading,\* where a servant girl was found dead on the stairs from this cause. Though this is unusual, the subsequent collapse is, as a rule, very severe; it varies, however, in degree, and may be almost absent.

**Abdominal rigidity.**—The abdomen at first is often retracted, and nearly always rigid or "board-like," the contraction of the left rectus being sometimes especially marked—a point which should always be looked for.

**Tenderness.**—There is usually marked tenderness in the epigastrium—an important symptom, I think.

**Absence of liver dulness.**—Even at an early stage free gas in the peritoneal cavity may cause obliteration of the liver dulness, if this be absent, it is a valuable sign. This should always be investigated, though it is by no means invariably trustworthy. In cases where the foramen of Winslow has been sealed by adhesions, perforation into the lesser peritoneal sac may admit of the persistence of an impaired percussion note. In these instances the apex beat of the heart may be displaced, with symptoms of so-called subdiaphragmatic pneumothorax, as in cases described by Dent† and Bennett‡.

**Respiration.**—The respiratory movements are shallow, and usually limited to the thorax. There may be dyspnoea, especially in cases such as the two just mentioned, probably caused by pressure on the diaphragm. A point not generally looked for is the absence of Litten's "diaphragm phenomenon," to which Weir calls attention.§ It consists of the successive recession of the lower intercostal spaces on inspiration, corresponding to the descent of the diaphragm. Weir thinks it might be absent on the side where perforation had occurred, that half of the diaphragm sharing in the general rigidity. This I have been unable to observe, and I think the sign would be a difficult one to be sure of in any but the sparest subjects.

**Pulse.**—This is as a rule frequent, feeble, and fluttering, but may be small, hard, and wiry, though this character is not usually observed till later.

**Vomiting.**—Dreschfeld stated in 1888 that vomiting was absent in cases of perforation, and Treves (*System of Surgery*, vol. ii, 1896) concurs with this view; but the reports of recent cases in no way bear out this assertion. In Weir and Foote's list vomiting was certainly present in 36 per cent., while in only 8 per cent. (four cases) was it stated to be absent. In the others the point was unfortunately not noted.

Struve's experience was that it occurred in two thirds of all cases of perforation, and was only likely to be absent where the aperture was large.

In my list of thirty cases vomiting was recorded in twenty-one, or 70 per cent.; not mentioned in seven, and stated to be absent in only two, or 7 per cent. In most instances the vomiting occurred soon after the perforation, and was not repeated more than two or three times. Vomiting of blood is very rare; in no case is it definitely mentioned. In three cases the vomit was remarked to have been dark, having in two a "coffee-grouts" appearance.

A valuable sign of rupture is the immediate pain, and often vomiting, at once brought on by anything, such as brandy, which the patient may have been unwise enough to take by mouth. In a few instances surgical emphysema of the abdominal wall has been remarked.

**Temperature.**—During the period of shock the patient presents the usual well-known appearance, being cold with blue extremities, and in many instances the thermometer has shown a subnormal temperature. After an hour or two the temperature frequently has been recorded to have risen rapidly to 101° or 102°—a valuable diagnostic sign, as Mr. Barling points out.]

\* *Lancet*, 1894.

† *Lancet*, 1896, vol. i, p. 1718.

‡ *Ibid.*, vol. ii, p. 310.

§ *Loc. supra cit.*

¶ *Birm. Med. Rev.*, 1896, vol. xi, p. 321.

**Reaction.**—After the initial stage of shock most authorities appear agreed that there is a period of reaction before symptoms of peritonitis and septic intoxication set in. The pain becomes less severe, the pulse improves, and the patient appears altogether somewhat better. Where operative procedure is practicable, this is the opportunity that should be seized. In many cases, however, little or no reaction is manifest, and the symptoms of collapse merge into indications which are still more alarming. The pain becomes diffused over the whole abdomen, which is now distended and tympanitic—the liver and splenic dulness being lost—and exquisitely tender. The knees may be drawn up, and the respiration is entirely thoracic. The expression is anxious, the well-known Hippocratic facies being frequently observed; and the temperature in many instances at this stage has been found to be over 100°, while the pulse is quick and wiry. In fact, there is now the usual picture of what Gubler terms "peritonism."

If no operation has been undertaken for the relief of the trouble the patient rapidly sinks, usually dying in a few days, though the end may come in as many hours. The shortest time in which death occurred at St. Bart.'s was seven hours, the longest fourteen days. Death may be due to shock, collapse, peritonitis, or other septic complications. A case of death from shock has already been mentioned, and another instance may be cited from our hospital records. A boy, under treatment for appendicitis, suddenly died. At the post-mortem, although there was a distinct perforation, there was no peritonitis in the neighbourhood.

(To be continued.)

### Some Notes on the Plague

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**T**HIS is with the greatest diffidence that I venture to write an article for the JOURNAL on a subject of which my knowledge is but superficial. But yet having gained by personal experience some knowledge of a disease which in England is happily not now seen, I thought that it might be interesting, and perhaps even helpful, were I to relate some of its characters as I have learnt them, and the part I was appointed to play in combating the disease. Beyond my personal experience I will not venture, except in the most general terms where it seems to me necessary.

The Plague, or Bubonic Disease, is, as is well known by all, by no means a new disease, and of all its ravages the Black Death comes soonest to memory; this, despite the descriptions of novelists, was undoubtedly the same disease, and took its name from the greater number of the pneumonic cases of the fever which I will presently describe.

The Plague, though not endemic in India, is constantly present in certain Eastern places, of which lately China has been, *par excellence*, the one chosen. In the two successive years before the disease reached Bombay it was raging in Hong Kong. It was in August, 1896, that the first cases occurred in Bombay, though the disease was not generally recognised as such until two or three weeks later. The links connecting the disease with that still existing in Hong Kong are not difficult to forge, nor is it difficult to see why Bombay was attacked. This town is an immense one with a

large maritime trade, and in point of population is larger—of course excepting London—than any British town. It is a city built on islands, though, as far as I could see, these islands are only made such by shallow tracts of water and marshes. The air and soil are thus kept constantly saturated with moisture, the ground water is at high level, and so the absorption of watery refuse—a mode of drainage much in favour with the natives—is largely prevented: these conditions, being favoured by the heat, aid decomposition of organic matter, which goes on rapidly on the surface of the ground. So, with the overcrowding of the inhabitants, and their general habits of uncleanness and poverty, we have here all the conditions usually associated as most favourable for the spread of contagious diseases. The causation of the disease is clearly proved, to my mind, to have taken place by means of the rats in the ships trading with China. That rats were dying in large numbers was soon noticed, and when post-mortem examination was made a general glandular enlargement was found, from which glands it was easily possible to obtain Kitasato's bacterium. Many, indeed, considered that the disease was chiefly conveyed in the grain, but Mr. Hankin has clearly shown that the bacterium cannot live more than a very few days in any sort of grain.

On the recognition of the disease its importance was grasped by the late Surgeon-General of Bombay; but the Government of India, always slow to move, would not then countenance the extreme measures that were recommended as necessary, such as segregation, isolation, and house to house visitation. Later all these were employed,—not, however, till the disease had developed most alarmingly in the city, and spread over very wide areas in the Presidency.

It was undoubtedly shown that this tardy effort at stamping out the disease was attended with much harm; it must be remembered, however, that the disease was in India, *i. e.* in a country peopled by ignorant masses, whose whole life is built up on the question of caste, which is dearer than life itself, and any apparent violation of which is resisted to the death. This caste is the stumbling-block of all reforms, and must be considered in all our dealings with the Hindoo population; in the same way with the Mussulmans, the purdah system is at the root of their life. To institute any apparent interference with these prejudices an extremely strong cause must be shown.

Among many others, in the beginning of February, 1897, Mr. Walton (formerly house surgeon to Sir Thomas Smith) and I received orders to go on special plague duty; we travelled down from the Punjab together, some sixty hours in the train, and on the way held long discourse on our good fortune, which undoubtedly would lead to our rapid promotion, and to our being generally recognised by the Government for our valuable services. Since then we are wiser.

While waiting in Bombay for orders we proceeded to

learn what we could of the plague by visiting the hospitals to gain clinical experience, and the laboratories to learn about the microbe and its wicked ways. From the pathologist we learnt that the microbe was an easily discoverable one, and he courteously gave us all the information that he could. He also warned us against being inoculated by Haffkine's preventative serum, which was at that time in its infancy; he had been inoculated himself, and had been made rather ill for about a week, and he did not think anything had been proved of its efficacy at that time to compensate for this. As we were not very keen we accepted his advice. Our first cases of the disease we saw in a building called the Arthur Road Hospital. This was a long shed divided into two for the sexes; the flooring was made of dry mud, which, on inquiry, I learnt had been in the dirty condition in which I then saw it for some months, dating from the time when the shed had been used for ordinary infectious diseases. At one end of the men's half were some twenty convalescents, separated only by an interval of a few feet from some fifty men lying about on bare bedsteads in all stages of the disease. In all there were some hundred sick, for which three Sisters of Mercy were doing the little they could to relieve the general misery, which to be realised must have been seen. There was also a non-medical gentleman working there, who was merely on a visit to the country, primarily made for pleasure, but who had stayed in Bombay to do his best in the nursing of the patients.

After two or three days Mr. Walton and I were sent different ways on railway inspection duty, with but the most general orders as to the work required. Arriving at Ahmedabad station with the title of Chief Medical Inspecting Officer, Plague Duty, Ahmedabad, I had to arrange all the details for carrying out the inspection and the isolation and treatment of suspected or actual cases. With the kind help of the local authorities of the town, the civil surgeon, the railway police, and my assistants, the following arrangement was made and acted on:—An isolation and a plague hospital were erected about half a mile from the station; each of these consisted of detached rows of huts, four or five in each row, made of bamboo, grass matting, and grass roofs. The two hospitals were some two hundred yards apart, and each under the immediate charge of a native medical assistant, with an apothecary and some policemen. To the isolation hospital all cases of indefinite fever were sent; these would remain here for some twenty-four hours, or till the cause of the fever was recognised. If it were plague the case was sent to the plague hospital, and the shed which the patient had inhabited was burnt; while when one was satisfied the patient was free of the plague he was discharged. Definite plague cases were taken straight from the train to the plague hospital. One friend was to accompany the patient, remain with him, and look after him. If the patient died the friend

was to be kept some six days, and then allowed to go after his clothing had been disinfected.

At the station some ten trains a day had to be inspected, and the method of examination I adopted was this:—All carriage doors were locked at the preceding station, and only opened in the presence of an examining officer, when all the passengers in it were examined. I quickly found out that the disease could not exist without fever, and also that, had a man fever, it was impossible to tell in the absence of other signs whether he had plague or not. Therefore in examination only the presence or absence of fever was sought for, and every case of fever detained, however slight it might be. When more experienced I did not keep rigidly to this last part. In examinations at most of the other stations glands were always sought for; this, however, seemed to me, in the absence of fever, to be a useless annoyance. After a few weeks I found that a thermometer was only wanted very rarely, and that a temperature of 99° F. could be readily told by the hand on the chest or arm of the individual, even at a time when the temperature of the air stood at 110° F. in the shade. To count the pulse was, apart from other signs, useless, as the fact of being examined caused the pulse to rise immensely in rate, and very often to become markedly irregular. As may be supposed, this work, lasting over four months, became very monotonous; however, even here there were enlivening incidents. One of these arose when I was examining some negroes in the retinue of a prince. Circumstances occurred in which I had to knock one of them down, whereupon getting up he promptly drew a large curved knife (of which he had more than one in his belt) and made a rush at me; luckily for me his intentions were frustrated. Another incident, somewhat less dangerous and much more pleasant, was, on my going to examine a carriage, finding two Bart.'s nurses, who, however, defied my authority, and whose great idea was to get some breakfast and not be kept waiting. I learnt that they were proceeding with some more nurses on plague duty to Mandvi, in Cutch, a place where the disease was at the time extremely bad, both in virulence and in the number of cases.

The characteristics of the disease as I noticed them were briefly as follows:—Cases could be broadly divided into those with a sudden onset and no premonitory malaise whatever, and those in which two to four days of an indefinite fever preceded the generally sudden onset. A Eurasian railway guard aged twenty-six years was suddenly seized, whilst on duty in his van, with a feeling of feverishness, dizziness, and headache; he almost immediately began to vomit and suffer from an acute pain in the left groin. On seeing him twenty minutes after the onset I found him unable to stand, his face pinched and white, skin hot and dry, temp. 103°, pulse small; vomiting a frothy fluid from time to time, and complaining of much pain and tenderness in the groin. Here I found a swelling situated over Scarpa's

triangle, slightly reddened and very tender, the patient keeping the leg slightly flexed. Symptomatic treatment relieved him, and his condition of collapse did not increase. After seventy-two hours the vomiting ceased; the enlargement in the groin was less tender, but larger; in forty-eight hours all marked symptoms had disappeared, his only complaint being that of weakness: the glandular character of the enlargement was now readily made out. In ten days the patient was quite convalescent, and the glands had practically disappeared. Had the man been an attenuated, ill-nourished native with fatalistic ideas, death would probably have taken place within a few hours of the onset, as in many such cases that occurred.

Another case illustrating the less sudden onset would be that of a native removed from the train to the isolation hospital on account of fever (temp. 101°, no other symptoms), all the time loudly protesting against being considered in any way ill. For two days the patient continues with slight fever only, and many protestations as to perfect health; at the morning visit of the third day the patient would perhaps be seen sitting on his cot looking dazed, and appearing dizzy on trying to stand up out of respect. The temperature is now, say, 104°; he still says he is well, but is not so persistent, and on examination a slight swelling in neck, axilla, or groin may be discovered. Twelve hours later the patient would be found lying down, and perhaps for a moment able to recognise his surroundings, but is for the most part delirious, the delirium generally being one of a low type—the pulse feeble, intermittent, and irregular; temp. 104°. One learns that he has sunk rapidly into this state without any effort on his part to rouse himself, that he has complained but little if at all. Some six hours later, after a gradual increase in intensity of this typhoid condition, the patient dies. The glandular enlargement during the last eighteen hours, if present, becomes more marked, and perhaps appears elsewhere.

Such were many of the cases, but a not uncommon variety of the disease, occurring after either form of onset, was what might be called the pneumonic form of the plague. In these cases, as often as not with no glandular enlargement, there was rapid development of marked pneumonic symptoms with much cyanosis and dyspnoea, attended with marked collapse; at the same time the usual pneumonic signs in the lungs were absent, the appearance of moist sounds over the lungs, generally increasing with the progress of the disease, alone being discoverable. These pneumonic cases were among the most generally and rapidly fatal, and were attended with comparatively little cough or pain, but with marked circulatory collapse. Indeed, in all cases it seemed as if the heart suffered directly and severely, and the nervous system secondarily from the action of the plague poison: death was due in every case to cardiac failure.

When patients recovered the convalescence was rapid, as

might be judged from the generally short duration of an attack.

Owing to the circumstances in which I was, the performance of post-mortems and the working at the bacteriology of the disease was an impossibility. However, from the Professor of Pathology at Bombay I learnt that post mortem a fairly general enlargement of the internal glands could in all cases be found, even when during life there had been no external manifestations; that in the pneumonic cases an acute congestion of the lungs was to be met with; and that from such the bacteria could be readily cultivated from the glands, lungs, and spleen, and also from the sputum and vomit of the patient during life. These bacteria are slightly oval cocci, tending to occur as diplococci. They stain readily with the ordinary dyes, grow on gelatine and agar-agar in a characteristic way, and answer to Koch's canons, the identity of the disease as appearing in rats and man being allowed.

In the absence of an epidemic, diagnosis, apart from bacteriological work, would often be extremely difficult, and it would be necessary to depend on the fever of short duration, with, however, rapid and marked collapse, with or without signs of glandular enlargement. In the pneumonic cases marked dyspnoea and collapse with but few signs in the lungs, and a fever of short duration, would point to plague. The bacteriological examination is best made from the sputum or, after aseptic precautions, from the removal of a small quantity of the sanious fluid contained in a swollen gland by a hypodermic syringe.

The finding of the microbe in the lungs, glands, and spleen shows that the disease is one of general infection of the whole body. But it is open to doubt whether this is so from the commencement in all cases; for sometimes a local glandular swelling with but slight fever is found, which perhaps may go no further; while, on the other hand, all the phenomena of plague may develop. It is argued that we have here a local infection from the skin, an infection of slight intensity, which is stopped by the gland from becoming general. However, these may be slight cases of a general infection primarily, apparent only by the above slight signs. That post mortem many more glands are found affected than were suspected is to my mind an argument for general infection in all cases from the first. Indeed, local treatment to a gland has never shown any good result, as is the case in the treatment of the malignant pustule of anthrax.

As regards the channels of infection, that by means of the skin through cuts and abrasions was at first largely exaggerated, and was based on the then generally accepted view of the disease as being at first a local one. Infection by the air-passages is proved, I think, by the great number of cases in which the affection of the lungs is the first and most prominent feature, and by the very great quantity of bacteria to be found in them in such cases; that the

mouth may be the channel seems possible by the presence of the bacteria in the vomit.

The advanced disease at any rate being due to a general invasion of the body, it will readily be seen what great care must be taken in dealing with any of the excreta, for, by analogy with such a disease as typhoid, the intestinal and renal excreta will be as infectious as the sputum and vomit, in which I have seen crowds of bacteria. In dealing with a case the nurses, attendants, and doctors should remember this, and act accordingly; for their own safety they should be extremely careful in keeping their hands clean, remembering that a brush, soap, and water are far better when used vigorously than a perfunctory dip in some antiseptic lotion. The mere attendance on the patient, provided this is within reason, seems almost without danger, and can, I think, rightly be compared to that on a case of typhoid fever.

Apart from the serum methods, the treatment of plague is essentially one of stimulation, and in no disease is the presence of a skilled nurse more needful, for the doctor cannot be present except at intervals. The sudden changes to which the patient is subject require a skilled and almost constant attendance for the proper and timely administration of stimulants, which, owing to the rapidity of the disease, should be pushed from the very first. Strychnine, brandy, and rum, with digitalis, were the medicines I chiefly used, but I formed no predilection. The local treatment resolves itself into fomentation, with belladonna if there is much pain, of the swollen and inflamed glands. Should pus form, though this is not usual, it should be let out at once. There is no call for the incision of the gland in the earlier stages, or its irritation by iodine, &c. This I have seen employed on the idea that if the gland suppurred rapidly all would be well, and this in cases where the patient was manifestly suffering from a general invasion. As regards the serum treatment of the disease, I know nothing at first hand; from one who had watched Yersin's treatment in Bombay I gathered but gloomy tidings; indeed, this cannot be surprising seeing how rapidly the disease develops, the patient getting almost immediately overwhelmed with the toxins. Of Haffkine's preventative serum there is much more hope; it would, however, be idle to speculate on this from the few statistics at present available. The direct effect of the inoculation of his serum was after two or three days a feeling of malaise, with fever 101°—103°, often making the subject keep to his bed and feel extremely sorry for himself. One or two glands became enlarged; the whole illness, however, subsiding after a duration of two or three days, with no subsequent ill effects.

The disposal of the dead is a matter of serious consideration; and fortunately burning—the best method is in accordance with the religious customs of the Hindoo. With the Mussulman, however, the plan of placing quicklime with the bodies was thought to be the most effective method, which was done, though not without a good deal of objec-

tion at first. Luckily, however, their leaders were able to find and translate a passage in the Koran which allowed this, and so all parties were satisfied.

When the patient gets well his convalescence is rapid, as in the case of the guard I previously mentioned, who within four weeks was back at his work, apparently not much the worse.

Of the death-rate of the disease, its course as regards seasons, its method of convection over the country, the methods of segregation, house visitation, &c., all of which are extremely interesting, I do not wish to speak. They were beyond my personal observations, to which in the above account I have kept as closely as possible.

### Notes.

THE presentation of the testimonial and picture to Mr. James Berry, to which we alluded in our last number, will be made in the Library on Thursday, March 24th, at 5 o'clock. Subscribers and others will be glad to have this opportunity of publicly expressing their high appreciation of Mr. Berry's work as Surgical Registrar.

To Sir Thomas Smith's resignation—the event of the month—we have alluded elsewhere. The election of a Surgeon to fill the vacancy will take place on Thursday, March 24th.

OUR readers are reminded that communications with respect to subscriptions, &c., should be sent to the Manager, Mr. W. E. Sargant, and *not* to the Editor.

MR. BUTLIN gave the first Hunterian Society Lecture for 1898 at the London Institution on February 23rd. He took as his subject, "What Operation can do for Cancer of the Tongue."

MR. WARING'S Erasmus Wilson Lectures on "The Pathology and Treatment of those Diseases of the Liver which are amenable to direct Surgical Interference" were delivered at the Royal College of Surgeons on February 21st, 23rd, and 25th.

MR. C. TODD, B.A., has taken the degree of M.D. in the University of Cambridge.

MESSRS. A. E. JEAFFRESON, C. S. MYERS, T. H. MOLESWORTH, H. W. SHEWELL, and J. G. FORBES have taken the degrees of M.B. and B.C. of the University of Cambridge.

DR. J. CALVERT has been re-elected Demonstrator of Materia Medica and Pharmacy.

DR. J. MORRISON has resigned the office of Assistant Demonstrator of Physiology.

THE office of Assistant Demonstrator of Materia Medica and Pharmacy is now advertised as vacant.

DR. W. J. HORNE has been appointed Casualty Physician, *vice* Dr. J. Hayward resigned.

MR. A. EICHHOLZ, Emmanuel College, Cambridge, has been appointed one of Her Majesty's Inspectors of Schools.

We are requested to call attention again to the claims of Horace Dewick Sawtell on the Governors of the Royal Medical Benevolent College, Epsom. He makes his third application for a Foundation Scholarship in May next, and has already polled 1750 votes. The case is strongly recommended by Dr. Gee, Sir Dyce Duckworth, Dr. Champneys, Mr. Butlin, and Dr. Shore, among others. Proxies will gladly be received by Mrs. Oliver-Smith, 5, South Row, Blackheath.

We note with surprise the decision of Mr. Sheil at the Westminster Police Court that although a medical man may be struck off the register for certain offences, this does not disqualify him from continuing to practise. If this be so, what does the disciplinary authority of the General Medical Council amount to, and what protection does it afford to those who are still within its fold? The matter can hardly be allowed to rest here.

PROFESSOR KANTHACK and Dr. LLOYD JONES have been appointed Surgeon-Lieutenants of the Third (Cambridgeshire) Volunteer Battalion, the Suffolk Regiment. In the Third Volunteer Battalion the Cheshire Regiment Surgeon-Lieutenant E. T. Sidebotham has resigned his commission and been appointed Captain. Surgeon-Lieutenant-Colonel John Adams, of the Twenty-first Middlesex (the Finsbury) Volunteer Rifle Corps, has had the Volunteer Officers' Decoration conferred upon him.

At the recent examination for the Indian Medical Service three Bart's men were successful. Dr. H. B. Meakin secured the third place, Mr. H. Boulton was seventh, and Mr. Twigg thirteenth.

We greatly regret to announce the death of Miss McDougall, formerly a Bart's nurse, of plague, on February 23rd at Bombay. She had but recently left the Hospital to undertake special plague duty in India. As to her ability as a nurse, the fact that she obtained the Gold Medal in her final examination is a sufficient testimony. Great sympathy will be felt by all with her family in their sad bereavement.

THE Anthropological Expedition to Torres Straits, New Guinea, and Borneo, which started under the leadership of Prof. A. C. Haddon, on March 10th, included two Bart's

men, Dr. W. H. R. Rivers, formerly House Physician to Dr. Gee, and Mr. C. S. Myers. They intend to devote themselves more especially to the experimental psychology, which is to form a prominent part of the work. The expedition lasts about a year, and we wish them all success in their enterprise.

### Amalgamated Clubs.

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T. B. A. Haggard.	F. E. Murray.

#### RUGBY UNION FOOTBALL CLUB.

##### ST. BART'S v. LENNOX.

Played on January 15th at Dulwich. A very close game resulted in our defeat by a try to nil. Our team was weakened by the absence of Body, Mason, and Walker, and, under the circumstances, our performance against the powerful Lennox team was very creditable. In the first half our forwards, playing a capital game, attacked strongly, and gave the outsiders several opportunities. The home defence was good, however, and we could not score. After half-time the game was very even, until the last minute of the game, when one of the Lennox's three-quarters scored after a clever run, and we were therefore somewhat unluckily beaten.

*Team.*—C. A. S. Ridout (back), A. J. W. Wells, T. A. Mayo, C. Dix, J. M. Plews (three-quarters), A. W. Nuthall, W. C. Hirst (halves), W. F. Bennett, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, H. G. Boyle.

##### ST. BART'S v. OLD LEYSIANS.

January 22nd at Winchmore Hill. We met with a most unlucky defeat by a dropped goal (4 points) to a try (3 points). At the beginning of the game we rushed the ball down, and within a few minutes Robbs receiving a pass from Mason crossed the line. The kick, however, failed. We continued to have the better of the game, but could not add to our score. In the second half the Old Leysians' back took an excellent drop kick which landed between the uprights. In its flight the ball was touched by Bennett, but this was not noticed by the referee, who allowed the goal. This reverse demoralised us, and for the rest of the game we were hard pressed.

*Team.*—H. Goodman (back), S. Mason, C. Dix, T. A. Mayo, C. A. S. Ridout (three-quarters), H. Walker, W. C. Hirst (halves), W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren (forwards).

##### ST. BART'S v. HARLEQUINS.

January 29th at Catford. A hard game against London Hospital on the preceding day had worked havoc amongst our team, and only seven of the Cup Tie team turned out. We met with a severe defeat by 27 points to nil. For the first quarter of an hour we held our own fairly well, but afterwards had to act chiefly on the defensive. The Harlequins had two good halves, and were able to feed their three-quarters continually. They scored three times in the first half, four times in the second. For us, Mayo, Bennett, and O'Neill were several times conspicuous in defence.

*Team.*—C. O'Brien (back), S. Mason, T. A. Mayo, C. A. S. Ridout, J. M. Plews (three-quarters), W. H. Scott, F. Shont (halves), W. F. Bennett (capt.), A. J. W. Wells, C. H. D. Robbs, A. O'Neill, J. A. West, N. Maclaren, H. E. Stanger-Leathes, F. Harvey (forwards).

##### ST. BART'S v. NORTHAMPTON.

February 5th at Northampton. This match resulted in a loss by 8 goals and 1 try (43 points) to a try. The home team had a very

clever lot of outsiders, and completely outplayed us. Bart's forwards played a good game, and several times took the game into our opponents' twenty-five. Mason on two occasions made excellent shots at dropping a goal, his kicks only just going wide. Our try was scored by Walker from a pass by Mayo.

*Team.*—T. M. Body (back), S. Mason, T. A. Mayo, G. C. Marrack, A. J. W. Wells (three-quarters), H. Walker, W. C. Hirst (halves), W. F. Bennett, H. C. Adams, A. M. Amsler, A. O'Neill, J. A. West, G. H. Adam, L. R. Tosswill, N. Maclaren.

##### ST. BART'S v. MARLBOROUGH NOMADS.

February 12th at Winchmore Hill. Bart's started well, and for the greater part of the first half we pressed. Body dropped an excellent goal from outside the twenty-five. The Nomads scored just before half-time. We crossed over leading by 4 points to 3, and immediately added to our advantage, Mayo crossing the line after a good dribble by O'Neill. The Nomads improved immensely after this, and scored three times, winning by 18 points to 7. It should be mentioned that Mason had to retire early in the first half, and Bennett was also injured, so that for the greater part of the game we had only six forwards in the scrum.

*Team.*—T. M. Body (back), S. Mason, C. Dix, T. A. Mayo, A. J. W. Wells (three-quarters), H. Walker, W. C. Hirst (halves), W. F. Bennett, C. H. D. Robbs, H. C. Adams, A. M. Amsler, A. O'Neill, J. A. West, J. M. Plews, L. R. Tosswill.

##### ST. BART'S v. EAST SHEEN.

Wednesday, February 16th, at Richmond. The home team had a powerful team, and beat us by 2 goals 1 try to nil. The game was much more even than the score would represent, and it was only our weakness in attack that prevented our scoring. The loss of Bennett and Mason was greatly felt. With the wind in our favour we had the best of the first half, and should have scored on one or two occasions. Our opponents scored twice from the line out. Adams, O'Neill, and Adam played a hard game throughout.

*Team.*—H. Goodman (back), J. C. Sale, C. Dix, T. A. Mayo, A. J. W. Wells (three-quarters), W. C. Hirst, W. H. Scott (halves), C. H. D. Robbs, H. C. Adams, A. M. Amsler, A. O'Neill, J. A. West, G. H. Adam, L. R. Tosswill, H. L. Stanger-Leathes.

##### INTER-HOSPITAL CUP TIE.

##### SECOND ROUND.—ST. BART'S v. KING'S.

This match was played on Tuesday, February 8th, at Richmond, and resulted in a victory by 1 goal and 2 tries (11 points) to nil. Winning the toss we had the advantage of a slight wind. Directly the teams turned out a sharp shower began, which lasted for some fifteen minutes. During this time the game was very evenly contested, our opponents showing good defence. At length a bombardment of their line resulted in Hirst scoring a try, which Bennett converted. We scored once more before half-time, Mason running over close to the touch line—the kick failed.

After ends were changed Bart's opened out the game. The outsiders were given several chances, but the wet ball prevented accurate passing. On one occasion, however, a good bit of play resulted in Wells running round. The kick again failed.

On the whole our play was ragged. The forwards were not nearly so good as usual, though much heavier than the opposing eight. The outsiders at times did well, but were slow. Goodman did his work well at back. King's deserve credit for the good fight they made. Their halves were both good, and their forwards untrifling.

*Team.*—H. Goodman (back), S. Mason, T. A. Mayo, T. M. Body, A. J. W. Wells (three-quarters), H. Walker, W. C. Hirst (halves), W. F. Bennett, C. H. D. Robbs, H. C. Adams, A. M. Amsler, A. O'Neill, J. A. West, G. H. Adam, L. R. Tosswill (forwards).

##### SEMI-FINAL.—ST. BART'S v. ST. THOMAS'S.

Played at Richmond on Tuesday, February 22nd. Bart's won the toss, and St. Thomas's kicked off against a slight wind. The ball was badly returned, and play settled close to our 25. Several scrums took place, in which neither side could claim any advantage. At length some good work by our forwards gained ground, and Mayo made an excellent run into our opponents' 25. Directly after this a great misfortune befell us—Mason was heavily grounded, and was so badly hurt as to necessitate his retirement. O'Neill took his place at three-quarters. With seven forwards we held our own very well, and a strong rush very nearly resulted in Tosswill scoring, the ball going into touch in goal. Good kicking by St. Thomas's backs brought back the play to mid-field, and a smart piece of passing amongst their outsiders resulted in Greg scoring. The kick just failed. After this reverse Bart's played up hard, and had the best



final sutures given are those of Lembert, Czerny, Gussenbauer, and Halstead, together with a few modifications thereof, a perusal of which descriptions can give no excuse for not understanding, especially as the diagrams are clear and well chosen. For enterorhaphy we read the methods described are (1) by circular suture, or (2) by Mansell's; and (1) is performed by (a) immediate suture, or by (b) one of the many "mechanical appliances." Of these latter we are burdened only by the Murphy's button, a bone tube, and a bobbin, Senn's plates being relegated to lateral anastomosis. No criticisms are given, the author contenting himself with impartial statements, for which he will probably be unjustly criticised. We think the passages containing these descriptions and classifications of methods good examples of the precision and lucidity of the diction throughout the book.

For urethrotomy only Wheelhouse's operation is described, and it is probably sufficient. The suture method for inguinal colotomy is described fully, and is preferred to Keelus's operation. The operations on the rectum are those usually performed at St. Bartholomew's; but the trans-sacral operation is fully described, and is easy to follow in its various stages. Simplicity is again evolved out of disorder in the chapter containing the operations for removal of the tongue, Whitehead's and Kocher's methods being alone given, and we quite think they give ample choice for most cases. The surgery of the brain is well and fully dealt with, the clearness of the directions for the site of incisions being very pleasing. The operations for ligation of blood-vessels are accompanied by very useful diagrams of transverse sections of the limb in question. We have also nothing but praise for the chapters on amputation and excision, and what we have said as regards the wisdom displayed in selection of methods where there are many and disordered applies equally to the chapter on plastic surgery, that bugbear (in book knowledge) alike to beginners and, judging from their directions, to seniors. It cannot be a matter otherwise than easy for a critic to find errors of both kinds in any work of so wide a range as the one before us. Operative surgery in 1898 is a vast and growing subject; the choice of knowing what to include or exclude must be difficult, and we can, for our part, easily imagine that omissions have not been made without due thought. Yet we must confess we should have liked a page or two on the procedures associated with suppurative peritonitis, and were disappointed not to find some rules laid down for the length of flaps in the flap amputation. Again, we think the subjects of plugging the nares, incision of tonsillar abscess, and some others perhaps more suitable for a book on surgical handicraft, might have been well replaced by advice on the treatment of anal fissure, webbed fingers, and on the injection of hydrocele. The treatment of ruptured urethra is not mentioned. We think, too, that Paul Berger's operation of amputation of the shoulder by an external flap which is brought over the wound left after excision of mamma deserves a place in the book, and we think abdominal section in some cases of hernia where gut is gangrenous should have been alluded to. Most of the figures are very good; some strike us as unnecessary, a quite unusual feature in books on the subject. Except these remarks, the nature of which indicates the difficulty of much adverse criticism, we have nothing but unqualified approval for the *Manual*. The language is crisp and clear, and the information "get-at-able." There are no annoying sarcasms, and we are not burdened with historical details, which the authors of some larger but less useful manuals think necessary. We consider it one of the *multum in parvo* works which are in no sense cram books (it contains over 600 pages), but may rather be considered concentrated essences of what is known of the subject at the time of writing, and as such we cordially approve of it, and recommend it both to students and practitioners, and think it is destined to be largely read. Mr. Jessop also gives a clear and judicious account of some of the more important ophthalmic operations, and, like all the books of its series, it is neat and well got up.

### Pathological Department of the Journal.

SPECIMENS sent by subscribers to the JOURNAL will be examined in the Pathological Laboratory, and a report furnished under the supervision of Dr. Andrews, at the following rate:

Ordinary examination, Bacteriological or Pathological, such as tumour, membrane, or sputum	s. d.
	2 6
Ordinary (qualitative) urine examination	2 6
Any further report will be charged at a special rate. If a mounted specimen be desired an extra charge of 1s. will be made. If a telegraphic report be required the cost of the telegram will be charged in addition.	

Specimens must be accompanied by the fee and a stamped addressed envelope, in which the report will be sent as soon as possible. Specimens, with, if possible, a short history of the case, must be addressed to "The Manager of the Journal," with "Pathological Department" written in some conspicuous place on the wrapper.

### Appointments.

CORNISH, S., M.B., B.S.(Lond.), appointed Ship's Surgeon to the ss. Merionethshire, Japan Line.

LAWRENCE, B. E., M.R.C.S., L.R.C.P., appointed House Physician to the Victoria Hospital for Children, Chelsea.

FARMER, W. H., M.R.C.S., L.R.C.P., appointed Surgeon to P. & O. ss. Canton.

JOY, N. H., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Southport Infirmary.

WAY, A. O., M.R.C.S., L.R.C.P., appointed House Surgeon to the Tottenham Hospital.

BRIGGS, J. A. O., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Finsbury Dispensary.

WILSON, NORMAN O., F.R.C.S., appointed Honorary Medical Officer to the Princess Louise Home for Young Girls, Kingston Hill, in conjunction with Mr. Arthur Gale.

COLBY, J. G. E., M.R., R.Ch.(Oxon.), L.R.C.P.(Lond.), F.R.C.S., D.P.H.(Cantab.), has been reappointed Medical Officer of Health by the Norton Rural District Council.

GIBBES, HENRIAGE, formerly Lecturer on Physiology at the Westminster Hospital Medical School, and afterwards Professor of Pathology at the Ann Arbor University, Michigan, has been appointed Health Officer to the City of Detroit.

BEIT, F. V. O., M.R.C.S., L.R.C.P., appointed Temporary Plague Officer to the Indian Government.

### Examinations.

UNIVERSITY OF LONDON.—*Preliminary Scientific: First Division*.—H. V. Wenham. *Second Division*.—F. M. Bishop. *Chemistry and Physics*.—A. C. Brown, W. P. Price, E. G. Fringle, E. B. Smith. *Biology*.—W. C. F. Harland, R. V. G. Monckton.

UNIVERSITY OF LONDON.—*Intermediate M.B.: Second Division*.—F. M. Howell, R. H. Paramore. *Excluding Physiology*.—J. C. M. Bailey, R. C. Bowden, A. B. Brown, A. H. John, E. M. Niall, T. M. Pearce, E. Wethered. *Physiology only: First Division*.—A. G. Ede, A. T. Pridham. *Second Division*.—W. S. Danks, C. S. Frost, I. H. Gandy, J. C. Marshall, and F. W. Sheppard.

SOCIETY OF APOTHECARIES.—*Surgery (Section I)*.—G. C. Hobbs. *Medicine (Section II)*.—J. B. Cautley (Diploma).

### Births.

PENNY.—On February 13th, at Muswell Hill, the wife of A. Gervase Penny, M.A., M.D., B.C.(Cantab.), of a daughter.

SELBY.—On February 11th, at Teynham, Kent, the wife of Prideaux George Selby, of a son.

SHUTER.—On February 4th, at Oaklands, Chiswick Lane, the wife of George Percy Shuter, of a daughter—prematurely.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette*, *The Gyvescope*, *St. Thomas's Hospital Gazette*, *St. Mary's Hospital Gazette*, *St. George's Hospital Gazette*, *London Hospital Gazette*, *Middlesex Hospital Journal*, *The Student*, *The Hospital*, *The Nursing Record*.

# St. Bartholomew's Hospital



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### St. Bartholomew's Hospital Journal.

APRIL 14th, 1898.

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

### Cases in which Life is endangered by Large Hæmorrhage, and their Treatment.

A Clinical Lecture

By HOWARD MARSH, F.R.C.S.

SOME examples of imminent danger to life from large hæmorrhage have lately been under observation, and I propose to ask your attention to them to day. The subject is obviously one of first-rate importance in clinical surgery, and one with which you may all, in the future, have to deal in a practical form, unless—as can rarely happen—you are engaged entirely in the treatment of medical cases. To those who practise in

districts where severe accidents are common, or who attend many confinements, instances of dangerous hæmorrhage must be of frequent occurrence. The subject acquires additional interest at the present day from the fact that, as I will presently show, we are now in possession of means of treatment which, when adequately used, are successful in a much larger proportion of instances than was formerly the case, and with which, therefore, it is the duty of every surgeon to be familiar.

Hæmorrhage so severe as to threaten the life of a patient may occur as the result either of a surgical operation, or of an injury, such as extensive laceration of a limb or a wound, gunshot or otherwise, by which large blood-vessels are divided.

As to profuse hæmorrhage in connection with surgical operations. The cases in which it is most likely to occur, if the proper steps are not taken to prevent it, are amputation at the shoulder and the hip joints. There are some other proceedings in which the same peril may exist, at all events if the operator does not possess sufficient experience, or if he omits to adopt the necessary precautions; but it is only the two operations that I have mentioned of which it can be said that under ordinary circumstances hæmorrhage is their main danger. I need scarcely remark that in operations in which this risk is present, the obvious duty of the operator is to make all his preparations with care and forethought, and to secure a full amount of the best assistance within his reach.

As to amputation at the shoulder-joint. This operation is performed by different methods according to circumstances, and the danger of hæmorrhage will depend almost entirely on the case. In some instances it will be comparatively small. This is the case when amputation is performed for some condition which involves only the lower half of the arm, and leaves all the structures in the neighbourhood of the joint in a normal condition. Here, for instance, is a humerus which presents a tumour (myxosarcoma) projecting from the middle of its shaft. The patient was a lady of fifty, in whom I amputated the limb. All the parts in the upper third of the arm were