

INDEX TO VOL. L III

	PAGE		PAGE
Retirement of Miss Helen Dey ... ..	69	Tuckwell, E. G. Vagotomy ... ..	46
Rifle Club ... ..	84, 221	Turner, E. Grey. Health on Active Service ...	151
Rilke, Rainer Maria. The Birth of Venus ...	265	Turner, J. W. Aldren. Clinical Value of Electroencephalography ... ..	109
Robert Gooch, by Wilfred Shaw ... ..	48	Twelfth Decennial Club ... ..	90
Roberts, G. Fulton. Agony Column, <i>Corres.</i> ...	262	Tyne, Phyllis. A Short Essay on Rugby Supporters ... ..	121
Ross, Sir James Paterson. Honour, <i>Portrait</i> ...	108	Ullmann, H. A. View Day, <i>Corres.</i> ... ..	141, 240
Rugby Union Football Club ... 14, 37, 82, 97, 120, 153, 199, 244, 267		Unusual Space-Occupying Intracranial Lesion, by A. B. Haigh ... ..	79
S., P. M. Bad Taste, <i>Corres.</i> ... ..	262	Vagotomy, by E. G. Tuckwell ... ..	46
Sailing Club ... ..	269	Vasco-vagal Attack, by H. W. Balme ... ..	263
St. Bartholomew's Fair, by Con Molloy ... ..	59	Vick, Reginald M. Disappearing Diseases ...	2
St. Bartholomew's Hospital, The Ordre of, by G. C. R. Morris ... ..	70	Retirement ... ..	204
St. Bartholomew the Great ... ..	157	Vishnu. The Duty Clerk ... ..	185
Sandiford, H. A. The Empire Medical Advisory Bureau, <i>Corres.</i> ... ..	52	Laboratory Aids to Bacteriological Techniques ... ..	24
Scholarships and Prizes ... ..	105	"Past History" ... ..	68
Sense of Humour, A. by David Carrick ... ..	167	W., J. A. Hypochondriasis ... ..	266
Shaw, Ernest H. Pathology at Bart's in the Nineteenth Century ... ..	75	W., W. G. Sixty Years On ... ..	260
Shaw, Wilfred. Robert Gooch ... ..	48	Walker, A. J. Epithelioma of the Angle of the Mouth ... ..	194
Utopia? <i>Corres.</i> ... ..	33	Ward, R. Ogier. Campaigning in Conditions of Great Heat, <i>Corres.</i> ... ..	118
(Portrait) ... ..	180	We Are Such Stuff as Dreams Are Made On, by Dan Wooding ... ..	173
Sir James Paget and St. Bartholomew's Hospi- tal, by John L. Thornton and Gweneth Whitteridge ... ..	95	Wells, A. Q. The Place of Artificial Immun- isation in the Prophylaxis of Tuberculosis in Man ... ..	19
Sir William Osler, by A. W. Franklin ... ..	138	Wendell-Smith, C. P. William Harvey, Man- Midwife ... ..	212
Sixty Years On, by W. G. W. ... ..	260	Wessex Rahere Club ... ..	270
Ski-ing Injuries, by E. D. Vere Nicoll ... ..	251	What is Homeopathy? by John Paterson ...	181
Smoke, <i>Editorial</i> ... ..	179	Wheelwright, J. A Theca Cell Tumour in the Ovary ... ..	170
Some Aspects of Pain, by V. C. Medvei ... ..	88	Whitteridge, Gweneth. The Henry VIII Gate- way into Smithfield ... ..	148
Sport ... 14, 37, 82, 97, 120, 153, 174, 197, 221, 243, 267		(John L. Thornton and Sir James Paget and St. Bartholomew's Hospital ... ..	95
Strauss, E. B. The Treatment of Schizophrenia	134	Why Read the Journal? ... ..	220
Students' Union Ball ... ..	6, 44	William Harvey, Man-Midwife, by C. P. Wendell-Smith ... ..	212
Students' Union Council Meeting ... 16, 55, 147		Winston, F. "Dites-Moi" ... ..	141
Swimming Club ... ..	15	Taking the Waters ... ..	215
Table Tennis Club ... ..	198	Winter Sports, <i>Editorial</i> ... ..	250
Taking the Waters, by F. Winston ... ..	215	Women's Hockey Club ... ..	99, 269
Terry, Richard. Liver Biopsy ... ..	202	Wooding, Dan. We Are Such Stuff as Dreams Are Made On ... ..	173
Theca Cell Tumour of the Ovary, by J. Wheel- wright ... ..	170	Words, <i>Editorial</i> ... ..	226
Thirteenth Decennial Club ... ..	95	Zadigism and the Cinema, by Sir Ernest L. Kennaway ... ..	7
Thornton, John L. In Our Library ... 16, 219			
Portrait of Abernethy, <i>Corres.</i> ... ..	50		
and Gweneth Whitteridge. Sir James Paget and St. Bartholomew's Hospital ... ..	95		
Tois, Alan. Bullseye ... ..	242		
How to Pass Examinations ... ..	126		
Treatment of Schizophrenia, by E. B. Strauss ...	134		

# ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

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No. 1

*Good morning, Algernon: good morning, Percy.  
Good morning, Mrs. Roebeck. Christ have mercy!*

*Hilaire Belloc.*

It may be doubted whether the person exists, whose circle of acquaintances does not include at least one member of the family Roebeck. Fat or thin, tall or short, they have one characteristic feature in common; they share the ability to make an ordinarily sane and civilized being cast off the cloak of reason, and, in an orgy of mental atavism, harbour thoughts more appropriate to a sabre-toothed tiger.

Perhaps it is the way Mrs. Roebeck talks, or the way she walks, or the things she says and does: perhaps it is a gesture, an attitude, a mannerism—or just an indefinable something about her, an air too subtle to be analysed, that makes her call forth such bitter thoughts and silent profanities. She is, as it were, the spark that fires the murky pitches of the mind; she is the focal irritation that brings on the fit.

When first encountered Mrs. Roebeck is merely irritating, but as time passes by she is endowed, first with one deadly sin, then another, and gradually, almost imperceptibly, she becomes the devil's walking parody. It is a curious process, but still more odd is the fact that your friends are entirely oblivious of her sinister appearance—of the little sprouting horns and the peculiar gait, which to you are so apparent.

It may be the woman with the amber cigarette-holder and scarlet talons, who talks of "progress spiring round, of light and Mrs. Humphrey Ward." It may be the fourteen-stone forward who says *What! ho* and slaps you on the back. It may be the vicar's wife who starts talking when she is still twenty yards away, is apparently able to dispense with breathing for fifteen minutes on end

and is still hard at it when you finally make a break and are receding as rapidly as is possible into the distance. It may be the man who has already told you that story three times in a week; it had no point, it wasn't funny and, as you rightly concluded when you cut yourself shaving while thinking about the beastly thing, it was all his fault anyway.

Opinions differ as to the best way of countering the effects of Mrs. Roebeck; much advice has been given. Saki thought that the best course was to send for Clovis. Mr. Wodehouse recommends the hunting of gnu. Mr. Thurber is frankly pessimistic and wishes we were all dogs, because then we should behave rationally. Mr. Chesterton, with a true blend of generosity and justice, would make a present of a butt of malmsey and hope for the best.

Any form of direct action is most unwise, in fact it is doomed to failure from the start. If Mr. Roebeck is a fourteen-stone forward and you, so to speak, hand him one on the kisser, he will undoubtedly fell you on the instant and your chances of ever getting equal with him will be gone. Whenever you meet he will continue to slap you playfully on the back and make asinine remarks, such as, "How are the molars today; champing away as usual?", while you grind your teeth in fury—the few, that is, which remain. Roebecks will almost invariably get the better of you in the long run if you try to be clever at their expense. The vicar's wife has the ear of every lady in the surrounding half-dozen villages; the woman with the scarlet finger nails can wither you with a look. It is one of their characteristics that they should be able to do this. Jimmy

Twitchee, the fourth Earl of Sandwich, forgot this and chancing to meet his Roebeck, John Wilkes, one day, when the latter was an outlaw, foolishly accosted him and said, "The gallows will get you now, Wilkes—if you don't die of the pox first." "That, my lord," Wilkes coldly rejoined, "will depend on whether I embrace your principles or your mistress," and walked away.

## DISAPPEARING DISEASES

WHEN I was thinking what subject I should choose for my clinical lecture to-day, I had just been reading the excellent Editorial in the October Bart.'s JOURNAL, in which the importance of the history of medicine was so well and clearly stressed. I have always felt that the medical students of to-day should know about the diseases of the past as well as the diseases of the present. They should as far as possible be knowledgeable (what an appalling word) about the enormous advances that have been made in the years that have passed—some of the most epoch making of them so very recently.

I have often felt when I have been telling my dressers about the past that they have thought I was "drawing the long bow" and I fear that I have earned a reputation—entirely undeserved—for "telling the tale." And, indeed, when one thinks of the past and of the improvement in preventive medicine, hygiene and treatment, it is so great that one can hardly believe that it has really happened.

The period that I can cover is 42 years—which to you in the pride of your youth may seem a very long time but for me it has passed only too quickly. Needless to say, I shall deal mainly with surgical conditions, though there must be some overlap into medicine. It is true to say that certain diseases, which were common when I was a student have now almost disappeared and, of course, some new diseases have become fashionable.

One new disease—or relatively new—that comes at once into one's mind is "nerves"—a product of our jet propelled lives. Another is coronary thrombosis—which has taken such a toll of surgeons in my generation and the one before it. It is said that one surgeon, who had suffered from coronary thrombosis and recovered conceived the idea of forming a coronary thrombosis club amongst his colleagues but disbanded it owing to fluctuation in membership. He is, himself, still alive and very active.

The outcome is always the same. The Roebeck is, so to speak, always a Boojum, and no advice can be of avail. Bitter consolation may, however, be delivered from the envoi to the Ballade of Hell:

*Prince, on their iron thrones they sit,  
Impassible to our despair,  
The dreadful Guardians of the Pit:—  
And Mrs. Roebeck will be there.*

Another great change has been the development of a new terminology for which psychologists are largely responsible. If you meet someone who isn't, perhaps, as brave as he should be you say he has a "low threshold for pain." If you are very worried about your examinations and inadvertently risk your life by stepping in front of a bus—you say that you are suffering from an "Anxiety neurosis," not merely that you are being infernally careless.

Now for some of the conditions about which I feel you should know the past history.

I can well remember the time, when the coronation of King Edward the VIIIth was postponed because he had developed appendicitis. From that time, appendicitis became fashionable. Before that time, the obscure manifestations of Typhilitis and Perityphilitis—subsequently, proving to be those of an undiagnosed perforated appendix, had been described. Go ahead surgeons had even opened the abdomen and straightened out the appendix and put it back. They did not know whether it was useful or not so they did not like to remove it.

How very different from some surgeons of to-day, who have so little respect for the human anatomy that they think nothing of pinching, cutting or avulsing nerves for which previous generations had the highest respect.

When I was a dresser and a house surgeon, it was not at all uncommon to have to deal with children admitted on duty, moribund with peritonitis due to a gangrenous appendix. They were admitted to hospital, cold and collapsed and most of them died. To-day, that is unknown. The signs, symptoms and treatment of acute appendicitis are so well understood even by the most casual pooh-pooh doctor that such patients are sent to hospital at once. They have their appendixes removed and live and thrive.

## ACUTE INFECTIVE OSTEO-MYELITIS

I am not suggesting that this very grave infective condition does not occur nowadays but it is certain that it has become more and more rare and, of course, its treatment by penicillin is so dramatically successful that it is no longer the lethal or crippling disease that it was. Why should the condition have become less common? There are a lot of possible answers but one reason cannot be disputed. The children of to-day are not neglected—nor undernourished. They are fed at their schools and have their diet supplemented by extra milk. The school sisters look after them and call in the school doctor or send the children to hospital, if necessary. The pathetic, small, starved and verminous children are no more.

The disease is due to the Staphylococcus, an organism which is always lurking ready to pounce, if and when the resistance is lowered. If the patient is fit, the staphylococcus pounces in vain. But in the bad old days, the child might develop an acute specific fever which, often inefficiently treated, brought down their resistance with a bang.

Then the waiting staphylococcus flew to the metaphysis of a growing long bone. There deep hidden in the bone, it produced an acute reaction often leading to an almost immediate septicaemia. When admitted into hospital, these children were gravely ill. They had high fever with rigors, rapid pulses and all the signs of toxæmia. The diagnosis of the site of the infection was not easy and the patient was treated as an emergency.

The bone was laid open and gouged out and the wound left open. The dressings, subsequently were extremely painful and, even when done under anaesthesia destroyed the child's morale. It was not unusual for the disease to progress and require second and third operations. Amyloid disease was not unknown and sometimes amputation was done to save the child's life and, even then, did not always succeed.

Penicillin and the sulphonamides have revolutionised the treatment. The limb is now put in plaster and at rest and the infecting organism is often defeated, even without any operation at all.

You may say, why do we need to know about this disease? For many reasons. You may meet the disease one day. You will, most certainly, be shown specimens in your examinations of the results of acute infective osteo-myelitis, showing the ravages that it has

made. That may be a low motive for knowing about it but a good one. But the chief reason is that you should know and realise how wonderful is the change in health and hygiene, which has cut down the incidence of the disease and that even when it does occur nowadays the treatment is so infinitely more satisfactory.

## WAR WOUNDS

The thought of war is again so much in our minds that I do not wish to distress you by talking about it. But, under this heading, I can give you one more example of an impressive advance.

In the 1914-1918 War, a soldier who sustained, say, a compound, comminuted fracture of his femur was absolutely certain to develop an intense infection and his life and his limb were in grave danger. In the more recent war, his wound would be excised, his limb put in plaster and he would be injected with penicillin. The agonising dressings of the past were eliminated—and more often than not he would end up with a reasonably useful limb of his own and, only in the early days of the infection would he be in grave danger.

## THE ADENOID CHILD

I remember years ago seeing two pictures of children in the same class in the same school, one taken in 1906 and one in 1926. The same number of children at the same age in the same school, and yet they looked like children of different races.

In 1906, most of the children had the typical adenoid faces—with flat chests, the open mouth, the rat-like teeth—the undeveloped nose and the general lack of development due to the fact that they could not breathe properly.

In 1926, the exact opposite was the case. And the children, though not all beautiful, looked fit and strong and with normal faces. And why? Again the more efficient attention to diet. The practice of breathing exercises—the care of the throat—and the removal, if necessary, of the tonsils and adenoids. This operation has not the vogue that it had in the past, when it was often absolutely necessary. Now it is often not performed until after the age of five and then only when the tonsils and adenoids are pathological.

This may appear to be an incursion on my part into a special department. But I would remind you that when I came to Bart.'s the Throat Department was only in its infancy.

The first throat surgeon at Bart.'s was Mr. Douglas Harmer and he is still in active practice.

General surgeons removed the tonsils and even dressers were allowed to do the operation in the surgery. And how badly they did it.

#### SEPSIS

Sepsis in 1906 and for many years afterwards was the great danger of surgery in any part of the body. In those days, there were two septic wards—Coborn and Radcliffe—and they were always full. Erysipelas was rife, breast abscesses were very common. In fact, the accommodation was often so fully taken up, that you would see women with breast abscesses with multiple tubes being treated as out-patients and doing their fomentations at home. Later, all such patients were admitted to hospital and then healed rapidly and well.

C. B. Lockwood was one of the first great protagonists of asepsis at Bart.'s and all the surgeons practised it to the best of their ability. But the theatres were not like the beautiful aseptic palaces of to-day. They were small, ill-ventilated and opened often on to the outside world. There were no rounded corners, no filtered air and the theatres were full of shelves loaded with jorums of antiseptic and other bric-a-brac. And no matter how carefully the surgeon worked the dread of infection was always there. I can remember when I was a dresser two knee cases—both infected after repair of a fractured patella. One lost her life and the other his leg—both as the result of infection.

It was, in those days that one learned how resistant the peritoneum is to infection. And, when anaesthesia began to improve, surgeons operated more and more in the abdomen. But they feared the chest, the joints and the head. And, remember, they had nothing satisfactory in the way of drugs to counteract infection when it did occur.

#### ANAESTHESIA

Without reference to this subject, this lecture would be very incomplete. For the very reason that if there had been no advance in anaesthesia, there could have been no advance in surgery.

When I first came to Bart.'s the senior honorary anaesthetist was called, and was, the chloroformist. Chloroform is a most dangerous drug and is now used only in combination with other drugs. And it was a most unsatisfactory anaesthetic, patients often col-

lapsed during induction and not infrequently died of delayed chloroform poisoning. They usually went through a wild excitement stage during induction. You could hear them yelling outside the theatre and sometimes even when they came into the theatre they were not under. I remember my chief once making an incision for an appendix and the patient putting his finger into it. Then came Ether and then Gas and Oxygen—given in the apparatus invented by a Bart.'s anaesthetist, Boyle—with the endotracheal catheter.

And now intravenous anaesthesia and, even more recently, Curare which has changed the whole picture and patients need no longer dread their anaesthetic. I don't need to elaborate this any further but it is obvious that no surgeon, however skilled, can do extensive operations without efficient anaesthesia. Many a time, I have asked students why the surgeons of the past did cholecystotomies instead of cholecystectomies—drained the gall bladder instead of removing it. The correct answer is that, with the inefficient anaesthesia of earlier days, with the patients not properly relaxed—with the abdomen going up and down—the surgeon was only too glad to be able to catch hold of the gall bladder, open it, take out the stones and drain it.

Heaven knows those surgeons of old were not wanting in courage—they performed deeds of great daring but they could not advance. With the advance in anaesthesia and the improvement of aseptic methods they could go ahead. And, to-day, with the arrival of penicillin, the dread of infection after operation anywhere in the body—even when involving extensive bowel resection and anastomosis—or in the thorax or in the head is sub-minimal. Another result of the lack of adequate anaesthesia was that surgeons had to learn to operate quickly. Nowadays, a surgeon can, within reason, take his time. But a surgeon in earlier days had to be rapid because the anaesthetic did not last. My chief, Sir D'Arcy Power, was one of the most rapid surgeons known. He did his last appendicectomy, at the age of 65, in seven minutes and his last gastro-jejunostomy in 17 minutes. Needless to say, his emergencies did splendidly as shock was cut down to a minimum—"Quick in and quicker out" was the motto in acute abdominal surgery.

But now, thank God, we can work quietly, systematically, and gently, thus cutting shock

down to a minimum and lessening the risk of septic infections and dread complications like ileus by gentle handling.

#### SYPHILIS

This venereal disease with its so-called protean manifestations is no longer providing the students of to-day with all the wonderful clinical material that they enjoyed in the past. It is difficult to estimate the incidence of the disease to-day. We were told of its alarming increase during the war owing to the relaxation of the moral code, whatever that may mean. But one thing is quite certain and that is that the treatment of syphilis with penicillin, arsenical compounds, bismuth and the older methods with mercury and potassium iodide, the secondary stage is often not seen at all and all the many complications of the tertiary and parasyphilitic stages are becoming rarer and rarer.

#### GUMMATA

I would remind you that in the days gone by, the differential diagnosis of almost any tumour included gumma. They could occur almost anywhere.

Gumma of the testis with its large hydrocoele of the tunica vaginalis, its tumour of the body of the testis, its relative painlessness and its resulting destruction of the organ is not often seen even in V.D. clinics.

Gummatous infiltration of the tibia, resulting in a pseudo bowing of the bone—severe pain in the bones when the patient got warm in bed—was a differential diagnosis of Paget's disease.

Gummatous infiltration of the stomach was a possibility in a case of supposed diffuse carcinoma of that organ.

Stricture of the oesophagus, due to the same condition, might be confused with carcinoma of that region. Curiously enough there is a case of this in the hospital at the present moment in an old lady.

Gummata of the skull produced the most incredible moth-eaten appearance of the bone.

Gummata of the palate was a not uncommon cause of acquired perforation. And the characteristic chronic superficial glossitis with the stages of enlargement of the papillae, leucoplakia, red glazed tongue, fissured tongue and its end result carcinoma, were early tertiary manifestations.

These conditions have not gone for ever but they are much less common. Epithelioma of the tongue following upon chronic superficial glossitis is one of the best

illustrations of malignant disease as a sequel to irritation. When I was a dresser, there were usually two or three cases of epithelioma of the tongue in the male ward. And the most mutilating and unsuccessful operations were performed. The cure rate was lamentably low and the end of those patients was tragic in the extreme. If they died of secondary haemorrhage, they were lucky. But they often lingered on for months unable to eat or sleep owing to the agonising pain of the local condition and the infiltration into nerves and ultimately died of septic broncho-pneumonia.

#### ANEURYSMS

Here is another interesting clinical condition which is disappearing, except the traumatic type. I am sorry that you are not seeing aneurysms of the aorta, great pulsating swellings in the chest eating their way through the sternum—or in the abdomen eroding the vertebrae, producing incredible pain. But it is good to know that these terribly painful conditions are disappearing.

One of the advantages of having an aneurysm in the ward was that even the youngest and dimmest clerk could hear the bruit—in fact he could not help hearing it and this helped him greatly when first using a stethoscope and being told to hear this and that and hearing nothing at all. And he began to think that all men, especially physicians, are liars.

My Chief was one of the first surgeons to wire aneurysms—he had an apparatus invented by one of his house surgeons, Colt. A trocar and cannula were driven right into the lumen of the aneurysm. On removal of the trocar, the blood from the aneurysm hit the side of the theatre if you forgot to put your finger on it. Then little metal umbrellas were pushed into the aneurysm to produce clotting. Most of them died very quickly but a few were cured. And not to put too fine a point upon it, they were much better dead.

Charcot joints, now raised in status by being called neuropathic arthritis, were a common result of parasyphilis. You will still see them at the Examination Hall or in bottles. And so if time allowed, one might go on amplifying the list of diseases that are disappearing.

But my time is up and I think I have given you enough examples. They are disappearing diseases and I do not for a moment suggest that you should cease to look for them or include them in your differential diagnosis.

And, once more, I would remind you that all good pathological museums (and the museum at the R.C.S. is one of the finest pathological museums in the world) are full of specimens of the diseases of which I have spoken. But my main theme has been to drive home to you the very dramatic changes which have taken place—to persuade you to interest yourselves in the surgery of the past—without which knowledge you are so much less well equipped either mentally or clinically to understand the present.

### MAN-MIDWIFE

*"The Further Experiences of John Knyveton, M.D., late surgeon to the British Fleet during the years 1763-1809," pp. 104-105.*

"Aug. 12th. The uncle of our cook, a candle maker who suffers from a dropsy and to whom I gave a letter to the Governor of St. Bartholomew's Hospital that he might enter the Cutting Ward to have the dropsy relieved, has returned again saying he prefers to die in peace rather than be trimmed to death by a pack of b— sharks! But on enquiry I learn that on presenting my letter, it was not considered to cover all expediencies; so that he was requested to pay 19s. 6d. for burial fees (returnable of course if he lived) and in addition moneys to cover the following items: One shilling to the beadle for notifying his friends of his decease; one shilling to the porter for taking the certificate of his death to the parish where he was to

be buried; two shillings each to the bearers of his corpse for carrying it to the hospital gates and no further; one shilling to the Matron for providing an old black cloth as pall; and one shilling to the Steward for certifying the death. Nor was this all for the Sister of the Cutting Ward requested 2s. 6d. for supplying bandages, and her helper one shilling; and the beadle wanted sixpence for carrying him into the ward and his helper sixpence also. And so after a lengthy argument and some high words, particularly with the Beadle whom he described as a bloated maw-worm and a carrion crow, he returned again home.

Let me end this lecture with this tribute to them.

But I think Mr. Norton may be able to assist him."

But I think Mr. Norton may be able to assist him."

### STUDENTS' UNION BALL

The Students' Union Ball will take place on February 4th, 1949, at the Dorchester Hotel (8.30 p.m.—2 a.m.). Tickets are £2 10s. (double) and may be obtained from the Hon. Sec., Students' Union.

### QUERY

Our textbook of Midwifery includes this observation on the Second Stage of Labour.

*"During the height of the pain there may be expiratory groans. These expiratory or convulsive efforts are partly voluntary but largely reflex due to the presence of a foreign body in the vagina."*

This demands elucidation.

Question One. "What constitutes a foreign body?"

Question Two. "Is this condition pathognomic of a foreign body?"

### ZADIGISM AND THE CINEMA

By Professor Sir ERNEST L. KENNAWAY

VOLTAIRE has told the story of the young Babylonian, Zadig, who was renowned for his powers of observation and inference, and may be regarded as the founder of the school which flourished later under Sherlock Holmes.

How would Zadig have reacted to the modern cinema? Perhaps he would have found amusement in the detection of errors on the part of some members of the prodigious staff of experts which, as the screen tells us, is required for the production of every picture. Thus we may be shown Anne Boleyn's lover creeping stealthily to an ecstatic meeting with her through a part of Hampton Court Palace built in the reign of William and Mary. And in a fine Indian film of the life of Buddha one is shown the Prince Siddhartha as he escapes from his palaces into the outer world; for a few moments we see him riding with his servant along a well-metalled road with neat granite kerbstones, things not characteristic, one would imagine, of modern India, and still more rare about 500 B.C.

Perhaps Zadig would have ignored such crude errors as beneath his notice. Voltaire tells us that "il étudia surtout les propriétés des animaux et des plantes, et il acquit bientôt une sagacité qui lui découvrait mille différences où les autres hommes ne voient rien que d'uniforme." He could have pursued these biological studies at the pictures. The ecology of animals and plants is a common source of error in films claiming to present them under natural conditions. A common ecological incompatibility of the pictures is the monkey-eucalyptus association which is often seen in alleged scenes of jungle life. Nowhere do these two occur together naturally. But the Australasian family of eucalyptus has spread in abundance over the Pacific coast of the States and provides excellent climbing facilities for the Hollywood monkey. Again, it is of course perfectly possible for a White-Woman-in-Central Africa (accompanied by the inevitable Two-White-Men) to have a pet monkey, but this animal is very unlikely to be a Humboldt's Woolly Monkey, a South American species which is transported far more easily to Hollywood than to the remote parts of Africa.

Such questions of the geographical distribution of animals and plants arise very

frequently on the pictures. Does the cobra occur as far up on the northern frontier of India as it does in "Lives of a Bengal Lancer," where the snake embarrasses the officer who, with no intention of snake-charming, is learning to play the recorder? One may note in passing that this film solves, by means of a brilliant cavalry charge, the problem of how to storm a town enclosed by walls of great height and strength. In "How Green Was My Valley" the boy, during his long period in bed, tames two birds of remarkable plumage, which come to his window-sill; whatever they may be no such species would be found in a Welsh mining village. A mountaineer engaged in an exacting climb which, one feels sure, must have taken him far above the tree-line, the "Baumgrenze" of former days, is fortunate indeed when we see his catastrophic fall arrested by an uprooted tree-trunk which must have fallen from still greater heights.

To turn from such biological matters, one recalls that in the picture "David Copperfield" one sees on Mr. Micawber's sideboard a small dish of fruit including a banana. Is it likely that anyone of Mr. Micawber's financial limitations would possess a banana? Possibly he had never seen one. Even sixty years ago they were a rarity. (While speaking thus of Micawber, one may note in passing, how easily one comes to think of Dickens' characters, especially the more agreeable ones, as real persons. Can anyone traverse Goswell Road today without wondering how it looked "when Mr. Pickwick lived there"? This easy merging of fiction into fact, which we can observe even in our modern and rational selves, is of interest in connection with the growth of religious myths in earlier times.)

Russian films do not usually underate Russian achievements in science and technology. But one is shown the attempted assassination of Lenin, when at the height of his power and authority, by a revolver shot, and the subsequent "probing of the wound" at the bedside by a surgeon in the best tradition of the day-after-Waterloo, any assistance which might have been obtained from X-rays being ignored.

Even the sound track has possibilities of error. An electrically-driven train in Switzerland does not start with that series of

sonorous puffs which in trains on the screen announces the separation of the Person-in-the-Train from the Person-on-the-Platform. Again, in an excellent film of the discovery of vaccination, the narrator, possibly more familiar with continental languages than with English, spoke of "Dr. Jenner" throughout.

### RECENT PAPERS BY BART'S MEN

- BOURNE, GEOFFREY: Sympathectomy for hypertension. *Brit. Heart J.*, Vol. 10. April, 1948. Pp. 99-101.
- DARMADY, E. M.: Dialysis of blood for the treatment of uraemia. *Proc. Roy. Soc. Med.*, Vol. 41. July, 1948. Pp. 418-9.
- \*DISCOMBE, G.: L'Origine des corps de Howell-Jolly et des anneaux de Cabot. *Sang*, Vol. 15. v. 1948. Pp. 262-4.
- (and H. O. Hughes): How important is transfusion as a cause of haemolytic disease of the newborn. *Brit. Med. J.* August 14th, 1948. Pp. 329-30.
- \*FRANCIS, G. E. C. and WORMALL, A.: The use of radioactive isotopes in immunological investigations. *Biochem. J.*, Vol. 42. iii. 1948. Pp. 469-74.
- GARROD, L. P.: Current therapeutics. viii. Surgical antiseptics. *Practitioner*, Vol. 161. August, 1948. Pp. 130-138.
- : Factores que afectam o êxito da penicilino-terapia. *Coimbra Medica*, Vol. 15, ii. 1948.
- : Some observations on streptomycin. *Cadernos Científicos*, Vol. 2, i. 1948. Pp. 23-35.
- GREEN, BERNARD, See RUSSELL, BRIAN, and others.
- GUNZ, F. W.: Culture of human leukaemic blood cells in vitro. Normal and abnormal cell division and maturation. *Brit. J. Cancer*, Vol. 2, i. 1948. Pp. 41-8. — Technique and the growth curve. *Ibid.*, Vol. 2, i. 1948. Pp. 29-41.
- HARTRIDGE, H. (and L. C. THOMPSON): Methods of investigating eye movements. *Brit. J. Ophthalmol.*, Vol. 32. September, 1948. Pp. 581-91.
- \*HORDER, LORD: Signs and symptoms of impending death. *Practitioner*, Vol. 161. August, 1948. Pp. 73-5.
- \*HOSFORD, J. P.: Peritoneoscopy. *Brit. Med. J.* August 14th, 1948. Pp. 348-9.
- \*HOWKINS, JOHN: Movement of the diaphragm after operation. *Lancet*, July 17th, 1948. Pp. 85-88.
- HUNT, ALAN H.: Regional analgesia. *Post-Grad. Med. J.*, Vol. 24. October, 1948. Pp. 539-45.
- (and A. LAWRENCE ABEL): Stainless steel wire for closing abdominal incisions and for repair of herniae. *Brit. Med. J.* August 21st, 1948. Pp. 379-82.
- \*KERSLEY, G. D.: The present status of gold therapy in rheumatoid arthritis. *Practitioner*, Vol. 161. September, 1948. Pp. 158-162.
- MCKENNA, R. M. B.: Primary focus of tuberculous infection in the skin. *Proc. Roy. Soc. Med.*, Vol. 41. August, 1948. Pp. 531-2.
- MAXWELL, JAMES: Conditions simulating pulmonary tuberculosis. *Med. Press*, No. 5701. August 11th, 1948. Pp. 106-8.
- MURLEY, R. S.: A case of neuroinoma of the vagus nerve in the neck. *Brit. J. Surg.*, Vol. 36. July, 1948. Pp. 100-101.
- OLDFIELD, JOSIAH: Science and the Bible. *Med. World*, Vol. 69. October 8th, 1948. Pp. 207-8.
- RADCLIFFE, WALTER: Dr. John Burton and his whimsical contrivance. *Med. Bookman & Hist.*, Vol. 2. Aug.-Sept., 1948. Pp. 349-55.
- \*RAVEN, RONALD W.: Carcinoma of the oesophagus; a clinico-pathological study. *Brit. J. Surg.*, Vol. 36. July, 1948. Pp. 70-73.
- : Radical excision of the rectum without colostomy. *Med. Press*, Vol. 220. August 25th, 1948. Pp. 139-42.
- \*ROBINSON, MRS. A. M. (and others): The colorimetric determination of stilboestrol and dienoestrol. *Biochem. J.*, Vol. 42, i. 1948. Pp. 151-6.
- (and F. L. WARREN): Presence of substances inhibitory to acid phosphatase in normal human urine. *Nature*, Vol. 161. March 13th, 1948. Pp. 397.
- \*RUSSELL, BRIAN (and others): Latent tetany caused by BAL. *Lancet*. July 31st, 1948. Pp. 169-74.
- \*SAVAGE, OSWALD: Speransky's method of spinal pumping in rheumatoid arthritis. *Brit. Med. J.* March 13th, 1948. p. 496.
- STALLARD, H. B.: Anterior flap sclerotomy with basal iridencleisis (a preliminary note). *Brit. J. Ophthalmol.*, Vol. 32. October, 1948. Pp. 753-9.
- : Radiotherapy of malignant intra-ocular neoplasms. *Ibid.*, Vol. 32. September, 1948. Pp. 618-39.
- THEOBALD, G. W.: The use of post-pituitary extract in physiological amounts in obstetrics. *Brit. Med. J.* July 17th, 1948. Pp. 123-7.
- \*TURNER, G. GREY: Rutherford Morison and his achievement. *Newcastle Med. J.*, Vol. 23. June, 1948.
- \*VERNEY, E. B.: Die Hemmung der Wasserdiurese durch Erhöhung des osmotischen Druckes im Karotisplasma und ihre Vermittlung über die Neurohypophyse. *Archiv f. exper. Path. u. Pharm.*, Bd. 205. Heft 2-3. 1948.
- WAND, L. G. R. See RUSSELL, BRIAN and others.
- WEBER, F. PARKES: Note on haemangiomas, its causes and results. *Med. Press*, No. 5707. September 22nd, 1948. Pp. 222-3.
- WORMALL, A. See FRANCIS, G. E. C. and —

The practice of Zadigism adds to the great pleasure which one can get from the pictures. One sees a film set in a Western state about 1860. A Borzoi appears. A Borzoi in such a place at such a time? Perhaps. And so on . . .

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### A NEW METHOD OF STIMULATING THE LIVER

by D. CARRICK

IT WAS the week-end after Guy Fawkes; I was not feeling at all well. I had a headache, there were more spots in front of my eyes than usual, my digestion was out of order and, worst of all, I had no wild yearning for work—an unusual thing for me: so I went to see my doctor.

He looked at and felt me and pushed me around for a time, then expressed the opinion that my liver was out of order. I asked him how he knew, and he said that he had come across other people in a like condition before, he had even suffered with it himself on occasions, particularly after week-ends. It was the rich nature of the post-war diet that was responsible, he said, and advised me to keep off eggs, butter, pastry and other such luxuries; eat plenty of meat and take a lot of exercise. This latter injunction appeared to be the only one really difficult to obey, but I promised to do my best.

The following morning, Lord Mayor's day, I wandered wearily up to the hospital after a frugal breakfast of dry toast and coffee. I was still feeling out-of-sorts, and the thought of a full day's work fatigued me. As it happened, the fates decided that my brain (or that part of me which I refer to as my brain) was to remain untried for the whole of the day.

On rounding the corner by Aldersgate Station, I was surprised to see a large procession of students wheeling the famous effigy "Percy" before them. Noticing a number of friends of mine among the retinue, I inquired as to the purpose of the display and was informed that their intention was to join in the Lord Mayor's Show. Having never even viewed this picturesque pageant, the thought of actually participating in it appealed to me immensely, so I followed in the wake.

All went well until we reached St. Paul's station where we were met by a *posse* of police. They seemed to have some unaccountable objection to our presence, and told us so. We discussed the situation with them for a time, but they were extraordinarily stubborn in their views and as the conversation seemed to be getting us nowhere, we made to continue. This displeased them and, without a word of warning, a number of them

made a savage attack on the innocent Percy who was soon lying disconsolately on the ground.

The sight of him lying so sad and lonely, moved us to go to him in his trouble, and a stern attempt was made to put him back on his feet. It looked, for a time, as though we were going to succeed; then, in the words of the *Times*, "the police sent for their mounted colleagues." These gentlemen were not slow to accept the invitation and in no time there were slim brown legs amongst ours, hot, horsy breaths down our necks, and large police above our heads. The chances of saving Percy were now remote; in fact, it seemed likely that the whole affair would draw to a dismal conclusion.

Then it happened: a senior police officer lost his hat!

Nothing seems to vex a constable more than losing his hat; it is as though a vital part of his dignity has been irretrievably destroyed, he also loses nearly a foot in height which brings him down to the level of the taller civilians; he becomes almost human. But when an officer loses his, anything may happen.

This man was grieved and irritated beyond all reason, and began to struggle towards the wicked fellow responsible for the foul outrage. His progress was severely hampered by the crowd who were inclined to hinder rather than help his efforts. A mild, accidental dig in the ribs excited him still further and he called for assistance. His men, hardly able to recognise their superior without his head-dress, were severely shocked by what they saw and grabbed hold of those nearest to them and began to take them towards a Black Maria which had artfully crept up unnoticed.

According to the evidence (heard later), I was responsible for an attempted rescue bid. Whether it was true or not, I cannot say, but I do know that I was suddenly grasped violently round the middle. It is the birth-right of every Englishman to sell his liberty dearly; I tried to make mine as expensive as possible: I succeeded. Before I knew where I was, I found myself in a seething mass of blue-uniformed giants. The struggle continued for a while, during which someone

trod heavily on my foot which was most painful; whether a horse or a policeman was responsible, I do not know, more probably the latter because the weight seemed too great for a horse.

Anyway, this injury seriously interfered with my defence and I suddenly found myself airborne with a "Peeler" firmly attached to each extremity. The position was invidious, yet not uncomfortable, and I was quite sorry that the journey was so short, ending abruptly by a precipitate headlong dive into the Maria. Here I found two friends waiting and, within a few seconds, was joined by a third who appeared to be in a great hurry. The doors were slammed and we moved off.

The five constables in the vehicle were a taciturn mob, disinclined for conversation. They were apparently all non-smokers for they refused an offer of cigarettes quite gruffly and my observations as to the smooth running and comfort of the wagon were received in stony silence; of course, we had not as yet been introduced formally and I expect that they regarded our attitude as a trifle forward.

On arrival at Snow Hill we were surprised to find that a goodly crowd of police had gathered to welcome us. There were no fewer than 30 forming an impassive alleyway. I think that the four of us would have felt rather proud and honoured by this attention—quite like Royalty—had we had time to consider it, but when there are two hefty men on each of one's arms, a journey of a few yards can be made at a remarkable speed.

Accompanied by our bodyguards, we were bundled into a room and placed within a sort of cage affair and a dolorous looking sergeant proceeded to read out the charges. There were a lot of them and as they were reeled off we began to feel like real criminals; perhaps we were, the police seemed to think so anyway.

We were then measured and our descriptions taken (I was described as of sallow complexion which I thought unflattering, I prefer pale, it sounds better); we were asked whether we were married or single, to which one of our number, in a moment of nervous excitement, replied: "N'no, Sir, I'm a medical student," a remark which caused the three other prisoners to laugh, and even brought a faint hint of benignity to ruffle the sergeant's otherwise granite-like countenance. Then we were searched.

This latter business caused me a certain amount of embarrassment. Although, at the beginning of a term, my pockets contain some money and a few essential articles such as pens and pencils, as time goes by, the proportion of useful to useless articles tends to vary immensely. This occasion proved to be no exception. I had not intended to spend the day in prison, otherwise I would have visited a bank earlier; as it was, I had but three-halfpence in cash, a wallet (empty), two bottles of aspirins, a packet of indigestion tablets, one scalpel (described as a penknife), four pencils, a piece of string and a three-weeks-old edition of the *Daily Mail*. It was an impressive assortment and I felt quite proud when signing the list.

This done we were marched off to the cells and found that, owing no doubt to our dangerous characters, we had been given the privilege of solitary confinement.

There is something appallingly final about the slamming of a prison door. It is as though a chapter in life has been irretrievably closed. The past has gone for ever, the present is cramped, the future unknown. For the first few minutes one examines the cell and marvels at the solidity of its construction. The extreme austerity of the design and fittings is immensely impressive. One recalls tales of escape and wonders how on earth, without the aid of dynamite, the fictional heroes ever managed it. Authors who make such things possible must be law-abiding citizens.

This cell was quite up to the usual run of such things. There were two doors together, one made of iron bars and the other of invincible wood. There was a bench on which were two very firm leather "pillows" and two blankets of a remarkably rough texture closely resembling very coarse sandpaper. The window, heavily barred, was set high up in the wall and could only be reached with difficulty. Looking at the bars set me musing on the possibilities of one of the women students bringing a pie containing a file, in the traditional fashion, but I considered that, in the unlikely event, my release would come before I had dealt with the sixteen bars.

The designer of the cell had not forgotten all the decencies of life: for, at the distal end, in the words of the German, there found itself a lavatory. It was not an elaborate affair, though, and decidedly eccentric, for

there was no chain, the flush being operated by a lever set near the door. Why it was so far away, I cannot imagine, unless it was done to prevent really desperate characters from attempting suicide by putting their heads down and then flushing; a difficult operation at the best of times and distinctly unhealthy.

There was nothing to do. Despite our protestations we were not even allowed the enjoyment of picking oakum or sewing mailbags. Time dragged, I tried to count the tiles and had reached three thousand nine hundred and fifty-two when the kindly jailer lent me a *Daily Express*. Being a modern newspaper, I had devoured its contents, including the advertisements, in under five minutes. Then I attempted to do the crossword in my head and nearly went mad. This mental effort was disturbed by the distant sound of continued flushing coming from the adjoining cell.

I shouted out to its occupant an enquiry as to whether he was feeling all right. He roared back that he was, and explained that he was merely working the lever in an effort to dispel boredom. It was a good idea and I followed his example. Quite an interesting physical problem could have been evolved from this experiment to do with the time lag between the operation of the lever and the arrival of the water; so many factors have to be taken into consideration; mechanical disadvantage, water pressure, gravity and all the rest. Having no log tables with me prevented any accurate observations, but I do earnestly wish to draw the attention of those people whose job in life is to set such problems to this, hitherto unplumbed, field of endeavour.

## OXFORD-BARTS CLUB

The Annual Dinner of the Oxford Barts Club was held at the White Hart, Giltspur Street, E.C.1, on the evening of Friday, November 26th.

At the end of the Dinner, the President, Dr. E. B. Strauss, F.R.C.P., proposed the Toast to the Club in a succinct and characteristic manner. Other speeches were made proposing the health of the senior members, and also of the ladies—four of whom were present and lent grace and colour to the occasion.

In conclusion, the President thanked the

At last the key grated in the lock; the doors swung open. We gathered our belongings, received our summonses, and were released on bail into the fresh air.

To use the phraseology of a certain Sunday newspaper when reporting such incidents: "A Students' Rag on Lord Mayor's Day had a sequel when four young men appeared in court charged with obstructing the police."

We appeared. We sat on our front-row bench and listened to other cases of a less or more serious nature. The trivial offences arising from our much-controlled existence were presented in miniature. There were the costermongers who had committed the unforgivable sin of carrying on their trade in a "Yellow Band" area: there was the man who had appropriated three sausage rolls—the property of British Railways: there were the motorists who had parked their cars. Then our turns came; we were led one by one to receive sentence. The magistrate was very kind, he let us off lightly with a pound and a reprimand: the game was over.

Yes, the game was over and life returned to normal once more; and so, strange to relate, did my liver. The battle and its consequences evidently had done it the world of good.

So there is the method referred to in the title: get involved with the police, resist them, recline for some hours in prison, and Nature will do the rest. But it is an expensive cure—it cost a pound and a damaged foot—and I strongly advise others, suffering from a like complaint, to content themselves with a box of pills—it saves time and can be achieved with less publicity.

secretaries for their efforts in arranging the Dinner and the secretaries and treasurer for the ensuing year were announced. The steward, particularly, is to be congratulated on the excellence of the wines.

About thirty members were present and together spent a very enjoyable evening.

The officers for the year 1949-50 will be:

*President:* Dr. E. B. Strauss.

*Hon Treasurer:* J. Ainley-Walker.

*Secretaries:* J. M. L. Gilks,

Miss M. Raynor.

## POST MORTEM

... a note on the reptilian ritual celebrating the lost soul's departure from the body.

Julia wandered screaming through the roof  
While slow worms were cavorting on her grave.  
Slowly they danced and pleaded, "Give us proof!"  
"The thread is severed" was the reply she gave.

Chrysanthemums were taken off the train  
As Julia's limbs corrupted one by one.  
"For God's sake put a label on her brain!"  
The slow worms chanted, e'er their dance was done.

Dismembered and disgruntled, she forced on,  
Her limbs still writhing, while her eyes burned bright.  
The slow worms sleep in blood, their dance is done,  
And Julia screams throughout the eternal night.

J. McO.

## GUY'S BART'S SOCIAL

Held at Guy's Hospital on Thursday, November 25th, at 4.30 o'clock.

The evening began with a lecture from Mr. Bragg on hypnotism. The popularity of his subject was amply borne out by the size of his audience which was such as to completely fill and overflow the lecture theatre, with the result that late comers from Bart's were unable to hear the beginning of his talk owing to lack of accommodation. This, however, was soon remedied and we settled down to hear a very fair evaluation of the place of hypnotism in general practise. Mr. Bragg emphasized that there is no particular technique in hypnotism which demands any specialized training. Any one of us present, he said, could learn this apparently magical art with the minimum of practise—visions of startling drawing room tricks immediately rose to one's mind. He told us what could be done with hypnotism, achievements which to the scientist appear beyond the bounds of all possibility. However he soon brought us down to earth again by pointing out that hypnotism has remained in a condition of stasis ever since Dr. Memner first introduced it to an unbelieving world. In fact, he said, hypnotism has really no place in medicine, for the time/efficiency ratio involved in using hypnotism as a general procedure did not justify the results achieved by such a time consuming process. He himself had practised hypnotism from dawn till dusk in the first flush of his enthusiasm, but now that he had recaptured his equilibrium he had not hypnotized a patient for over a year. He ended with an attempt at mass hypnotism by trying to put his audience of some 300 to sleep with ten minutes of soporific patter. His results of one asleep and two doubtful merely served to illustrate his statements that hypnotism is of almost negligible value as a therapeutic measure. It must be admitted, however, that conditions were far from ideal for such an exacting test.

Having had our faith in hypnotism shattered, the next item on the programme was a conducted tour of the hospital. This included both a medical and surgical demonstration. One particular feature which greatly impressed the writer was an exhibit of the causes of dysphagia, arranged in a room set aside for this purpose. It was illustrated with numerous specimens, attractive drawings and

admirably concise *précis* covering every aspect of the subject. It appears that such demonstrations are left intact for three weeks, to be replaced at the end of this period by one of a similar nature on some other subject. In the meanwhile it is open through the day for anyone who may wish to while away a profitable half-hour. At Guy's such demonstrations are a permanent feature and the introduction of a similar series into this hospital cannot be too strongly recommended. The excellence of the Guy's museum, which we also visited, emphasized strongly the deficiencies of our own.

Having completed the tour of the hospital we proceeded to a really magnificent dinner.

During its course a map was circulated showing the bomb damage sustained by Guy's and its neighbourhood. It was a sorry reflection to realise that although the damage at Guy's was considerably greater than at Bart's, it had been meticulously cleared away. The rubble and ruins at Bart's is painfully obvious for every eye to see.

Afterwards we listened to speeches by Professor Willis and Mr. Palmer, on behalf of Guy's, greeting our presence there that night, and replies by Mr. Aldren Turner and Mr. Molloy thanking them for the warm welcome which they had extended to us. All emphasized the importance of continuing such "get togethers" in the future and extending the principle to the other teaching hospitals.

Finally we heard a most enlightening five minutes on the history of Guy's from Mr. Scott. The evening ended with a Table Tennis match, the result being a draw, and a Squash match which Bart's won 4-1. This, however, did nothing to stem the flow of Guy's hospitality and the Squash team at least spent a very pleasant half hour investigating the qualities of the beer to be found in the Borough.

Our thanks are due to Guy's and in particular to Mr. Palmer, who was responsible for the most part of the organisation, for expending so much energy and good will in providing us with such a pleasant evening. May it not be long before we see Guy's at our table enjoying Bart's hospitality as much as we did theirs.

## ANNOUNCEMENTS

### MARRIAGE

**FYFE-MURPHY.** On September 11th, 1948, at Christ Church, Chelsea. Alexander, elder son of Mr. C. T. Fyfe of Regina, Sask., Canada, and the late Mrs. Fyfe, to Mollie, only daughter of Mrs. Murphy of West Kirby, Cheshire, and the late Dr. T. T. Murphy, of Wawota, Sask., Canada.

### DEATH

**HAMILTON.** In November, at New York, U.S.A., G. Johnson, M.R.C.S., M.D., late Lt.-Col., U.S.A.M.C.; whilst riding

### ABERNETHIAN SOCIETY

Meetings to be held in January, 1949.

Thursday, Jan. 13—Prof. Henry Cohen (Liverpool University) on "Clinical Analysis of Pain."  
Jan. 27—Prof. John L. D'Silva (London Hospital).

## BOOK REVIEWS

**THE CLINICAL APPRENTICE** by J. M. Naish and J. Apley. John Wright & Sons, Ltd., Bristol, 1948. Pp. 200. Price 15s.

A successful attempt to present within small compass the fundamentals of clinical examination and its rationale. In two hundred well-written and illustrated pages, the authors have dealt with Examination at leisure and Examination of Acute Cases. The examples cited in most chapters are particularly well chosen. All students should read this book early in their clinical career.

**AN INTRODUCTION TO MEDICAL STATISTICS**, by Hilda M. Woods and William T. Russell. Pp. X + 125. Revised edition, 1948. Staples Press, London. Price 8s. 6d.

The average medical man has little time to devote to the study of statistics and statistical methods, yet he is expected to have a working knowledge of their elements; indeed, writers in current journals assume such knowledge.

This useful little book provides, within small compass, a simple and concise review of the principles involved, not only in the collection and analysis of statistical data, but in the drawing of legitimate conclusions from them.

The manner of presentation is such that the book is eminently readable. The subject is tackled from fundamentals and only after a method has been thoroughly dealt with, is a general formula cited.

There are nevertheless one or two small points which call for derogatory comment, viz., in the chapter on Correlation, capitals and small letters represent different factors, whereas in the chapter on Life Tablets, they are used without such discrimination. This is confusing. Another small point is the use of the technical term "weight" before its application has been explained.

However, these detract but little from the value of the work as a whole, and it will be found particularly useful to Medical Officers to public bodies and institutions, since it contains the neces-

sary practical material for outlining an Annual Report. It should be read by all who will, in the future, have such reports to prepare, and should stimulate the student to further reading of this far from dull subject.

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**MODERN METHODS OF INFANT MANAGEMENT**, Edited by W. R. F. Collis. William Heinemann Ltd., London, 1948. Pp. 285. Price 17s. 6d.

The authors of this little book, two pædiatrics, a gynecologist and the sister of a children's ward set out to describe "what the doctor should know that the nurse should know." This they do admirably and it would appear to be an excellent guide for the intending midwife.

The first section deals with ante-natal care and the hygiene of birth. Section II includes chapters on the management of the new-born baby, the techniques of breast and of artificial feeding together with the dietetic principles involved, and

the normal development of the infant. Section III discusses the problems of infant feeding, while the last hundred and fifty pages are devoted to the various pathological conditions associated with birth and infancy.

For the medical student the accounts of the various nursing procedures and general management are invaluable; the descriptions of disease are, however, wholly inadequate.

This book emanates from the Rotunda Hospital and some of the procedures are different from those used in this country. The occasional descent into description of the social conditions of the neighbourhood and of local politics may be of interest to the intending traveller. The book is well produced and on good paper.

## SPORT

### R.U.F.C.

#### ANNUAL TOUR

This year a coach was hired to take the team on tour and this proved to be a very popular innovation as well as saving the Club a considerable sum of money.

On the whole the tour was very successful, winning one game and narrowly losing two in four days. We were very unfortunate to lose Green in the first match who was forced to retire to the local hospital for the duration of the tour having sustained an injury to his knee.

The team acquitted itself very well both on and off the field and the Cornish rugger following is already looking forward to the time when Bart's will visit them again.

Detailed results of the tour are as follows:—

**November 13th v. Penzance and Newlyn**  
RESULT: LOST BY 5 POINTS TO 0.

Accounts of this match in the local press agreed that the "Pirates" were fortunate to win, although during the first twenty minutes our play was very ragged and the opposition were able to score a goal. After this, in spite of some excellent runs on the right wing by Murphy, still Bart's could not score.

After the interval, Green (stand-off) departed from the game with a dislocated knee and so Bart's were one short. In spite of the reduction in number, our forwards continued to hold their own against a heavier pack and they gave the outsiders plenty of the ball but still we could not score.

Persistently baulked in their efforts to reach the "Pirates" line our team provided their hosts with an open, sturdy game and none will regret the encounter."

**November 15th v. Falmouth**  
RESULT: WON BY 3 POINTS TO 0.

This game was played in driving rain and the conditions made normal rugger impossible. Bart's played against the gale first and although the ball was in our "25" for most of the half there was no score.

In the second half our attack, although less consistent than Falmouth's had been, was successful when Griffiths gathered a loose ball to score the only try.

One feature of the match was the faultless handling in such conditions of Strong at full-back.

**November 16th v. Hayle**

RESULT: LOST BY 13 POINTS TO 8.

Played in similar but less fierce weather than at Falmouth this match was disappointing in that Bart's failed to hold on to an 8-3 lead at half-time. In the first half the side was very lively and some good handling produced two tries for Bart's. After the interval, playing against the wind and a heavier pack the team began to feel the effects of three games in four days but the forwards were by no means beaten in the loose: Moyes, Dick and John were outstanding among the forwards especially in the closing stages of the game.

Once again Strong played well at full-back

#### OTHER MATCHES

**November 20th v. Stroud**

RESULT: LOST BY 20 POINTS TO 0.

Following the Tour, this became the fourth game for the team within a week and although acquitting themselves fairly well, it was a tired team which lost to Stroud.

For the first half both sides were evenly matched, Third and John showing up well among the forwards. Once, Griffiths on the left wing raced round his man and only just failed to score. But at half-time there was no score.

In the second half the superior weight of our opponents began to tell and in spite of some gallant work by the forwards, the home side scored repeatedly.

**November 27th v. Saracens**

Match cancelled owing to fog.

**December 4th v. Old Alleynians**

RESULT: LOST BY 21 POINTS TO 0.

With the backs having an "off-day" Bart's lost to a more determined side.

The Hospital forwards, however, were excellent and never gave up worrying the much heavier opposing pack. All the forwards played together extremely well and consequently Bart's had more than their share of the ball from both loose and tight; Third and Carter both excelled in the loose and Moyes hooked well in the tight but most praise must go to all forwards for combining so well.

At half-back, Wynne-Jones had a good day but fly-half Clare was not always certain although taking the ball well. The three-quarters were weak in defence allowing opponents to run through them and in attack the handling was poor.

The backs must be more certain of tackling and handling. A. M. B.

### SWIMMING CLUB

The winter programme of the Club will be held each Wednesday afternoon at the Central Baths, Finchley Road. A race for men and women members will be held each week and will be followed by a water polo practice. The bath temperature is maintained at a high level and all members are asked to attend and make the sessions a success.

The baths are reached by travelling on the Bakerloo or Metropolitan Tubes to Finchley Road station, or else direct by a No. 13 bus which stops outside the baths. G. C. H. C.

### BOAT CLUB

The officers for this year are as follows:—

*President:* Dr. B. W. Town.

*Captain:* J. C. M. Currie.

*Hon. Secretary:* M. Cohen.

*Clinical Representatives:*

G. E. Chorley, G. H. C. Melotte.

*Pre-clinical Representatives:*

W. P. Fitt, R. E. Nottidge.

We were able to start training in October with two eights on the river regularly, both of which were entered for the United Hospital's Regatta. It is hoped to have a third boat ready for the London University Winter Eights in December.

The keenness and enthusiasm which has marked the beginning of rowing this year was well rewarded by our success in the United Hospital's Regatta. Usually held in May, the regatta had been postponed until November 10th and we were fortunate that conditions were ideal for rowing so late in the season. A decisive win by the Junior Eight in the first heat of the day contributed much to a spirit which resulted in five successes, including the Senior Eights, out of the seven events that we entered. The club thus recorded its first victory in an Inter-Hospital race since 1931, when the Senior Eights Challenge Cup was won in that year. The increased interest in sculling was shown by three entrants from the hospital in the Junior Sculls, G. E. Chorley putting up a very fine performance to win the event. Our thanks are due to R. S. Atkinson who kindly undertook to cox the Senior Eight, when, owing to the activities of "Percy" in the Lord Mayor's Show, we were unexpectedly deprived of that very vital member of the crew, on the morning of the race. We were also very pleased to have five members of the rugger club actively engaged in the regatta and their support was greatly appreciated.

The two crews entered for the United Hospitals Regatta will be kept in training for the summer regattas and further junior eights will be built up from the active new members who have put considerable effort into learning to row this season. For the first time it is hoped to be able to send an eight to represent the hospital in Senior up-river regattas.

All members of the club have worked hard this

term and certainly demonstrated that nothing is gained without considerable effort. Due to the overcrowding at the University Boat House, rowing arrangements are not as satisfactory as could be desired, but it may be possible to improve this position by making an effort to increase our equipment over the next few years. More use of the tank and tub-pairs by everybody is necessary to maintain the standard of rowing reached during the last few weeks.

I would like to take this opportunity of pointing out the marked disproportion between clinical and pre-clinical members and say that we need more people from Charterhouse to come along and learn to row in the New Year. We rely entirely upon your support and if the Hospital's Cup is to remain here for another year, need a steady supply of new oarsmen.

### SOCCER CLUB

The Captain and Secretary of the Club remain unchanged again this season. They are T.A. Duffy and W. H. A. C. Cox respectively. Getting together a team has again been a difficult task for them. Several players have now qualified and as last season we have had no fresh support from the newcomers.

The first three games, therefore, were rather a tryout, and we lost to the Old Cholmeleians, Birmingham University and Wimbledon F.C. The defence showed its weakness except for A. N. H. Wright and M. K. Mangan, who were, as always, towers of strength.

Going to Cambridge again helped us, for although we lost to Emmanuel and Downing College we scored a decisive 3-1 win against Jesus College.

The crowning success of the season came the following Wednesday when we defeated St. Mary's Hospital 4-3 at Chislehurst. The whole team played well and it proves the point that we can turn out a better side on a Wednesday than on a Saturday.

We were happy to beat Mary's for they had knocked us out of the Cup last season in the semi-final and we have to meet them again this year in the 2nd round.

We trust this success will be a good omen for the future. W. H. A. C. C.

### HOCKEY CLUB

*The editor regrets that in the last number of the Journal the Officers of the Cricket Club for next season were erroneously listed under the heading of the Hockey Club.*

*The officers of the Hockey Club for this season are as follows:—*

*President:* Professor J. Paterson Ross.

*Vice-Presidents:* Professor Hopwood.

Mr. H. B. Stallard.

Professor Christie.

*Captain:* G. Hurst.

*Secretary:* J. W. Mellows.

*Hon. Treasurer:* E. J. Griffiths.

*Match Secretary:* N. Hicks.

*Capt. 2nd XI:* D. F. A. Aubin.

*Sec. 2nd XI:* J. McL. Hill.

*Committee Members:*

J. W. Platt, J. B. Dossetor.



## STUDENTS' UNION COUNCIL MEETING FOR DECEMBER

The following points of general interest were discussed:—

**Abernethian Room.**

The A.R. has been inspected with a view to its re-decoration in the near future. Six frames will be purchased for prints, which will be hired, and changed each term by School Prints Ltd., for further adornment of the A.R. A similar scheme will be used to brighten the Refectory in Charterhouse Square.

**Catering Company Report.**

After a recent meeting of the Directors of the Catering Company, it is hoped there will be a very marked improvement in both Refectories within the next two or three months.

**Women's Hockey Club.**

The Women's Hockey Club presented their Constitution to the Council and after several amendments, was approved and passed.

**Election of Officers.**

Vacancies for the offices of Junior Secretary and Financial Secretary of the Council were filled by the election of Mr. M. Cohen and Mr. A. D. Munro-Faure respectively.

**Rifle Club.**

There has been much enthusiastic work put into the revival of this Club. A report of progress achieved to date was read. The chief difficulty at the moment is the lack of a range, there being little prospect of regaining our own at the moment as it is being used as a Hospital store. Meanwhile, the range at the Cripplegate Institute is being used at a cost of 1/- per hour. Rifles are few, but application is being made to the Military Authorities to regain those appropriated from the Club during the War.

**Radiogram.**

A suggestion from the "Suggestions Book" to purchase a radiogram for "hops" and music recitals was discussed; but it was felt that due to our present financial position such an expenditure could not be considered.

**"Vicarage."**

Suitable accommodation to house a new "Vicarage" is being sought; the main difficulty being to find a place with running water.

When such a place is found, the matter will again be brought before the Council.

## IN OUR LIBRARY No. 13

## JACQUES GUILLEMEAU (1550-1613)

by JOHN L. THORNTON (*Librarian*)

FRANCE has fostered many brilliant surgeons, among whom the inspired Ambroise Paré is an outstanding example. One of his pupils, Jacques Guillemeau, also achieved prominence, and his writings are of great interest even to contemporary eyes. Unfortunately little is known of the life of Guillemeau beyond the fact that he was a native of Orleans, a disciple of Courtin, Riolan and Paré, and a colleague of Paré in his practice in Paris, and during his campaigns. Guillemeau became surgeon to Charles IX, Henri III and Henri IV, and to the Hôtel Dieu, acquiring a prominent reputation in his profession.

The first publication of Jacques Guillemeau was his translation into Latin of Paré's surgery, which was published at Paris in 1582, to be followed by several others, including *Traité des maladies de l'oeil*, Paris, 1585, and Lyons, 1610, translated into English by Anthony Hunton, and published between 1585 and 1589; this is very rare, and constitutes a summary of existing knowledge,

chiefly from Greek and Arabian authorities. His *La chirurgie française recueillie des anciens médecins et chirurgiens*, [etc.], Paris, 1594, is available in an English translation from a Dutch version. A copy of *The French chirurgery*, Dort, 1598, is housed in our Library, and has a dedication to Queen Elizabeth. The book contains two figures illustrating the surface anatomy of the human body, two showing the external veins, followed by 11 engraved plates of surgical instruments. The lettering on the plates is in Dutch and English, and the text is very entertaining.

Yet another of his books, *L'Heureux accouchement des femmes*, [etc.], Paris, 1609 and 1621, was translated into English, being entitled *Child-birth, or the happy deliverie of women. Wherein is set down the government of women . . . . To which is added, a treatise of the diseases of infants, and young children*, [etc.], London, 1612, and a copy is housed in our Library. Unfortunately it is incomplete, a vandal having removed certain

pages, but the text is of interest, and the views of the author are worthy of study. He quotes freely from the classic authors, as well as from his own experience, and deals with the diagnosis of pregnancy, the diet and dress of prospective mothers, the conduction of labour, and with the selection and duties of midwives. Guillemeau recognised the limitations of his craft, and wrote in the Introduction to his book, "But grant that the child comes into the world of it selfe, without the helpe of either Chirurgion or Midwife." He appreciated the value of psychology, and under the heading, "A good deceit," wrote:

"And if the feare of the paine doth hinder the delivery, then the woman must be incouraged, telling her that shee shall bee quickly freed from this sicknesse, and that it is common unto all women, to have such paines, cherishing her with good hopes, assuring her that her travaile will bee very easie, and promising her, that she shall have either a sonne or a daughter, according as you know she desires, as we have said before, flattering and soothing her as much as you can, without chiding or giving her any crosse speeches at all." (p.117).

Jacques Guillemeau was called in to attend Anne, the daughter of his former master Ambroise Paré, and records the case-history in this book:

"The yeere 1599. *Madam Simon* yet alive daughter to *Mr. Pareus*, Councillour, and chiefe Chirurgion to the King; being ready to lie downe was surprisid with a great flux of bloud, having about her *Mad. la Charomie* for her Midwife, and likewise *Mr. Hautin* the Kings Phisition in ordinarie, and *Mr. Rigault* Doctors in Phisicke in Paris, and because of great swoonings that tooke her every quarter of an houre through the losse of bloud she had: *Master Marchant* my son in law and myselfe were sent for; But I finding her almost without pulse, having her voice weake, and her lips pale: I told her mother and her husband that she was in great danger of her

life, and that there was but one way to save her, which was, to deliver her speedily: the which I had seen practized by the late *Mr. Pareus* her Father, who had caused me to do the like, unto a Gentlewoman of *Mad. de Seneterre*. Then her mother, and her husband earnestly intreated us to helpe her, and that they would put her into our hands to dispose of her. And so sodainly, following the advise of the Physitions, she was very happily delivered of a lively child." (p.128.)

He recommended podalic version, but was strongly prejudiced against caesarian section:

"Some hold, that this Caesarian Section, may and ought to be practized (the woman being alive) in a painful and troublesome birth: Which for mine owne part, I will not counsell any one to do, having twice made triall of it my selfe, in the presence of *Mons. Paræus*, and likewise seen it done by *Mons. Viart*, *Brunet*, and *Charbonnet*, all excellent Chirurgions, and men of great experience and practice; who omitted nothing, to do it artificially, and methodically: Nevertheless, of five women, in whom this hath been practized, not one hath escaped." (pp.187-8.)

It must indeed have been a hazardous operation before the introduction of anaesthesia, and the advent of antiseptic surgery; any survival in such primitive conditions must be considered as little short of miraculous.

The details in Guillemeau's book on midwifery cover every eventuality, commencing with the diagnosis of pregnancy, how to forecast the sex of the child, and terminating with directions for the future welfare of mother and child. His remarks to a mother upon the happy termination of labour re-echo his belief in the value of psychology in midwifery:

"Let her banish all griefe and heaviness, having regard only of her health, and to be merry, praising God for her delivery." (p. 194.)

## THE JOURNAL

Contributions for *The Journal* should reach the Editor not later than the first Tuesday of the month for inclusion in the ensuing issue.

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## HOSPITAL JOURNAL

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### EDUCATION

RECENTLY the Medical Curriculum Committee of the B.M.A. published an extensive report of its activities entitled "The Training of a Doctor." The aim of this body was to investigate the present system of medical training and to propound from all that it had seen and heard, a system which would bring the education of the present student into line with the enormous strides in technique and knowledge of Medicine made in recent years. These advances have been made at a breath-taking and ever increasing velocity, and it is only now that the authorities are beginning to realise how inadequate and archaic are the methods followed in the majority of medical schools. The problems of education are by no means confined to Medicine but in no other field are the scales of life and death balanced so precariously between ignorance and knowledge. There is no more exacting master than Medicine nor yet one so loyal and it is therefore imperative that the training for such a task be the finest that can be made available. As medicine advances so are more and more uncorrelated and unexplained facts thrown at the head of the defenceless student until eventually, if he is not very careful, he becomes no more than a stultified medical dictionary and a heavily abridged one at that.

No man can expect to become a Solomon of Medicine and the aim, therefore, of a medical school should not be to teach a mass of indigestible theories and facts which a man must be ready to recite to his examiners should he wish to become qualified, but rather to teach the fundamentals of his subject upon which are built not only the whole structure of medical practice but also of human society—for the two are inseparable.

Galen in his opinion gave eleven years as the shortest time in which a man might become a competent physician and he did not exaggerate. The education of a doctor does not begin with brief sketches of Physics, Chemistry and Biology but when he enters his first school, where his character first begins to be shaped by a liberal education and where he will acquire the foundation of a background and philosophy which will remain with him for the rest of his life. The prime object of education should be to develop and substantiate these first foundations, and this it can only do by giving to its pupils as broad and perfect an instruction as can be achieved. This is the most important part of his education and therefore any tendency towards early specialization should be rigorously avoided before the student leaves school.

In this material world the accent is coming to lie more and more upon the achievements of science with the result that medicine is surely being replaced by a false god of mechanics. The doctor is becoming an automaton, a servant to his knowledge. The old conceptions and philosophies which guided the G.P. of one hundred years ago are being lost beneath a welter of facts applied by rule of thumb methods, and yet it is exactly the qualities of wonder and humanitarianism which those men humbly possessed that are the fundamentals of Medicine.

More and more is the doctor becoming the confidant and guide of his patients. In the past such a role was played exclusively by the parish priest for then the Church was the only hope upon which a man might lay his ills of body and mind. But now that medicine is in a position to provide a real

alternative to the often less effective answer offered by the Church to his troubles, there is inevitably a move whereby the doctor replaces the priest in this role. This move, however, does in no way affect those duties which at one time were exercised by the priest; it merely divides them into two spheres—the one where priest should guide, the other where physician should act. Where one wise man sufficed, two are now necessary and the broad wisdom which must be displayed in the execution of these duties is lamentably a great rarity.

Such qualities are not taught by an inadequate scientific background; a doctor is a humanist first and a scientist second. That science is an essential in the training of a doctor is not questioned, but it should be his servant and not his master. Nothing is more dangerous to such a profession than a conception of its duties based on a small and wholly misleading knowledge of the meaning and application of science.

The report has appreciated these dangers and lays stress on the importance of a liberal pre-medical training but it offers no suggestion as to how such an education can be

achieved for that is not its province. The N.H.S. has created an enormously increased demand for doctors, but Mr. Bevan in his grim determination to antagonise and flout any authority which may know better than himself has merely blundered into a morass of contradictions and impossibilities. Doctors are not made in a day, and the education which should be theirs is becoming more and more expensive and therefore available to fewer and fewer of his future bondsmen. Thus the country will be faced in the near future with a N.H.S. staffed by an inadequate number of doctors, who have neither the approach to their subject nor the breadth of mind so vital to the execution of a truly great vocation. The solving of this problem requires a great degree of consideration and clear thinking, neither of which two factors does Mr. Bevan appear inclined to employ, but unless he wishes to see his premature child sink to a depth of unprecedented misery in a few years time, he will very soon have to mend his ways. It is easy enough to offer destructive criticism but no one is inclined to shoulder a burden created by an act comparable to the greater follies of history.

## THE PLACE OF ARTIFICIAL IMMUNISATION IN THE PHOPHYLAXIS OF TUBERCULOSIS IN MAN

By A. Q. WELLS, D.M.

Now that almost every country in the world is either using or contemplating using B.C.G. vaccine as part of a national campaign against tuberculosis, it is an opportune moment to consider what is the proper place for vaccination in such a campaign. Before coming to a decision, it is necessary to know the answer to three questions—(1) Is there such a state as acquired specific immunity against tuberculosis? (2) Does increased acquired resistance follow vaccination? and (3) Is B.C.G. the best available antigen to induce increased resistance? The answer to the last two questions is clearly dependant on the answer to the first one.

The presence or absence of specific acquired immunity can be demonstrated in the case of many infectious diseases, whether they are of bacterial or viral origin, by means of some laboratory test or from epidemiological data. Three examples are diphtheria, measles and typhoid fever. A person who

has recovered from an attack of diphtheria, or who has had injections of diphtheria toxoid, has an increased level of circulating diphtheria antitoxin which can be demonstrated by a Schick Test. We know that the incidence of diphtheria in persons who are Schick negative is only a minute fraction of what it is in those who are Schick positive. It is possible, therefore, to deduce that specific acquired immunity has followed infection or artificial immunisation, always bearing in mind that the word immunity is being used loosely to mean raised resistance rather than absolute protection. In the case of measles, although there is no test for susceptibility in the individual, we know from epidemiological studies that the incidence of the disease in those who have already recovered from one attack is far less than in those who have never been infected. It is assumed, therefore, that relative immunity follows infection. In typhoid fever vaccina-

tion has been shown to reduce very greatly the incidence of the disease by producing increased specific resistance, an indication of which can be obtained by examining the agglutinin content of the serum.

There is, as yet, no means of finding out the individual state of resistance to tuberculosis by means of any clinical or laboratory test. We are forced, therefore, to try to determine whether increased acquired resistance follows infection by means of epidemiological study. Here we immediately come up against a fundamental difficulty. The great majority of urban dwellers have been infected with the tubercle bacillus by the time they reach adult life. This can be shown by the development of a sensitivity to tuberculoprotein and demonstrated by the tuberculin test. Only a small proportion of those who have been infected have ever shown signs of clinical tuberculosis, yet it is certain that they have been infected because many show healed lesions either by X-ray or at post-mortem examination in addition to their specific sensitivity. These infected, but not tuberculous, persons have resisted the spread of infection either because of a natural resistance or because of an individual ability to mobilise acquired resistance soon after infection. It seems more likely to be a natural resistance. A proportion of those infected before reaching adult life are unable to resist the infection and develop clinical tuberculosis as a result of which they may either succumb or gradually overcome the infection. Clearly, then, those who are tuberculin positive when adult represent a selected group and cannot fairly be compared with another unselected group which are those who have never met infection and are therefore insensitive to tuberculin. Yet it is just these two groups who are usually chosen to demonstrate acquired specific resistance following infection. Several surveys are now available showing that the incidence of tuberculosis among nurses in training is greater in those who are initially tuberculin negative than in those who are initially tuberculin positive. If the comparison between these two groups were to be a fair one, then the initially tuberculin positive group ought to have added to it those girls who would have become nurses in that particular group had they not succumbed to tuberculosis before reaching the starting age. That number is manifestly impossible to determine.

The answer to our question, then, is not forthcoming from either a laboratory test or epidemiological data. Are there any indirect means of arriving at a probable conclusion? There is the evidence of animal experiment and morbid anatomical study. Animal experiments have shown conclusively that resistance can be raised by vaccination, whether the experimental animals are the completely susceptible guinea pig or the relatively resistant cow. There is a very large literature on this subject—far too large to attempt to summarise. The animal most used has been the guinea pig, which is a particularly unfortunate choice except that it is a convenient size and readily available. The guinea pig, unlike man, has no demonstrable natural resistance to the tubercle bacillus. It can be infected with very few bacilli and, once infected, disease will continue its inexorable course to death. Attempts to produce an acquired resistance in the guinea pig have been made by using a vaccine of killed tubercle bacilli, bacilli whose virulence has been reduced by laboratory cultivation and strains of bacilli which are naturally avirulent. None of these methods has produced immunity to subsequent infection with virulent tubercle bacilli, but they have produced a resistance which can be shown by the increased survival time after virulent infection compared with that of the unvaccinated controls. This increased survival time may be very substantial. What happens in the guinea pig, however, does not necessarily happen in man. Tuberculosis in man is very different from tuberculosis in the guinea pig, so this experimental evidence cannot be more than a pointer. Experimental evidence in cattle is probably a much sounder guide. Cattle have some measure of natural resistance to the tubercle bacillus, as we know has man. Vaccination in cattle certainly raises resistance, but it is not yet clear to what extent.

This is not the place to discuss in detail the morbid anatomy of tuberculosis in man. A study of this reveals the compatibility of the histological picture with a condition of specific acquired resistance. The histology of a secondary tuberculous infection is very different from that of a primary infection and suggests that acquired resistance has followed the primary infection. It is only fair, however, to note that there may be many other factors at play, which may account in part at any rate for the difference between a

primary and a secondary infection. The position, then, seems to be that a certain degree of specific acquired resistance probably follows infection with the tubercle bacillus; that this acquired resistance is not very great and that more important factors in the resistance to the spread of infection are inherent in the individual and non-specific. This is clearly not a categorical answer to our first question, but it is the best that can be given at the moment.

Does increased acquired resistance follow vaccination? The number of persons now vaccinated with B.C.G. runs into millions. It would seem reasonable to suppose that an answer would be readily forthcoming from this great mass of material as to the value of vaccination. Yet not even the most bigoted supporter would contend that there is scientific proof that increased resistance has followed vaccination. The lack of scientific proof is due partly to bad experiments and partly to the inherent difficulty in devising a human experiment in prophylaxis which will give a clear cut answer. The latter difficulty is probably more accentuated in tuberculosis than in any other disease. As an illustration let us consider whooping cough. The objective in prophylactic vaccination against whooping cough is to prevent infection in the vaccinated subject when *Haemophilus pertussis* is encountered. If the persons in the experiment are divided impartially into vaccinated and controls and if the risk of exposure and conditions of life in the two groups are equal, then the incidence of the disease in the two groups will give an answer as to the efficacy of the vaccine. The fact that no convincing answer to the efficacy of vaccination against whooping cough is at present available shows the difficulty in satisfying experimental demands. Now the problem in tuberculosis is made more complicated by the fact that we are dealing with a chronic process where infection and disease are not synonymous. As we have seen, virtually all urban adults are infected yet few are diseased, and the borderline of infection and frank tuberculosis is not always apparent. So the object of vaccination against tuberculosis will be not so much to prevent infection but to prevent disease. Further, the experiment must be a long term one. There cannot be a quick answer as might be expected if we were dealing with an acute exanthem. The variables in the vaccinated and control groups will, therefore, be

correspondingly increased and statistical purity will demand greater numbers if the result is to be significant. Lastly, it is quite certain that vaccination will not produce a solid immunity, so that clinical opinion—a variable inherent in each observer—may easily enter into the interpretation of the result. Comparisons will, therefore, be conjectural and not scientific. If there is no scientific evidence about the value of vaccination against tuberculosis, is there any circumstantial evidence which can be accepted as a basis for further experiment? The answer to this must be a matter of personal opinion. I believe there is sufficient circumstantial evidence to justify an experiment, provided that the experiment is planned to make the conditions of the vaccinated and control groups as nearly identical as possible. This is not the place to discuss how best this could be done.

Is B.C.G. the best available antigen to increase resistance? The answer to this, our last question, is a tricky one. If it is agreed that the answer to the first two questions is by no means clear, then the answer to the third one, which is largely dependant on the answer given to the first two, becomes very unsubstantial. What are the alternatives to B.C.G.? They are a killed vaccine of tubercle bacilli, an extract of tubercle bacilli which is antigenic, and a vaccine made from the murine type of tubercle bacillus (vole bacillus). If animal experiments are used as a guide, then a killed vaccine gives less protection than a live one; no extract of tubercle bacilli has yet been shown to be as potent as the whole bacilli, and the murine type of tubercle bacillus, according to most workers, gives greater protection than does B.C.G.

The murine type of tubercle bacillus occurs naturally as a pathogen of voles and some others of the mouse tribe in Great Britain. It is pathogenic to the usual laboratory animals only in very large dosage, but if the number of bacilli injected into guinea pigs is sufficient progressive disease may follow. In other words it is a potential pathogen for the guinea pig, which B.C.G. is not. The spread of tuberculosis in the guinea pig which has been vaccinated with the murine type and subsequently infected with virulent tubercle bacilli is very much delayed, but the animal will eventually die from generalised tuberculosis. On the other hand, vaccinated cattle may resist entirely the injection of virulent tubercle bacilli in a dose

sufficient to produce progressive tuberculosis in the unvaccinated. Experience with the murine type in man is still very limited. My personal experience in about 150 cases suggests that it is safe. The vaccine dose and the route of vaccination has been varied, but in no case during the past 5 years has there been any evidence that infection has been other than local. That infection with the murine type has taken place is proved by the fact that all persons, who were insensitive to tuberculin before vaccination, have rapidly become tuberculin sensitive and have retained their sensitivity during the period of experiment. This retention of tuberculin sensitivity is sometimes claimed by those using B.C.G. as evidence that increased specific resistance is also present. This may or may not be true, but it must be stressed that sensitivity to tuberculin is no sort of measure of resistance. Sensitivity and resistance are two quite separate states, although one may usually be coincident with the other.

If B.C.G. produces increased resistance in man, then it is rational to conclude that the murine type of tubercle bacillus does also, possibly to a greater degree. If further experience should show that the murine type is safe in man, it has the advantage over B.C.G. that it is a naturally occurring patho-

gen whose virulence has not been reduced by laboratory culture and can be maintained by animal passage. B.C.G. is a bovine tubercle bacillus whose virulence has been reduced by successive cultures in the laboratory until it is no longer pathogenic even to the wholly susceptible guinea pig. Its degree of virulence cannot be maintained by animal passage and it is possible that it may become so degraded that it is no longer antigenic. Controlled trial of the murine type is much needed before any adequate conclusions can be drawn as to its efficacy.

Having attempted to answer the three questions posed at the beginning, the proper place of artificial immunisation in the prophylaxis of tuberculosis can be assessed. It seems that artificial immunisation has a place, but a minor one. Any campaign which depends in the main on vaccination will almost certainly fail. Unfortunately the problem is not so easy of solution as that. The ultimate objective in the eradication of tuberculosis must be the eradication of infection. In order to do this the risk of infection must be reduced as rapidly as possible. A preliminary to reducing the risk of infection is raising resistance so that infection does not lead to disease. Here vaccination may help, but the greater degree of resistance is almost certainly non-specific and dependant on social and economic conditions.

## MONSIEUR VINCENT

By PETER F. JONES, F.R.C.S.

July the 5th, 1948, saw the medical vocabulary lose that old, kindly, hated, misunderstood word "charity." The spirit which founded our voluntary hospitals to care for "the sick poor, which fired a Rahere and a Florence Nightingale, had done its work. A State and a nation, awakened by just such people and their successors, had recognised and met their responsibility.

We have passed beyond the medieval faith that the sinful are poor and the good are rich, beyond the Poor Law and the Workhouse, beyond the day when to be workless was to starve. We can look back 100, even 50, years and realise that "medical progress" is indeed a reality. Never, physically, have we been able to do more for our patients.

At such a time, then, it is fitting to examine the way in which we treat our patients as well as their diseases. We are rather tired,

perhaps, of being reminded about our regard for the whole patient, and yet never, perhaps, are we more tempted to forget it.

The general practitioner of the National Health Service is well aware of this as he surveys his surgery full to the doors morning and evening, and as he sees, more and more, his surgery becoming a sorting-house for the specialities. We may suspect it in hospital as special investigations lead us to a more exact diagnosis, in which the patient's words and general make-up perhaps play little part, as our special departments increase and treatments become more skilled and complicated.

Yes, we may be tired of hearing all this, but strange things happen when men gain medical degrees or don white coats. In their own eyes—and those of their patients—they gain Authority. So, indeed, would anyone who does, in fact, hold the issue of life and death in his hands, now and then. Unhap-

pily, our sense of the dramatic places us at the centre of the scene. Luke Fildes's picture may be outdated now, but its title is still "The Doctor" and he is still the centre of the picture.

So I have found it refreshing and humbling to see a film of a man who was very much the centre of his own special world of service to humanity and who yet kept fiercely before him, and all who served with him, his true status.

The film is *Monsieur Vincent* and it is the story of a priest in seventeenth century France. We see his developing sense of what he must do. At first he is content to relieve the bitter need of the time with soup kitchens and medicines, but almost at once his courage takes him to a stand against the ignorance which will wall up a woman in her own home, along with her healthy child and howling dogs, because she has an unknown fever, perhaps the plague.

We see him share the awful experiences of the royal galley slaves as they make sport for their masters in their sufferings and their deaths. We see him share the transitory, pathetic joys, the hard enduring sorrows of the poor of Paris. We see the rich ladies coming to help him in his relief work and his slow, painful realisation that they come for diversion and not in answer to the very need from which they draw their wealth and ease.

At the end we see him the Master of Saint Lazare, with a thousand sick and aged folk under his gentle, wise care, quick to detect

the one who will not help himself when he can, ever ready to help the needy who will not ask; a servant who does not work for money or thanks or for a halo in heaven, but out of a continuing love and a wise sympathy which alone can make his service—his charity—an honour and a blessing to receive. In his heart there burns more and more clearly the conviction that the poor and the sick are indeed his *masters*, and he their servant.

In print this may sound sentimental, but that is the last word you will use as you leave the cinema, with the strong, wise, courageous face of Monsieur Vincent before you.

He has, I am sure, a word for us in these days. Not a word we have not heard before, but a word which we all forget. A word for the days when we are specially busy and cease to worry that patients must wait; a word for the times when our patients seem dull and unresponsive and we are near to condescension or patronage and doubt whether all our explanations are worth the time they take; a word for the day when we have made a neat diagnosis and are rightly happy and encouraged.

Just then, when our white coats seem brightest and our calling so excellent a one, as we speed from this job to that, we should welcome Monsieur Vincent at our elbow as he shows us that the light from the window falls over our shoulders onto the patient's hopeful face.

## ANNOUNCEMENTS

### BIRTH

**BENISON**—On December 30th, 1948, to Eileen, wife of Ronald Benison, F.R.C.S., a daughter.

### ABERNETHIAN SOCIETY

Meetings to be held in February, 1949.

Thursday, February 10th—Clinical Evening.

Thursday, February 24th—Sir Hugh Cairns on "Blunt Head Injuries."

Both meetings will commence at 5.30 p.m., the latter being held in the Clinical Lecture Theatre.

### APOLOGY

The Editor wishes to apologize for the omission, in our last number, of the author's name under the heading "Disappearing Diseases." The article was a clinical lecture, delivered by Mr. Reginald M. Vick, M.A., M. Chir., F.R.C.S.

### EDITORIAL NOTICE

We announce the resignation of the Editor, Mr. A. D. Munroe-Faure. He is succeeded by Mr. J. M. L. Gilks. Mr. G. C. R. Morris has been appointed Assistant Editor.

## LABORATORY AIDS TO BACTERIOLOGICAL TECHNIQUES

SOME HINTS TO THE ADVANCED DIAGNOSTICIAN

Illustrations by Vishnu

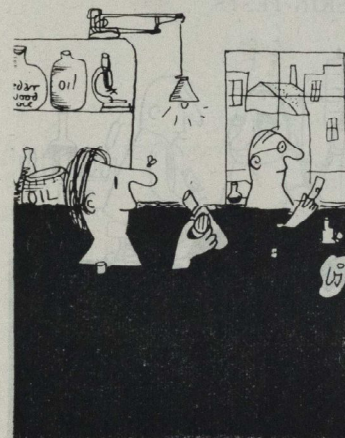
Many people look upon bacteria as enemies of mankind but without microbes we would die of starvation. There is no society of Prevention of Cruelty to Microbes.

They are roasted boiled or poisoned and no one makes a fuss except to hail the advent of a new poison.

Prof. Sir ALEXANDER FLEMING, M.D., F.R.C.S., F.R.S.

St Mary's Hospital,  
London.

### MICROSCOPIC TECHNIQUE



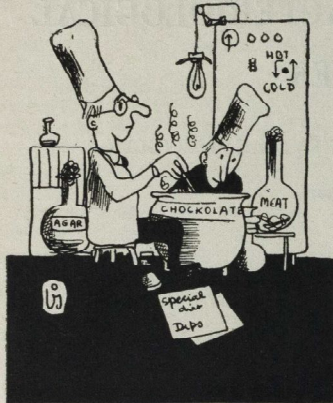
Some workers have their own peculiar version.  
Of getting good results with oil immersion.

### EXACTING STRAINS



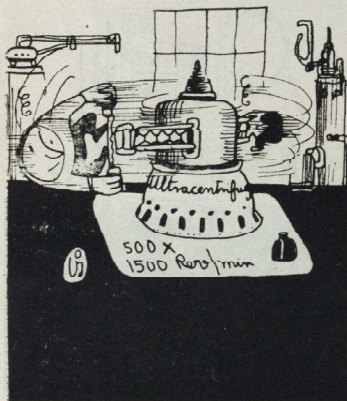
Some strains are troublesome in needing.  
Special diets and very careful feeding.

MEAT-EXTRACT MEDIA.



A factor never mentioned in the books.  
A well run lab. should have experienced cooks.

CENTRIFUGE-TECHNIQUE.



Some workers have been known to get too keen.  
When seeking viruses with this machine.

STAINING METHODS.



Correct technique in intravital staining.  
Requires a lot of skill and special training.

SKIN-TESTS.



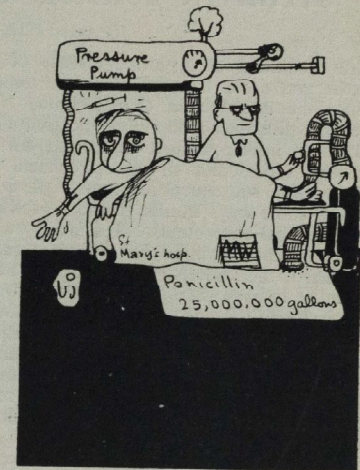
Comparing slightly different skin reactions.  
Assists in diagnosing some infections.

AGGLUTINATION-REACTIONS.



Some Dreyer tubes, pipettes and fluids too.  
Provide a good bacterial "Who's Who".

PENICILLIN-THERAPY



Giving penicillin in massive doses.  
May develop strange "syringe neuroses".

REFERENCES

A System of Bacteriology. Medical Research Council.  
Cowdry, F. V. Microscopic Technique. Baltimore, 1943.  
Fleming, Sir Alexander. Penicillin—It's Practical Applications. Butterworth's, 1947.  
Gradwohl, R. B. H. Clinical Laboratory Methods and Diagnosis. H. Kimpton, London.  
A Text Book on Laboratory procedures with their interpretations.  
Malloy, F. B. Pathological Technique. Saunders, 1938.  
Svederg, T., 1937. Nature. London, 139. Supp., 1051.  
Underwood, W. B. A Text Book of Sterilization.

(I wish to record my gratitude to Sir Alexander Fleming for his kindness in writing a foreword to this article and to Prof. Lawrence P. Garrod for his advice and criticism.—VISHNU).

## A CASE OF ACUTE CONGESTIVE HEART FAILURE DUE TO SYPHILITIC AORTITIS AND TREATED WITH PENICILLIN

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

THE treatment of syphilitic disease of the heart and aorta has become more hopeful since the introduction of penicillin. The general principles underlying the treatment, however, have remained unchanged, for the action of penicillin on the spirochaete and the possible subsequent reactions in the body, are in some ways similar to those produced by arsenical compounds. Satisfactory treatment of this condition can only be accomplished if the underlying pathology is borne in mind in each case. The first reaction of the aorta to the effects of the spirochaete is that of a subacute inflammation with its associated local hyperaemia and oedema. As the infection continues, the factor of fibrosis enters into the picture with the result that contraction of the inflamed tissue slowly and progressively develops. The spirochaetes are present in the middle coat of the aorta during the whole of these stages, so that the therapeutic substances, whether arsenic or penicillin, is apt to kill them in considerable quantity *in situ*, thus producing an increased inflammatory reaction which may be great, moderate, or minimal. A severe inflammatory reaction will produce a rapid coronary ischaemia, which may be fatal. This inflammatory reaction is as likely to occur during the early active inflammatory stage as during the late stage, but it is just at this early stage that successful treatment can be expected. If treatment is started when the process of fibrosis and scarring is already advanced, the healing or scarring process may be accelerated by the therapeutic measures, and this also produces coronary ischaemia.

It is thus extremely important to try to foresee whether the effect of the anti-syphilitic remedy will be to kill the spirochaetes without severe local reaction, or whether it will be to accelerate the fibrotic healing process. The tissue which will be dangerously affected by either of these alternatives is the coronary arterial opening into the aorta. Unpleasantly severe local swelling of the aorta can cause death by obstructing the coronary mouths rapidly, and this can usually be avoided by careful initial dosage; the fibrosis characteristic of healing during the later stage of aortitis threatens to close the coronary mouths much more slowly,

but equally fatally, and this is inevitable whether treatment is given or not. It is clear that the ideal is to administer the anti-syphilitic remedy so carefully that there shall be no acute or rapid local oedema of the aorta, but to administer it early in the disease and in adequate amount, before fibrosis has had time to occur.

The decision whether one is dealing with an early or a late stage of syphilitic aortitis should be made after particular attention to certain definite points. The condition, so far as the heart is concerned, usually manifests itself in one of three ways; shortness of breath and evidence of early heart failure from coronary obstruction due to inflammatory oedema; angina of effort from the same cause; and accidental discovery of an aortic regurgitation in an individual known to have had a healthy heart some few years previously. Physical examination is also helpful in deciding the age of the lesion. If aortic regurgitation is present, a slight leak suggests a fairly early stage of the disease, the size of the leak being judged by the position of the apex beat and the blood pressure reading. If the apex beat is little displaced to the left and is in the fifth space, rather than the sixth, the leak almost certainly is slight or very recent. If the diastolic blood pressure is normal or but little lowered, the same deduction is probably correct. If, however, the apex beat is displaced into the sixth space and well to the left, and if the diastolic pressure is much reduced, the leak is probably very considerable.

Another point of importance is the X-ray appearance of the aorta and of the heart. Should the aorta be normal in appearance, as it very occasionally is in such cases, the lesion is probably early. If the aorta is much elongated and dilated, and particularly if its outline is irregular, the lesion is obviously advanced. By judging the degree of enlargement, irregularity and elongation, it is thus possible to obtain some sort of estimate as to the stage of the aortitis. The size and shape of the left ventricle will be easily measured by cardioscopy, and enlargement of this chamber will also be proportional to the extent of an aortic valvular lesion.

The case here described is of great interest both because of the severity of the symptoms and signs, and also because a correct answer to the question whether these manifestations were due to early aortic oedema and inflammatory change, or whether they were due to subacute fibrotic change, had to be obtained or at least deduced. Because the history was very recent, because the apex beat was only in the fifth space, and because there was practically no aortic leak as judged by the diastolic pressure although the murmur of aortic regurgitation was present, it was decided that the symptoms and signs were those of aortic oedema and early inflammation, and not of the more chronic aortic fibrosis.

The patient was first seen on the 10th May, 1948. He had been for four months suffering from increasing shortness of breath on exertion. Whereas he had previously undertaken heavy work on his farm, he could now barely walk across the room without dyspnoea. For the previous three weeks swelling of the feet and legs had been noticed, and this had been increasing steadily so that the swelling had reached the thighs on the day of examination. For the previous week he had had attacks of shortness of breath at night, coming on suddenly and interfering seriously with his sleep. Orthopnoea had also been present during this same period. The congestive heart failure had thus been unusually rapid in onset and severe in degree. There was no history of anginal pain. He had never had rheumatic fever, scarlet fever, or other rheumatic infection. At a boy of 15 he fought against the Russians in the Russo-Polish war following the first World War, and was taken prisoner. He shared a cell with a Russian who was syphilitic, and it was suspected that infection might have occurred at this time. However, subsequent blood examinations were then negative. He led an active, vigorous life until the Second World War, when he fought in the Polish army and after the collapse of Poland, made his way across Europe on foot and eventually arrived in France. He then joined up again and had considerable active service in the Polish forces, during which time he was dropped as a parachutist three times into France on secret missions. There had been possibilities of venereal infection, but no definite history of this at any period. He got married four years ago, and his wife has since had a healthy baby.

On examination he looked extremely ill, pale, and distressed. The effort of undressing made him very short of breath and he was unable to lie at all flat on the examining couch. There was some distension of the veins in the nose, but no excessive arterial pulsation. There was slight cyanosis in addition to the pallor. The heart rhythm was regular, but the rate was increased (120). The blood pressure was 118/80. There was no excessive systemic arterial pulsation. The pupils were of unequal size, the right being smaller than the left. There was normal reaction both to light and to accommodation. Examination of the chest showed that the apex beat was present in the fifth space, this being slightly displaced to the left, the distance from the mid-line being 5 inches. No thrills were present. There was a local diastolic murmur at the aortic base conducted down the left border of the sternum to the apex. The lungs showed definite evidence of pulmonary oedema, many râles being present at both bases, especially on the right side. There was a lumbar pad of oedema. The liver was enlarged three fingers below the costal margin on the right side and was tender, and a small quantity of free fluid was present in the abdomen. Oedema of the feet was considerable, and this extended to both thighs. The urine contained a cloud of albumin.

The electrocardiogram showed left axis deviation and inversion of the T wave in Leads 1 and 4, typical of left ventricular stress. X-ray screening showed definite enlargement of the left ventricle but no enlargement, general or local, could be seen in the aorta.

He was referred to Dr. Aldren Turner for a neurological opinion, and his report follows. He had no symptoms definitely referable to the nervous system except that his wife said his memory had been becoming rather less good during the preceding three months and that he had attacks of violent temper lasting a few minutes at a time, which was a new feature for him.

On neurological examination both pupils were small and slightly irregular, the left being larger than the right; they both reacted somewhat sluggishly and through a small range of light, but they contracted briskly on convergence. There was some impairment to pin-prick over the front of his chest but apart from this and the findings in the pupils there were no other abnormal neurological signs.

A lumbar puncture was done on the 19th May, 1948, and the initial pressure was 230 mms., though this rise was probably due to congestive heart failure. The fluid was clear and colourless with no clot formation: it contained 42 lymphocytes, 1 polymorph, and 120 red blood cells. The protein content was 50 mgms. per 100 cc. and globulin was not increased, Wassermann reaction was strongly positive, and the Lange curve was 0011100000.

The diagnosis was very suggestive of a syphilitic aortitis with congestive failure, due to occlusion at the mouths of the coronary vessels. The recent onset of symptoms, and the general excellent health of the patient previously, suggested this occlusion was probably the result of recent inflammation and oedema of the aorta following a previous syphilitic infection. There was no evidence clinically or in the electrocardiogram of any coronary artery disease, and no indication of previous rheumatic carditis. The Wassermann reaction was found to be strongly positive.

He was, therefore, admitted to a nursing home on May 15th, 1948. The heart rate in bed was at first 118. The respirations were 30 per minute. The heart rate gradually fell over a period of a week, but remained at the level of about 90 for the next two months. The respiration rate fell at the end of the week to 25, but remained at or just above this figure for a further fortnight although he was resting in bed. Oxygen was administered for periods of three hours twice daily by mask for the first seven days. Morphine was required and was given for sleeplessness for the first week also.

In view of the very considerable oedema, mersalyl was administered by an intramuscular injection in doses at first of  $\frac{1}{2}$  c.c. and then of 1 c.c. at weekly intervals for three doses. This was preceded by ammonium chloride 45 grains during the preceding day. A good diuresis was obtained each time. As a result of this treatment the shortness of breath slowly subsided, the resulting distress disappeared, and the oedema vanished. The last of the swelling was visible at the end of eight days. The mersalyl was continued, however, because of the considerable pulmonary oedema which was shown by fine basal râles, for ten to fourteen days from his admission to the nursing home. The history of his heart failure subsequently was that the tachycardia remained for three months, after

which the heart rate gradually subsided to between 70 and 80 per minute at rest.

Early in August, 1948, three months after his first admission to the nursing home and after he had returned home, he had a series of severe attacks of nocturnal dyspnoea. These were very distressing and were accompanied by an increase in his still rapid heart rate from 90, to between 100 and 110. The attacks lasted from half-an-hour to one hour, and were clearly due to bronchial spasm from a second attack of left ventricular failure. He was, therefore, given daily injections of cardiophylin (0.24 grammes), intramuscularly for seven days, and the effect of this course was quite dramatic. The oedema of the legs and feet, which had returned, disappeared quickly and the breathless attacks subsided so that he slept well. Following this incident, he made an uninterrupted recovery.

After consultation with Dr. C. S. Nicol anti-syphilitic treatment was started, in spite of the severe congestive failure, within a few days of his admission to the home on May 15th. He was given at first a mixture containing potassium iodide, 5 grains t.d.s. p.c., but this was stopped after three days because it produced an iodine eruption on his face. One week after his admission, he began to receive bismostab injections intramuscularly. He was given twelve doses in all, the first being 0.1 grammes, the second 0.2 grammes, and the third 0.3 grammes. All the subsequent injections were of a strength of 0.3 grammes. During this period the state of his gums remained satisfactory, and the urine remained clear of albumin. After an interval of four months, his cardiac condition remained satisfactory. The blood pressure was then 160/88. The left ventricle was considerably enlarged on X-ray screening, and the electrocardiogram was unchanged, and still showed evidence of left ventricular stress. He was given the following course of penicillin starting on October 19th: 1,000 units three-hourly for four doses, 2,000 units three-hourly for four doses, 4,000 units three-hourly for four doses, and then 10,000 and 20,000 units each for 4 doses at three-hourly intervals. On the third day he was given 160,000 units per day in two separate doses. This was continued until he had received 3 Mega units in all. He received no other treatment for his syphilis. During the whole of his anti-syphilitic therapy, he manifested no reaction of any kind, either general or cardiac.

On December 9th, 1948, he was said to be wonderfully well. He was moving about his farm normally over rough ground, pasture, or smooth ground, and could manage two miles without shortness of breath. He had avoided lifting and physical strain as a precautionary measure. He had been sleeping well and had had no more nocturnal dyspnoea. The heart rate had kept between 70 and 80. He had only had one breathless attack which lasted four or five minutes, when he was extremely annoyed as the result of a discussion. His wife was very pleased with him and stated that he was much better than he had been a year before. There had been no return of any shortness of breath.

It would, therefore, seem that the attack of heart failure was due to recent inflammatory swelling of the aorta from syphilitic aortitis, which interfered with the coronary flow. This interference must have been rapid and considerable for the degree of

#### CHRISTMAS SHOWS

The first posters were up three weeks before Christmas, which meant that work on the ward shows had begun once more. Michael Linnett promised us, in his own elegant style, that Aladdin would be a fine pantomime; other shows were advertised by saucy titles and captions. It seems no longer fashionable to paint a poster profile of your chief. But most of us love a good caricature, so perhaps the fashion will come back.

On Christmas Day the Residents, Jack and the Beanstalk and Aladdin were soon in their stride. Those less experienced quickly lost their shyness for they were warmly received and there were barrels of comfort. Sunday was a day of rest, and by Boxing Day all shows were going with a swing.

This time the Pot Pourri was presented on New Year's Day in the Cripplegate Theatre. Tickets were sold out a week before. But shows had to be cut and rehearsed afresh; all the worries of stage management had to be met with but one trial run. That there were so few hitches is to the credit of John Latham and John Pittman. Peter Carter faced us over the foot lights while scenes were changed and he made us feel that even if the curtain rose too soon it was in keeping with the spirit of the occasion.

Bourne Fools opened the evening with an appropriate and well rehearsed song of Christmas at Bart's. The Light Blueumers let us see how an honest thirst might go unslaked in a nationalised pub. We chuckled, and hoped this nightmare would never come true. Harry Collymore sang to us about sweet chariots and, typically enough, how Israel entered Egypt. He well deserved the applause.

Then the Medical Unit's U-Nit Wits delighted us with some boisterous nonsense about the Laird of Stanmore and his ward round. There was a light quip here and there, but the main theme was happy carefree clowning.

congestive failure was unusually severe and acute. Anti-syphilitic treatment was effective in arresting the progress of the condition, and in restoring the coronary flow and the cardiac function.

Recovery of this extent, and with this rapidity, is unusual in heart failure caused by syphilitic aortitis; and it could not have occurred if the inflammation had passed into the late fibrotic stage of the disease.

The future history of the patient will be interesting. There is no reason why the remission of his symptoms should not be permanent. Continuance of the slight aortic leak is a matter of no consequence, so long as the coronary flow remains good and the heart muscle continues healthy.

I am much indebted to Dr. C. S. Nicol for his valuable co-operation in the anti-syphilitic therapy, and to Dr. Aldren Turner for his advice upon the neurological problem.

Life in the wards from Rude Awakening portrayed what might happen if Matron chose her nurses less carefully; Miss Edwards sprang a surprise by vigorously satirising her own department, she also sprang a back somersault without breaking her neck. Geoffrey Singer made a most gaunt but lifelike sister; he told how he found surgeons didn't like virgins—if his make-up had been kinder we might have believed him. Perhaps he didn't intend us to; anyway, Matron was amused.

Aladdin was a complete pantomime in miniature with Bert Hooper as the villain and Norman Capstick some sort of dainty sprite. The cast have done this type of show three years running and have quite mastered the art. They finished with verses about members of the staff which were gentle and witty. Then came the interval, and most of the audience and players squeezed into the Bar.

The Pagetears had performed in Paget Ward only, so many of us saw them for the first time. The high light was an original and clever sketch of a foetus that spoke from within.

Jack and the Beanstalk was another pantomime intact. Robbed of the easiest way to get a laugh, that is, a skit about the hospital, this form of show is hard to put over. So it is commendable that both this and Aladdin were so entertaining. The principal boy was dressed briefly, and this shapely display diverted our attention from the rhyming couplets; moreover, we couldn't follow the antics of the dummy cow when we knew who wagged the tail, bless her. Munro-Faure was a realistic black mammie, and Wendle-Smith as the wizard, had scope for his magic.

Before the war, there were more individual acts at Christmas. Trevor Roberts returned to give us his Freda and then sewed up his fingers with a hair, just as he did in 1938. He is a perfect mime and it was exciting to see him again. His act uncovered a stage in our evolution, for two of his



asides, the broadest in the whole show, were received coolly. Have the women raised our standard of humour?

The Residents' Mystic Specs combined pantomime with light opera; they were handicapped by curtain trouble but, how they succeeded! W. S.

#### ALAN TOIS writes of the Residents' Show.

Even if the major part of the population had to go turkeyless this year the fortunate authors of the Bart.'s shows were presented with plenty to sink their teeth into. What with July 5th, the Tribunal about that fellow—what's his name?—at Westminster, circulatory upsets in high places and, this above all, the recent tighter ties between Bart.'s and the City Corporation — no one could have been happier since the *Daily Express* first found a loss in a nationalized industry.

Mr. Gordon Leslie, whose writing has for some time been marked with all the diffidence of Mr. Bevan towards the Conservatives, made the most of it on behalf of the Residents. Masculine to the last fairy they were emphatically the Lord Mayor's Show. Their scenes left the conventional borders of Little Britain and Giltspur Street and touched on the Old Bailey, the Mansion House and Snow Hill.

As usual, the House at this time of the year appeared to have been thoughtfully selected by the Governors from R.A.D.A. Mr. Lonsdale was as carefully polished a principal boy as his teeth,

## MORANT BAKER CYST

By GEOFFREY R. FISK, M.B., B.S.,  
F.R.C.S. (Edin.)

MORRANT BAKER was born in 1839 and died in 1896. He had a long and distinguished career at Bart.'s where he held many appointments and was Surgeon to the Hospital from 1882 to 1892. He wrote on a variety of subjects and has been accredited with the invention of the rubber tracheotomy tube, the "duplex" form of burner for gas and oil lamps, and the fixation of the knee after excision of the joint by means of two obliquely placed steel pins—a method of splintage which has only recently been reintroduced.

He is best remembered, however, for his description of cystic swellings around the knee and other joints which appeared in two papers in the St. Bartholomew's Hospital Reports of 1877 and 1885. The description of "Baker's cysts" has been passed from one textbook to another and considerable confusion exists as to what they really are. It is a salutary experience to read what Baker actually did describe and to realise what enormous strides have been made in the diagnosis and treat-

Gilbert would hardly have been more telling; and the strut, the gestures that went with it . . . enough said. After that, a hurried finale, then the King, and it was over. Three and a half hours had just slipped away.

TADPOLE.

which glittered professionally in the foot lights till late on Boxing Day. He was supported by a cast including Mr. Royle, as a dyspeptic and apparently tabetic barman, and Messrs. Douglas and Tucker as the nice and naughty fairies, strongly differentiated by our friend Bert, who still takes his Christmas milk and grease-paint to R.S.Q.

Particularly appealing spots in this excellent show were Mr. Leslie, bearing a striking resemblance to Lord Justice Goddard, singing a rude song from the Bench about the traditions of Bart.'s; Mr. Whitely and Mr. Platt, looking remarkably like a couple of K.C.s singing a rude song about a couple of K.C.s; Mr. Matthias, appearing startlingly like a Lord Mayor, singing a rude song about a Lord Mayor; and Mr. Du Heaume, looking strongly like Mr. Du Heaume, singing with Messrs. Morgan and Rodgers a rude song about a spiv. There wasn't much subtlety or innuendo about the script. The only thing left blank was part of the verse.

Congratulations all round. All the performances went over tremendously. The sole patient who found it completely incomprehensible were the patients.

ment of disease since his day. He was not the first to draw attention to the condition, as Adams in 1840 and Gruber in 1845 had already published full accounts of popliteal cystic swellings.

In his first paper ("The formation of synovial cysts in the leg in connection with disease of the knee joint") Baker described in some clinical detail eight cases of swellings around the knee joint. The underlying condition is either labelled "osteoarthritis" or not diagnosed at all, but it is clear that his cases were a collection of widely differing conditions of which the only common feature was a cystic swelling near the knee in the presence of fluid in the joint.

His first case was almost certainly a neuropathic knee in which an acute effusion had occurred, this being a very common mode of onset. (" . . . she fell down and from that time the leg 'had been out of place' and dangling loose and useless. There has not been much pain.") The patient had a swelling in the calf which Baker considered to be

an escape of synovial fluid from the joint, which would be extremely unlikely. The condition, which proceeded to amputation, remained undiagnosed although Charcot had drawn attention to tabetic arthropathy in 1868. Another patient had an enlarged semi-membranosus bursa which was treated by the insertion of a seton. This resulted inevitably in an acute septic arthritis of the knee and an emergency amputation of the leg!! Other cases appear to be gonococcal or tuberculous infection of the knee with abscesses tracking into the calf.

Baker came to the conclusion that "in cases of effusion into the joint . . . the fluid secreted may make its way out of the joint and form by distension of neighbouring parts a synovial cyst of large or small size." He not unnaturally advised against exploring or draining them.

In his second paper ("The formation of abnormal synovial cysts in connection with the joints") Baker records similar swellings associated with the shoulder joint (biceps tendon sheath and subscapularis bursa), the hip (psoas bursa), the medial epicondyle and the external malleolus (adventitious bursae) and the wrist (probably a compound palmar ganglion).

#### Discussion.

It is still widely held that a Baker's cyst is caused by an actual herniation of synovium through the intact capsule of a joint which later becomes "nipped off" to form a cyst. This belief is supported by Heggert and other writers, but Wilson and his colleagues as the result of careful clinical and anatomical studies came to the conclusion that the swelling always arose by the distension of a bursa. They pointed out that firstly the cyst could always be shown to have arisen from a region in which a bursa was normally found, and that secondly its walls were intimately blended with surrounding muscle sheaths and tendons, which is a

characteristic of bursae. Furthermore these swellings may arise without any joint effusion and are indistinguishable from those that are secondarily distended. They may become enlarged as the result of systemic disease, especially gonorrhoea, tuberculosis and gout; from constant trauma (viz., the occupational bursae of "weaver's bottom," "student's elbow," etc.); and they may even be formed adventitiously over bony prominences, such as over the medial malleolus by the rubbing of an ill-fitting boot.

#### Conclusion.

Where cysts occur in the region of joints an attempt should be made to understand their underlying pathology. Morrart Baker's most valuable contribution was to draw attention to the fact that such swellings may indicate disease of the associated joint and this should always be examined carefully. At the same time, the diagnosis of "Baker's cyst" for any fluid swelling in the region of the knee is to be strongly deprecated. If the name is to be used at all it should be confined to those conditions in which there is fluid in the joint in association with a cystic swelling near it, but as "Baker's cyst" does not imply an accurate pathological entity it is a term which would be better avoided altogether.

My thanks are due to Mr. Higgs for his help and criticism of this paper.

#### References.

- Cravener. *Journ. B. & J. Surg.* 1932. 14. 186.  
Gray's Anatomy.  
Haggart. *Journ. B. & J. Surg.* 1938. 20. 363.  
Haggart. *Ann. Surg.* 1943. 118. 438.  
Mayerding & Van Delmark. *J.A.M.A.* 1943. 122. 858.  
St. Bartholomew's Hospital Reports. 1877. 13. 245.  
St. Bartholomew's Hospital Reports. 1885. 21. 177.  
St. Bartholomew's Hospital Reports. 1896. 32. vi.  
Snodgrass. *Journ. B. & J. Surg.* 1936. 18. 229.  
Wilson, Eyre-Brooke & Francis. *Journ. B. & J. Surg.* 1938. 20. 963.

## NEW YEARS HONOURS FOR BART'S MEN

### Knight

Griffiths, Hugh Ernest, C.B.E., M.S., F.R.C.S.

### C.B.

Strugnell, Surg.-Rear Admiral Lionel Frederick, M.B., K.H.P.

## BUXTON BROWNE PRIZE

Medvei, Victor Cornelius, M.D., M.R.C.P.

## CORRESPONDENCE

## UTOPIA ?

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

The correspondence on communism should provoke lively discussion. The idealism of communism is perhaps best exemplified by the Utopia of Sir Thomas Moore, but the same thought permeated such Elizabethans as Sir Thomas Wyatt—  
"How happy is he born and taught,  
Who serveth not another's will."

The attainment of a communistic Utopia was a frequent topic of discussion during the war, and the Russian resistance to Hitler's totalitarian military efficiency led men to hope that the Russian system of society was close to their ideal. Few seemed to have heard of the Red Terror, of the methods used by the Bolsheviks to obtain control in 1917, of the trials or of the purges. Lenin, Trotsky and the original Bolsheviks—professional revolutionaries—were nevertheless amongst the really great men of the present half century. Fundamentally, Lenin was vindictive, determined to overthrow the Czarist regime, as Krupskaya so clearly explained in her speech on the day after Lenin's death. To Lenin, Marxism was the only alternative to capitalism, but Lenin realized that the principle of—"From each according to his ability; to each according to his needs;" was more idealistic than practical. Consequently, until the frailties of human nature have been eliminated, there must be "The strictest control, by Society and the State, of the quantity of labour and the quantity of consumption." Domination by the Czars was therefore replaced by domination by the Communists. The necessity for discipline, the necessity for propaganda and the necessity for equivocal associations with other states were the three cardinal principles of Leninism. Cruelty and assassination are not censured so severely in Russia as in Western Europe. The Katyn murders were perpetrated by the Russians and not by the Germans, and I am surprised that Dr. Jopling, of all people, should have been persuaded by Russian propaganda to accept their story. I remember advising students, at the end of 1945, to read Wheeler-Bennett's "Brest-Litovsk," and Hoffman's Diaries, for it seemed to me that if Trotsky could be so difficult when Russia had completely collapsed militarily, the Russians would be impossible to appease in victory except by bribery or force.

Soviet communism leads in some directions to efficiency. Happiness is open to those who reach the high places. Suspicion and mysticism form part of the Russian character, and the Russian conceptions of honesty and truth are not the same as our own. What is, to us, a ridiculous attitude towards science is a fair example of the Russians' outlook on most things.

Yours faithfully,

WILFRED SHAW.

109 Harley Street, W.1.  
18th December, 1948.

## MOUNTAIN CLIMBERS DEATH

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

In the *Times* of November the 9th, a mountain climber is reported to have died "as a stretcher party carried him down Aonach Dubh"; he had fallen 200 feet. The italics are mine. I wonder whether he was carried down head first or feet first.

In the Arnheim film, shown some time back, I saw on the screen soldiers, presumably wounded, in hospital, being carried upstairs on stretchers head first. I felt a thrill of horror. They should have been carried up feet first—the foot end of the stretcher higher than the head.

If you want to kill a man suffering from shock, sit him up; if you are carrying him down an incline on a stretcher, carry him feet first—that with the jolts will finish him off.

All individuals suffering from shock, being transported, should be carried with the foot end of the stretcher elevated, higher than the head. That is the position of safety. This applies with greater force when descending a mountainside, because of the time. The position of the body alone may determine whether you arrive with a still living individual or with a corpse.

Yours faithfully,

R. H. PARAMORE.

4 Bilton Road,  
Rugby.

9th December, 1948.

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## BOOK REVIEWS

**STERILITY AND IMPAIRED FERTILITY** by C. Lane-Roberts, A. Sharman, K. Walker, B. P. Wiesner and Mary Barton. 2nd Edition, 1948. Hamish Hamilton Ltd., London. Pp. 400. Price 24s.

The second edition of this book is published nine years after the first. There has occurred a considerable increase of knowledge on the subject of impaired fertility in the last few years, particularly in relation to the male, and this is reflected in the present volume. No less than 177 pages are devoted to male sterility and infertility and the story is complete so far as present knowledge goes. A small chapter on artificial insemination is of interest and the authors give a balanced view and a timely warning on the pitfalls in the use of donated semen.

The latter half of the book is devoted to sterility and infertility in the female and reaches the same high standard as the section on the male. The whole volume gives an excellent account of the modern approach to this subject and there is an extensive list of references for those who wish to study the evidence on which statements are made about controversial subjects. Appendix 7 describes the interpretation of waking temperature records and explanatory charts are all that can be desired. Another appendix on the technique of post-coital and invasion test is valuable.

This book should be read by all who are interested in gynaecology but the authors have tried to cast the net wider and suggest that General Practitioners might be interested in it as the problem of infertility is so often brought first to the family doctor who can give excellent advice on many aspects of the subject.

**INTRODUCTION TO DISEASES OF THE CHEST**, by James Maxwell. 3rd Edition, 1948. Hodder & Stoughton Ltd., London. Pp. 307, with appendix of 66 photographs. Price 12s. 6d.

Dr. Maxwell, lately of this hospital, incurs a debt of gratitude from students for the lucidity of his book. The format remains as in previous editions. The first ninety pages deal with methods of diagnosis, and the physical signs are made as clear as they can be on paper. The rest of the book is devoted to diseases of the chest, and their treatment. The former are described fully but without unnecessary attention to rare syndromes; the latter has been revised where necessary. There is an appendix with some sixty X-ray photographs, which are printed as negatives thus avoiding any confusion by the student; they well demonstrate the author's insistence that X-rays are an essential part of the routine examination of the chest.

The printing and paper are so good that the publishers must be congratulated on being able to produce it at the price of 12s. 6d.

This is a book that can be confidently recommended to all who are starting their clinical training.

**THE NURSING OF TUBERCULOSIS** by O. V. Buxton and P. M. M. Mackay. John Wright & Sons, Bristol, 1948. Price 7s. 6d.

The sanatorium nurse will find described in this little book most of the procedures she will use in her work. It was a good idea to include a chapter

on the psychology of tuberculosis; more might have been made of this. Unfortunately the authors have been unable to include mention of streptomycin, or the use of vitamin D in lupus.

**MIDWIFERY**, by Ten Teachers. Edited by Clifford White, Frank Cook and William Gilliatt. 8th Edition, 1948. Edward Arnold, London. Price 20s.

This book of Midwifery will continue to recommend itself to students whose interest in the subject has been already kindled by previous acquaintance, but we hesitate to recommend it as an introductory text, if only because insufficient emphasis has been laid on general principles.

This is but one of the problems of collective authorship, in any such book, if the points which each author considers to be of special importance are to be adequately emphasised, there is little space available for general considerations, reiteration of points of special importance and other niceties which, out of place in a reference work, are of great importance in an introductory manual.

None the less, multiple authorship has the compensating advantage that theories and methods not generally acceptable are excluded, and no single author's whims and fancies are specially indulged. This book can, therefore, be relied upon to conform as strictly as is possible with orthodox obstetrical practice.

The student who does not consider readability a prime consideration will be well advised to use this text-book, the new edition of which is reliable, up-to-date, sensibly illustrated, and attractively produced. The text has been carefully revised and is singularly free from errors, but there is an irritating misprint on P.103 on which, for a picture of the birth canal (Fig. 60) we are referred to Fig. 16, which portrays a placenta succenturiata.

**LIVING ANATOMY** by R. D. Lockhart. Faber & Faber, London, 1948. Pp. 71, photos 149. Price 12s. 6d.

Professor Lockhart's photographic atlas of the human body in action is an interesting and stimulating volume, meriting great praise. In no other work of this kind are the actions of the surface musculature so extensively treated or so convincingly demonstrated. The medical student, at all stages of his career, will find in these pages not merely refreshment of memory regarding certain aspects of myology, but also, we believe, a salutary stimulus towards personal investigation of the role of individual muscles and muscle groups in a variety of operational circumstances. Much that these photographs show is familiar, if particularly well displayed; but much is new and not to be found elsewhere. Many of the pictures demonstrate especially the influence of gravity, posture and resistance upon muscle action and thus serve to correct the more limited impressions gained from cadaveric study and a reading of the formal texts.

The volume is attractively and excellently produced, and is modestly priced. The several models (male and female), the photographer, the author and the publishers have co-operated most successfully in the production of what cannot fail to be both a useful and a popular atlas.

**AIDS TO ANAESTHESIA** by V. Goldman. 2nd edition, 1948. Baillière, Tindall and Cox, London. Pp. 316. Price 7s. 6d.

To this edition several new chapters have been added and many old ones have been revised in order to bring the book into line with modern anaesthetic practice. Within its limited scope it is a useful volume for revising the subject, but the paper used for the introductory chapters would have been better spent perhaps in expanding on the later ones.

**HYGIENE AND HEALTH EDUCATION** for Training Colleges by M. B. Davies. 4th edition, 1948. Longmans, Green & Co., London. Pp. 438. Price 9s. 6d.

This is a comprehensive book designed to cover the course in Health Education for Teachers in training. It is vitally important that children during their school years should acquire the correct attitude towards anatomy, physiology, health and sex. This they can only do if the teachers themselves have a sensible approach, such as this book advocates.

**NINETY-NINE.** Editor: W. R. Bett. The Doctor Publishing Co., Ltd., London. Price 1s. monthly.

The days have passed when medical men considered that laymen should remain completely ignorant of progress in medical science, and although a little knowledge may well prove dangerous, it has been recognised that information based on scientific fact is preferable to knowledge derived from the quack. Several periodicals endeavour to educate the layman in matters relating to medicine, and *Ninety-Nine*, edited by a Bart's man, is undoubtedly the best of those with which we are acquainted.

The articles are mainly contributed by medical men writing under pseudonyms, and are of a high standard. Recent issues include articles on "The thyroid gland"; "Man's experiments on man," by Dr. J. L. Burn; "Hughlings Jackson and the thinking machine," by Dr. Edward Podolsky; "Fighting plague and pestilence in Edinburgh," and "Surgeons and surgery in Birmingham," by Laurence Dopson; a series of articles on "Some medical superstitions," by Warren R. Dawson; "David Livingstone," in a series entitled "He was a doctor"; Curare, by H. Lister; "Cancer and the atom bomb," by J. Lindsay Wilson; also, reviews, fiction, recipes, health topics in Parliament, annotations and other features.

This well-produced periodical should grace the table in every consulting room, but it is not only the layman who can be informed, as well as entertained, by the contents. While written in a popular strain, many of the articles might well be included in journals intended for the scientist, although it is very doubtful if the issues would then be made available for the small sum of one shilling. J. L. T.

**AIDS TO OPHTHALMOLOGY**, by P. McG. Moffatt. 10th Edition, 1948. Baillière, Tindall & Cox, London. Pp. 266. Price 6s. 6d.

In this book the subject matter has been covered in greater detail than is possible in most of its companion volumes; it provides, in fact, all that a student will be required to know for his qualifying examinations. Treatment has been brought up-to-date, and the chapter on war injuries

re-written. Some of the illustrations, which are in black and white, are a little difficult to appreciate (for instance, of the fundus), but that is probably a fault of the times rather than of the printers.

**INTRODUCTION TO PHYSIOLOGY**, by W. H. Newton, D.Sc., M.D. 1948. Edward Arnold, London. Pp. 284. Price 7s. 6d.

This is a book which deserves to become well known and widely read by medical student, nurse and general reader alike. To the medical student it may be recommended for reading after passing the First M.B. and before commencing the systematic study of physiology. It will satisfy his enthusiasm to begin more advanced studies and will provide a link with his previous training in Chemistry and Physics, which at times seem so remote from his final vocation. Further, it will offer a picture of the physiology of the body as a working whole, a picture which is so often lost, or never gained, in the mass of detailed knowledge which must eventually be acquired.

Since the central nervous system is the main factor responsible for the integrative action of the various parts, the brain and spinal cord have received considerable attention. It is in this important field, however, that the general reader, without adequate scientific background, would probably be presented with something of an enigma. The physiology of the nervous system is described by analogy. Though this is fully justified, it has its limitations and may even become confusing, as for instance, the description of nerve impulses in terms of trains of gunpowder, water cisterns and machine-gun bullets, all within a single page.

The operative words of the title are "Introduction to . . ." While this fact should be borne in mind, the reader need have no fear that accuracy has been sacrificed to simplicity and brevity. Indeed, the statement that oestrogen and progesterone produce their growth effects on the mammary glands through the intermediary of the anterior pituitary is probably more accurate than the direct action on the glands ascribed to these hormones by some of the larger tomes of physiology.

An interesting innovation for a physiologist is the use of the word atrium for the receiving chamber of the heart. Until now this word has been confined to the anatomists. If only all physiologists would adopt it, it would eventually find its way into the clinical vocabulary and prevent much confusion.

In covering such a vast subject in 276 pages it is easy to make criticisms of omissions. All the important general principles are present and illustrated by numerical data. Further detail would only detract from the objects of the book, which is to provide a physiological outlook and not to cover the whole of physiology on an elementary level.

An index is provided, and the text is admirably illustrated with pen and ink sketches which, for clarity and simplicity, might well be emulated by the authors of the larger and more comprehensive text books of physiology.

The book is well-printed and reasonably well bound, and it of such a size that it may be easily carried in the pocket—a tribute too rarely applicable to medical books.

#### EMERGENCIES IN MEDICAL PRACTICE.

Edited by C. Allan Birch, M.D., F.R.C.P. Compiled by eighteen Contributors. E. & S. Livingstone, Edinburgh, 1948. Pp. 468. Price 25s.

This book has been written for the general practitioner and the hospital physician to guide them in treating urgent illness and in handling critical situations. The editor has co-opted eighteen fellow contributors and together they have covered most crises that a doctor is likely to meet (apart from obstetrics and surgery). Enough is said to remind one of the salient features of diagnosis, and the treatment advised is usually clear, concise and up-to-date. The reader is told where the rarer sera and so on can be obtained.

It is a pity that the editor has included so much that is not emergency medicine—the sections on amenorrhoea, pernicious and microcytic anaemia, and tape-worms should be omitted and there is little point in parts of the chapter on emergencies at sea.

It is surprising to find that Dr. Gilchrist advises morphia in shock be given subcutaneously. Dr. Oakley's vital instruction about washing out the stomach in diabetic coma is well hidden in the text. Elsewhere there are minor faults, e.g., isotonic saline is sometimes called "normal," and phlebotomy is called "phlebitis."

The book has been well produced—the paper, printing and lay-out are of Livingstone's usual high standard. J. E. C.

**ANATOMY**, by A. D. Le Vay. E.U.P. Teach Yourself Series. 1948. Pp. 299. Price 4s. 6d.

In this volume, an attempt is made to expound human anatomy, including neurology, with some degree of detail, to the "layman." The task is formidable, but on the whole the book acquires itself well.

The approach is quite formal, following very much the pattern of standard anatomical textbooks, and divides the body up into the usual "parts" for topographical treatment. Illustrations are plentiful—an absolute necessity—and on the whole are of a satisfactory standard; many are taken from "Gray's Anatomy." The book is well written, and it is pleasantly surprising to find an adequate account of the human form in so short a space.

It cannot be said, however, that the book is likely to be of much value for medical students, for it says nothing which will not be found in any other book of anatomy intended for people who have access to material for dissection. Nevertheless, it is most probable that for nurses, physiotherapists this book will have considerable value.

**BILHARZIAL CANCER.** Radiological Diagnosis and Treatment, by M. A. Afifi. H. K. Lewis & Co. Ltd., 1948. Pp. 111. 60 illustrations. Price 16s.

In the early part the author discusses the incidence of Bilharzial and cancer in various organs, and discusses the relationship between the two. Diagnosis especially from the view of radiology, is illustrated with numerous excellent skiagrams. In the latter part treatment is discussed and at the end references are given to the extensive literature of the whole subject. The book should be of great interest to those likely to work in countries where Bilharzial disease is endemic.

**AIDS TO EMBRYOLOGY** by J. S. Baxter. 4th edition, 1948. Baillière, Tindall & Cox, London. Pp. 181. Price 5s.

To one previously unfamiliar with the Aids series this little book gives a surprisingly detailed account of general embryology. On comparison with the 3rd edition, published by Dr. R. H. Hunter in 1938, it is apparent that although the new author has not altered the general plan of the book he has brought it well up to date and corrected several errors by almost completely rewriting. For example the development of the alimentary system is much more clearly described. Unfortunately the section on the nervous system is still a little vague in parts.

For a summary of embryology the figures are good, clear and well labelled.

The main criticism of the book is that students finding it to be so detailed may be tempted to use it as a text book, for which it is inadequate, and not just as an aid. I. G. S.

**MATERIA MEDICA AND PHARMACOLOGY FOR NURSES** by G. Hinds and D. G. Ardley. Faber and Faber, London, 1948. Pp. 212. Price 7s. 6d.

Should the Minister of Health chance to read this book, he will be confirmed in his belief that the nurse's theoretical load is too heavy, especially when he reads such sentences as: "The original red dye stuff, sulphonamido-chrysoidin, breaks up in the body with the release of the white compound, para-aminobenzenesulphonamide . . . (p. 151) There are five words about coramine, and two paragraphs on infusion of broom-tops. This is, however, the most up-to-date book on the subject, and includes streptomycin, folic acid and the anti-histamine drugs.

**MODERN SURGERY FOR NURSES.** Edited by F. Wilson Harlow. William Heinemann Ltd., London, 1948. Price 25s.

In this book nurses will find a most helpful and thorough guide to Surgical Nursing, with clear operation details and pre-and post-operative treatment and complications. This includes Gynaecology, Orthopaedics, Ear, Nose, Throat and Eye Surgery, Venereal Disease and Anaesthetics.

Each section has been written by a surgical specialist in simple language, with good illustrations, and often well explained X-ray pictures. The special chapters on Diagnostic Tests and X-ray Preparations are most welcome, and will be a great help to many, including the harassed Night Nurse who has "Request Cards" signed on the Night Round. This is also true of the last chapters on Diets and Invalid Cookery, etc., in a Surgical Ward.

Some Surgeons will not approve of the treatment of shocks by the application of electric blankets or cradles to the Patient. This was discredited during World War II, because the extra heat causes the body to sweat and give out warmth and fluid which it so badly needs at that time. Nor are knee pillows or Fowler's knee rests popular after operation, when so much preventive thrombosis therapy is being carried out.

25s. is expensive for nurses in training, but as a Study and Reference Book in Surgical Wards and Class Rooms, this book should prove most helpful. The Shakespearean quotations are very pleasing.

**THE NATURE OF DISEASE INSTITUTE.**

First Annual Report, by J. E. R. McDonagh. Edited by Mark Clement. Pp. 174. Heinemann, London, 1948. Price 21s.

"Sir," said Dr. Johnson to an antagonist, with polite finality, "You raise your voice when you should reinforce your argument." Mr. McDonagh's Boswell (Mr. Mark Clement) should be reminded of this reproof, for this work, though sometimes abusive, is seldom convincing. It is obscure and conjectural when we should like it to be factual and concise.

**SPORT****CROSS COUNTRY CLUB**

Only three matches were held in the first half of this season, but all members of the Club have been running with the United Hospitals Hare and Hounds, at Petersham. Results to date have been disappointing, and it has become increasingly evident that new members are urgently needed if the club is to keep up the high standard of last season. Nevertheless all credit is due to those stalwarts who turn out regularly every Saturday.

**November 10th, v. University College**

**RESULT:**  
1st U.C., 51 points. 2nd, Bart.'s, 54 points.  
This match, run over 6½ miles at Chislehurst, resulted in a narrow victory for U.C., this being due to the excellent packing of their team from numbers 8-12. A lesson for Bart.'s.

Bart.'s positions were:  
1st equal, J. A. Menon, J. I. Burn—39 mins. 30 secs.  
5th, P. D. Matthews; 16th, G. Wallace;  
7th, J. Dodson; 17th, J. Taylor;  
13th, A. E. Dormer;  
18th, J. Nielsen.  
Team result: 1st U.C., 51 points.  
2nd Bart.'s, 54 points.

**December 4th, v. Bristol U. v. King's College v. I.C.**

**RESULT:**  
1. IMPERIAL, 34 points. 3. BRISTOL, 84 points.  
2. KING'S, 75 points. 4. BART.'S, 153 points.  
A sadly depleted Bart.'s team was well and truly beaten by all three opponents, our packing was good, but in the wrong place! A. E. Dormer ran well to finish 13th.

**LONDON UNIVERSITY CHAMPIONSHIPS**

**Held on December 18th at Roehampton**  
A record number of runners (140) took part in the Championships, 21 University College teams being represented. Bart.'s were 3rd in the corresponding race last year but could do no better than finish 11th this time. We were without the assistance of Menon and Matthews however, and those who did take part ran well against stiff opposition. The course record was broken by no less than three men, the individual winner again being the University Captain, P. Griggs, of Q.M.C.

Incidentally the race was started by Arthur Wint, who was given a hearty reception by all present. The team event was won by Imperial College with 47 points; Middlesex Hospital were 8th with 249 points; Bart.'s 11th with 296 points.

Bart.'s positions were:  
13th, J. I. Burn. 93rd, R. Zakon.  
24th, A. E. Dormer. 99th, J. Taylor.  
65th, G. Wallace. 109th, J. Nielsen.

Emotionally coloured diatribes are out of place in a work with such an austere title. The author's readiness to attack what he is pleased to term (more than once) the Medical hierarchy, and his indulgence in the luxury of apparently unrestrained criticism of modern medical practice, are both likely to preclude more than a cursory consideration of his views by physicians who are responsible for modern trends of medical opinion. This is the more unfortunate because, undoubtedly much of what the author has to say is interesting and some of it is important.

Fixtures in 1949 include Bristol, on February 5th, at Bristol; the triangular v. Middlesex and King's, on February 12th; and the Inter-Hospital Championships, on March 12th.

Winter training for all those intending to do athletics in the summer has now started. Sessions are held in the gym every Tuesday evening at 5.30 p.m., the club's coach, Mr. A. Drewer, being in attendance.

Athletes can receive specialised training in all branches of athletics, apart from the general training principles which are taught.  
J. I. B.

**R. U. F. C.****December 11th, v. Westminster Hospital**

**RESULT: WON BY 19 POINTS TO 8.**  
Bart.'s had a good win over the visiting side largely due to the magnificent loose play by the forwards; set scrums tended to be ragged but in the open the pack had the better of their opponents. The backs missed many chances and, apart from one sterling movement which ended in a try, never really got going. As a whole the side lacked dash and finish, a fact which kept the score down to its final level.

**December 12th, v. Old Millhillians**

**RESULT: LOST BY 3 POINTS TO 8.**  
Showing improved form Bart.'s were unlucky to lose this game. After a rather timid start Bart.'s opened the scoring through a try by Pichall who backed up a break through in the centre; with the Hospital forwards in command of the game the first half ended with Bart.'s leading 3-0.

After the interval, play was indeterminate until the home side equalised with a penalty. After this the game opened up and became faster with Bart.'s having more of the ball; however, there was no further score until the last minute of the game when a run-away try put the opponents five points ahead.

**January 1st, v. Catford Bridge**

**RESULT: WON BY 5 POINTS TO 0.**  
Played in wind and rain, this New Year's Day match was closely contested until Bart.'s scored through Mears, with Carter bouncing the ball on the post to convert. Bart.'s always had the measure of their opponents at forward and the backs were faultless in defence if not very powerful in attack. The side was unfortunate to lose Gompertz during the game through a kick on the head but the side hung on to their lead, leaving the field at full time, victorious if somewhat tired.  
J. L. C.

**EXAMINATION RESULTS****UNIVERSITY OF CAMBRIDGE****FINAL M.B. EXAMINATION**

**Part I. Surgery, Midwifery and Gynaecology**  
Bates, A. Kehoe, M. J. Roffey, P. J.  
Dawson, W. G. McGrigor, R. B. Struthers, R. A.  
Freeman, P. A. Morrison, W. P. L.

**Michaelmas Term, 1948**  
Wilkinson, M.  
Yerburgh, J. G. O. W.

**Part II. Principles and Practice of Physic, Pathology and Pharmacology**

Boulton, T. B. Langdon, T. C. McKerrow, C. B.  
Dench, P. G. R. Lavy, G. A. D. Millard, J. L.  
Kelly, W. P. Leech, K. W.

**Michaelmas Term, 1948**  
Weiss, A. L.  
Yerburgh, J. G. O. W.

**UNIVERSITY OF LONDON****THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES**

**Pass** **October, 1948**  
Begley, M. D. Jack, A. H. Rees, E. G. Taylor, D. G.  
Buri, R. Leverton, J. C. S. Rickham, P. P. Taylor, T.  
Davies, T. D. L. Mendel, David Rossdale, D. Thomas, O. G.  
Fisher, K. J. Partington, M. W. Segall, M. L. J.

**SUPPLEMENTARY PASS LIST**

**Part I**  
Bass, P. H. Ebbing, R. N. Kazantzis, G. Smyly, D. P.  
Bhandari, N. P. Franklin, C. B. Latham, J. W. Timmins, W. L.  
Brandreth, T. K. Gosling, R. E. G. Linnett, M. J. Willis, P. F.  
Capstick, N. S. Harris, J. W. S. Mehta, J. S. Wilson, F.  
Charles, D. Hayter, R. R. P. Melotte, G. H. C.  
Clifford, W. E. Hobbs, J. J. B. Mendel, Dennis  
Coombs, G. A. Hooper, E. R. S. Myers, S.

**Part II**  
Batten, K. L. Coombs, G. A. Lloyd, E. A. C. Sophian, G. J.  
Benett, G. R. Finer, B. L. Reiss, B. B. Weller, M. A.  
Charles, D.

**Part III**  
Davies, I. N. Johnson, W. Powell, F. J. Smallwood, R. I. L.  
Hawkes, P. H. R. Meyrick, J.

**CONJOINT BOARD****PRE-MEDICAL EXAMINATION**

**Chemistry** **December, 1948**  
Brewerton, M. E.

**First Examination** **December, 1948**

**Anatomy**  
Cohen, N. H. Luke, M. F.

**Physiology**  
Austin, S. Richards, J. B.

**Pharmacology**  
Abraham, R. J. D. Middleton, G. W.

Chorley, G. E. Hibbard, B. M.  
Cohen, H. James, D. C.  
Evans, T. L. Jenkins, G. C.  
Burn, J. I. Gosling, R. E. G. Kinsman, F. M.  
Cassells, M. J. Hale, B. C. Lewis, H. E.

Moore, G. J. M.  
Phillips, G. D.  
Stebbins N. E.  
Vercoe, M. G. S.  
Vince, A. A. P.

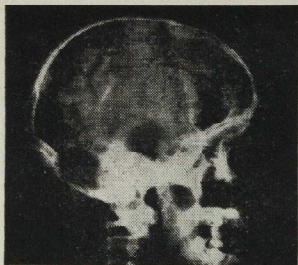
**SOCIETY OF APOTHECARIES****FINAL EXAMINATION**

**Pathology** **December, 1948**  
Mangan, M. K.

**THE JOURNAL**

*Contributions must reach the Editor before the first Tuesday of the month for inclusion in the following number.*

## LARGE DEPRESSED FRACTURE OF THE SKULL



Abono: Figure 1. Reloma: Figure 2.

### Post operative protection by skull cap of Gypsona P.O.P.

R. J. Age 49. Motor cycle accident. Admitted in deep coma, with large scalp wound and contusion over right temporal and parietal region.

X-Ray showed multiple linear fractures with large depressed fragments, plus fracture of right zygoma and fractures of the base of the skull. (Fig. 1.)

**Operation:** Toilet of the scalp wound, removal of large area of depressed bone which had penetrated the cortex in an area of 2-in. diameter. Cortical debris removed, together with fragments of bone. Temporal facial graft sutured over dural gap. Scalp wound closed. (Fig. 2.) Skull cap of Gypsona P.O.P. applied. (Fig. 3.)

Feeding by indwelling naso-pharyngeal catheter carried out during period of semi-coma.



These details and illustrations are of an actual case. T. J. Smith & Nephew, Ltd., of Hull, manufacturers of Gypsona P.O.P. and Elastoplast (Tensoplast) bandages, publish this instance — typical of many — in which their products have been used with success.

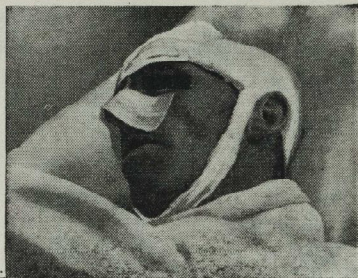


Figure 3.

## Are vitamins enough?

Obviously, no. The rationale of giving vitamin D, for example, alone, when calcium intake is limited, would be difficult indeed to justify. Similar considerations may apply to other factors, as for example iron and vitamin C.

All these, and other analogous considerations have been borne in mind in the design of Complevite, which provides, in rational dosage, vitamins and minerals commonly needed as additions to the dietary intake.

Complevite is thus the prescription of choice, both from the point of view of convenience and of economy. Prescription of Complevite is less expensive than prescription of the individual factors.

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The recommended adult daily dose provides:—

vitamin A 2,000 i.u.	vitamin C 20 mg.	iodine } not less
vitamin D 300 i.u.	calc. phosph. 480 mg.	manganese } than 10
vitamin B <sub>1</sub> 0.6 mg.	ferr. sulph. exsic. 204 mg.	copper } p.p.m. each

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## ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

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MARCH, 1949

No. 3

### "REACTION"

To be called a reactionary in this enlightened year of grace 1949, is an insult which few of us can bear with indifference. It is hurled with senseless vituperation from one end of the world to the other, a mixture of scorn and stabbing venom; and it is all the more damaging for it questions not only a man's character and his way of life but also his very ideals. The Oxford Dictionary lists under the heading "Reaction" this harmless definition . . . "A movement towards the reversal of an existing tendency or state of things (esp: in politics). A return or desire to return to a previous condition of affairs—a revulsion of feeling." Yet this seemingly insignificant word has become the byword of a massive structure of evil propaganda and has descended from this pinnacle to be bandied by the discontented man in the street at his more prosperous neighbours. It has come to assume a dogmatic character; every move which is labelled "reactionary" despite its true nature, must of necessity be one little short of slavery; every person so dubbed bears the aspect of a tyrant. It has become a useful catchword with which to justify one's personal dislikes to the smug approval of a thoughtless generation. This lack of mental discernment has been understandably engendered by the daily papers, the wireless and the cinema. We are content to allow our thinking to be done for us and, providing these manufactured thoughts do not prick the skin of our self satisfaction too often and too painfully, we are prepared to accept them as our own with the complete disregard for any final consequence, so characteristic of our age.

The changes which have been wrought by science and new creeds over the past few

years have been made at such a prodigious rate that mankind has had no time to assimilate them, and it is becoming more and more evident that a halt must be called soon, though it be but a personal one, in an attempt to evaluate the results of such change. The conception that so-called "progress" can bring nothing but good in its wake was bred in the Victorian era. Science was then a plaything in the hands of the unsuspecting player, not the dictator it is today. But though the roles of player and plaything have been reversed, the old conception still remains firmly embedded in the minds of the people. "My, isn't science wonderful" may well be the epitaph of mankind; and just as change stands dogmatically for progress, so reaction has come to stand dogmatically for regress.

This unfortunate state of mind has arisen directly as a result of the tendency to mass produced thinking. We are told categorically that reaction is by its very nature evil and this we have accepted without consideration.

The post war era has brought with it a mania for change and progress; examples are too obvious to require quoting, suffice it to say that the Government is well to the fore in the rush. The man who offers any opposition to such pathological behaviour is dubbed a "reactionary." He is regarded as a deluded fool or a criminal. The fact that he may have the experience of centuries to support his views, makes not one iota of difference and it is precisely upon this lack of true evaluation that rests the whole crux of the matter. The experience of generations and the tradition of centuries have not combined to formulate laws and rules of

behaviour that can be thrown overboard in a matter of a year or so. Indeed they would not have been handed down to us had not our fathers and forefathers before them proved by a system of trial and error that such laws and rules were in fact the only ones upon which society as a whole can maintain itself. True, such a fundamental institution must keep abreast of the times, changes must be countenanced but these changes should be made on a foundation which remains constant and inviolable. Such change is indeed progress and he who opposes it deserves the epithet "reactionary" with its full content of derision and condemnation. Changes, however, such as we are too often experienc-

## THE PRACTICAL APPROACH IN RESPIRATORY DISORDERS

By  
MAURICE DAVIDSON, M.A., D.M., F.R.C.P.

*Consulting Physician to the  
Brompton Hospital.*

In his peroration to one of the most distinguished addresses ever delivered by a Harveian Orator to the Royal College of Physicians of London<sup>1</sup>, Dr. Walshe adjured his audience in the following words:—

"The need for rebuilding the foundations of medicine was never greater than to-day, when we are being swept along on a spate of new knowledge and new techniques, and have so little time for their due contemplation and integration. Surely there could be no function more truly appertaining to our traditions or more in harmony with the life of that great natural philosopher whom we commemorate, than to seek to study and to consolidate those intellectual foundations, and to further what I have called a generality of understanding."

When your Editor did me the honour to ask me to write an article on any subject of chest conditions I might see fit, I thought of the address from which I have just quoted, and I felt that, in view of the segregation of chest cases into special departments and the increasing divorce of the study of chest disease from general medicine, I could not do better than endeavour briefly to review this subject from the general practitioner's point of view and to outline some of the main principles which should, in my submission, guide his approach to the diagnosis and general handling of such patients.

ing today, changes which have respect for neither tradition nor tried experience, smack strongly not of progress but rather an ultimate regression of society. He who opposes changes of this nature deserves a full share of commendation and encouragement, not the shower of abuse which he receives in its place.

The importance of distinguishing the dross from the gold in this matter cannot be too highly stressed. The apathy which has descended upon this generation, an apathy of mind engendered by its environment of lazy thinking has got to be swept away before our society can make any real contribution to the problems which beset the world today.

The medical student's career has always seemed to me to involve a rather distressing series of contradictions and disillusionments. In the earlier stages of his curriculum he is grounded in those basic sciences upon which the foundations of clinical medicine have indeed been laid. When first he enters hospital he is apt to be somewhat discouraged by the apparent disregard of those scientific principles by many of the most successful exponents of the practice of medicine as an art. Still later, when he leaves the sheltered waters of his training school to embark upon the stormy seas of practice, he is often sadly conscious of a return to a stage of apprenticeship in which the guidance furnished by the lecture-room and the ward-class is all too inadequate to enable him to cope with real satisfaction with the problem of disease as it is now presented to him. Patients do not come to him conveniently labelled with the secrets of their pathogenesis; many of the ancillary means of investigation on which he has learned in hospital days to rely so confidently are now denied to him; for the first time, perhaps, in his career he is thrown entirely on his own unaided resources and initiative, of the infallibility of which he is now compelled to entertain an unmistakable doubt. This is true of practically all branches of clinical medicine, and certainly of chest disease. The point may, perhaps, be better illustrated by a short reference to a concrete example,

which I may with advantage take as a text to the general practical advice that it will be my endeavour to offer to students and practitioners of this subject.

Some years ago I was asked to see a young woman, a lady's maid, aged about 30, on account of cough, progressive loss of weight, and attacks of dyspnoea similar to those seen in asthmatic subjects. Up to about 18 months prior to this (I saw her in October, 1926), she had been perfectly fit and healthy. She had caught a bad cold on one occasion and ever since then the cough had been increasing, and the amount of sputum first thing in the morning was now considerable, though expectoration at each bout of coughing was difficult. Her doctor said that she had lost a considerable amount of flesh, and she did indeed appear emaciated. The sputum had been examined for tubercle bacilli on numerous occasions, always with negative result. She had at one time been given a mixed vaccine (streptococci and m. catarrhalis), six doses in all, without appreciable benefit. She had also been given creosote, in addition to various expectorant mixtures, but was getting steadily worse and had become really unfit for work. Her employers were worried about her condition, and her doctor, finding no bacteriological evidence of tuberculosis, asked me if I thought there was any likelihood of her having bronchiectasis. On examination she appeared really ill. There was considerable wasting of the muscles above and below the clavicles, such as is often seen in cases of advanced phthisis; she was dyspnoeic and in obvious respiratory distress. Movement of the chest was restricted; there was little air-entry at the apices, which were dull to percussion; the respiratory murmur over the lower two thirds of the lung-fields was bronchial in character, the expiratory phase being prolonged, and musical sibilant rhonchi were audible all over the chest: no moist râles were heard. No X-ray examination of the chest had been made, and it may be remarked incidentally that the radiograms of that date were, in comparison with those of the present day, relatively poor, and much less reliance was placed on radiology in chest disease by most clinicians.

I have tried to give as faithful a reproduction as possible of the clinical picture as it was presented to me at the time, and I would emphasize that it is one which, in my ex-

perience, is by no means uncommon. I have already mentioned that this patient had stated that her cough had begun in the first instance with a bad cold. When I took up this point and cross-examined her on it, it became evident to me that she had had an attack of influenza with considerable secondary infection, and that the increasing respiratory trouble and marked deterioration of her general health dated from this. Examination of the nose and throat gave, as I had hoped and anticipated, valuable information. Both tonsils were hyperaemic, the right one being enlarged and septic. The epiglottis was red and inflamed. The space in the right side of the nose was large, but the left side was blocked, the middle turbinate being enlarged and in close contact with the septum, and pus could be seen issuing between the middle and inferior turbinates from the posterior portion of the meatus. In view of such circumstances, evidence of chronic sinus infection following an acute sinusitis associated with influenza, I referred her to a surgical colleague, who washed out the maxillary antra a day or two later. Both antra were full of stinking pus. She was subsequently admitted to hospital and a radical operation was performed, both antra being drained as well as the sphenoidal sinus which was also full of pus. The immediate relief of her respiratory distress was almost dramatic. When I saw her again a few months later (February, 1927), her chest was quite clear; the cough had almost ceased, though she still had some cough and expectoration first thing in the mornings and occasional slight dyspnoea on exertion. She had put on a considerable amount of weight, and felt once more fit and well and ready to accompany her employers to Scotland at the coming Eastertide.

I have quoted the above case at some length since it has always appeared to me to furnish one of the best illustrations of certain important principles that must underlie efficient work in this branch of medicine, i.e., recognition of the relation of chest disease to general medicine and pathology, and also a proper appreciation of what is really meant by the term "respiratory tract." Of the latter I can hardly speak with sufficient emphasis. I well remember a clinical lecture by one of my old teachers, the late Herbert Tilley, one of the best and most respected specialists in oto-rhino-laryngology. He began by reminding his audience that if they would but refer

to the Book of Genesis<sup>2</sup>, they would learn that when the Almighty first created man He "breathed into his *nostrils* (my italics) the breath of life." Among the essentials of a practical approach to the problem of a patient whose symptoms appear to be referable to the chest are first the habit of regarding the respiratory tract from a physiological standpoint as a functional whole, and second the recollection that anatomically this tract begins not in the bronchi but in the nose and mouth. This truth has been well emphasized by teachers in the nose and throat department, but is sadly neglected by most physicians. No examination of the chest, however, is complete without an examination of the upper respiratory tract.

The relation of chest disease to general medicine and pathology is not, I think, as well recognized as it should be. In the earlier stages of a student's hospital career it is, I suppose, inevitable that classification of disease into systems, with an accompanying stereotyped nomenclature, should form a not inconsiderable part of his elementary clinical teaching. To satisfy the understanding of those who are starting their ward-classes for the first time one must be simple and to a large extent dogmatic in one's teaching of the outward and visible phenomena of disease: otherwise the student may well be left confused in a maze of abstract principles with but little guidance as to how to apply them. So soon, however, as he has grasped what may be called the general grammar of clinical medicine, it is important that he should resurrect his knowledge of general pathology and get into the habit of regarding symptoms in terms of such pathology rather than as isolated phenomena to be correlated with particular visceral abnormalities according to some tabular system obtained from a textbook. Only by such cultivation of a broad outlook on the subject, combined with assiduous clinical apprenticeship in a department in which adequate clinical material is available, is the practical art of diagnosis and treatment in chest disease to be acquired.

The need for retaining a grasp on general medicine is nowhere better exemplified than in many of the "Chest Clinics." One of the commonest errors to which doctors are prone is the assumption that patients who consult them on account of symptoms which suggest that they are dealing with a chest case must necessarily be afflicted primarily with some organic disease of the lungs. Thus it not

infrequently happens that an individual suspected of pulmonary tuberculosis because of cough, lassitude, and occasional blood-spitting, and in whom physical examination reveals the presence of scattered râles in various parts of the lung-fields, usually at the bases, is promptly diagnosed as a case of phthisis, duly notified, and despatched to a sanatorium. Even then, the same unfortunate may be condemned to a long term of semi-invalidism, with the added stigma of consumption, and to a peripatetic existence in and out of sanatoria, before he is finally recognised by some better educated physician as a case of mitral stenosis with the pulmonary congestion that so frequently accompanies this condition. On the face of it this may sound incredible, but indeed it is a fact, of the truth of which I have frequently had to warn students, both undergraduate and post graduate, in lectures and in ward-classes.

Not only from the clinical but also from the radiological aspect is this mistake occasionally seen. The diffuse mottling of the middle and lower zones of the lung-fields often observed in mitral disease is easily mistaken for tuberculous infiltration by the inexperienced, who, concentrating their attention on the lung-fields, fail to notice such additional features as cardiac enlargement or undue prominence of the pulmonary conus.

Loss of weight, accompanied by tachycardia, has not infrequently been made the basis of a diagnosis of pulmonary tuberculosis when in reality the patient has been suffering from thyrotoxicosis and is a suitable subject for thyroidectomy. Cases of intestinal toxæmia may simulate the clinical picture of phthisis, and if the medical attendant, with this prejudice in his mind, discovers crepitations, real or imaginary, in some area of the chest, the error is consolidated, and correction of the diagnosis becomes a major business, often entailing much preventable worry and extra expense to the patient.

One could multiply instances of mistakes of similar character, but considerations of space do not permit me to record more than the foregoing clinical examples. The conclusion I would ask my readers to draw from these somewhat discursive remarks is that the practical approach in respiratory disease can be attained only by a methodical synthesis of basic pathological knowledge with the anatomical facts supplied by clinical and radiological examination of the patient. To this must be added the art of viewing the

patient as a whole and not as a mere conglomeration of component parts.

Too little attention is paid nowadays to the importance of anamnesis. A good clinical history, obtained from the patient without undue hurry and with proper allowance for ignorance and garrulity, is often of the greatest value in assessing the position and in providing the doctor with information which will give a real guide to the proper method of approach. The excuse commonly made by practitioners, especially on the surgical side, that they have no time to waste on taking a long and elaborate history, is only too often an illustration of the truth of the old proverb "more haste less speed." The familiar symptom cough, for example, even in cases in which there is no doubt as to the existence of structural disease of the lungs, should never be treated by the indiscriminate prescription of stock expectorant mixtures, regardless of the actual cause of the symptom itself. Cough in many cases of pulmonary tuberculosis may be productive, and caused by the accumulation in the respiratory tract of excessive amounts of sputum. On the other hand, it may be entirely unproductive, and due to dryness of the oro-nasal mucosa, to laryngeal involvement, or to reflex irritation from accompanying disease of the pleura. Diagnosis of the true cause in any individual case depends on a combination of good history taking with careful examination first of the chest itself and next of the upper respiratory tract. X-ray examination of the chest has now become a *sine qua non* of modern chest work. In many instances physical examination gives little or no information of real value, and the practitioner must rely upon information which is divulged only by radiology. This may be decisive in many cases; in others it may but point to the need for bronchoscopic examination before the correct diagnosis can be established and an adequate plan of treatment formulated. Every individual case must be tackled in the light of the general principles I have endeavoured to indicate, and with a realization of the truth that in many instances arrival at a correct solution is rather like the successful building up of a difficult jig-saw puzzle, in which numerous pieces have to be sorted out

and placed in their proper relation to each other before the whole picture can be obtained.

I am conscious that the information conveyed by these *obiter dicta* is somewhat sketchy, and for the many gaps and omissions of this short article I must crave my readers' indulgence. As a clinical teacher I am well aware of the difficulties experienced by many students in acquiring facility in auscultation of the chest, difficulties which I think are unnecessarily increased by many authors who persist, in their text-books, in adhering to the over-elaborate sub-division of râles into endless varieties, to say nothing of other minutiae of physical signs that have long outlived any usefulness they may once have possessed. The practical approach in respiratory disorders, as I see it, consists in a ready appreciation of the essential points in symptomatology, followed by careful physical examination of the chest and all its contents, and of the nose and throat region in any case in which the chest shows no obvious explanation of the symptoms. X-ray examination is now regarded, and rightly, as an integral part of the routine examination, nor should it be forgotten that lateral views will often give information which is not forthcoming from the standard radiogram taken in the postero-anterior plane. Bronchoscopy has very properly come into its own as an essential in a large proportion of cases: the necessity or otherwise of employing it will usually be determined mainly by the clinical history: no unexplained hæmoptysis should be dismissed without resort to this direct method of examination. The synthesis of anamnesis, physical examination, radiology, bacteriology, and last but not least an estimate of the individual patient's general make-up, is, like all else in clinical medicine, a practical art which can only be mastered by long apprenticeship. I have done my best to indicate the main lines on which I believe it can most successfully be pursued.

#### REFERENCES

- <sup>1</sup>Walsh, F. M. R. "The Structure of Medicine and its Place among the Sciences." *Being the Harveian Oration delivered before the Royal College of Physicians of London on October 18th, 1948.* Edinburgh. E. & S. Livingstone, Ltd.

<sup>2</sup>O. T. Genesis; Chap. II, v. 7.

#### THE DECENNIAL CLUB

The Editor would be grateful if the Secretaries of the respective Decennial Clubs would inform him of the intended dates of their next meetings for publication in the "Journal."

## THE STUDENT'S UNION BALL

Once again the year has run its accustomed round and brought with it the Bart.'s Ball. On previous occasions it had been held at Grosvenor House, but this year a move had been made and it took place on Friday, January 4th, at the Dorchester, with all its expected junketings and festivities. Four hundred and fifty guests attended and four hundred and fifty minds were set on enjoying themselves. Thrown aside were the cares of the hospital and the world; dark suits and sports coats were replaced by immaculate dinner jackets and tail coats; the annual miracle had once more taken place, the medical world had blossomed into paragons of fashion and grace.

Successive members of the Ball Committee, acting in the role of Cerberus, assiduously checking on an enormous sheet of paper each party as it arrived, greeted the guests; they were symbols of efficiency—none could escape their flickering pencils. Mrs. Canti in her magnificent mandarin's coat made an entry which even the Empress of China herself, would have envied.

Inside, the ballroom, with its sea of surrounding tables, filled rapidly. Dancing was the order of the evening and dancing there was to the strains of Bill Saville and his orchestra; and when they took their well earned break, the Bart.'s "Morons" replaced them on the stand. Mr. Lindsay Corbett, with a seraphic smile on his face and an enormous double bass in his arms for a change, gave us one more example of his hidden talents. Mr. Con Molloy and his tail coat were here, there, and everywhere, the perfect Master of Ceremonics. Spirits, both artificial and natural were present in high measure, and the atmosphere became mellow in its friendliness. New acquaintances were greeted as old friends and Mr. Pat Lawther introduced his charming wife to all comers. Mr. and Mrs. Rupert Corbett were presiding at one table watching the proceedings with a benevolent air, whilst Mr. Naunton Morgan at another was, in his own inimitable way, anticipating his visit to America. Dr. Cates was there too, condoning with a paternal eye the follies of the younger generation and adding to the atmosphere, an air of spirited conviviality, Mr. David Cairns on the floor, was performing the most polished gyrations as

the spirits within him rose, while Mr. Dick Fiddian was more than his usual genial self. Mr. Geoffrey Hirst, whom we must congratulate on his engagement, was there with his fiancée and was therefore on his best behaviour, while Mr. Ronnie Struthers and his charming wife were obviously enjoying the proceedings immensely.

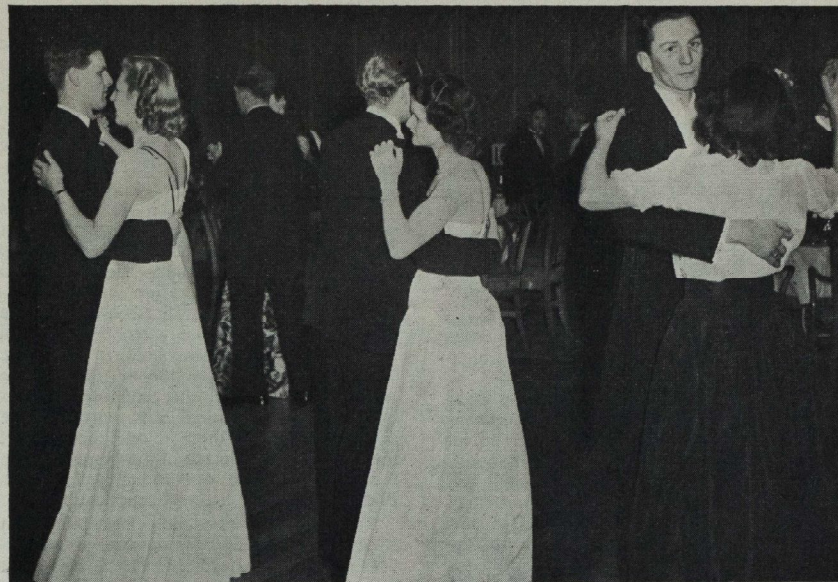
At midnight the high spot of the evening arrived. Announced by Mr. Con Molloy as the "ceremony of the cake" in came a pile of glittering icing topped by a single candle (might it have been to celebrate the first year of the N.H.S.?) and "Percy" drawing the Lord Mayor's Coach. It was wheeled round the floor to the plaudits of the company, finally to be ceremoniously and most becomingly cut by Mrs. Naunton Morgan.

Having been revived by an excellent buffet the dance continued—Mr. George March dancing with his usual vigour offered encouragement to all and sundry, whilst Mr. Maurice Hardman and his partner took the floor a trifle more sedately perhaps but with no less enjoyment. The Elimination Dance, where questions asked by Mr. Con Molloy were calculated to do as much damage as possible in the shortest of time, finally left Mr. Hugh Jukes and his partner the winners. In the Statue Dance, Dr. Armand Staunton and his partner won the prize for achieving a statue of such immobility as gave most of the onlookers a lesson in concentration and sobriety.

Mr. Capps in his role as President of the dance, graced the occasion in a truly presidential manner and it was indeed a great pity that, due to the indisposition of her mother, Mrs. Capps was not there to share in the evening's festivities.

But all good things must come to an end and *miserabile dictu*—at two o'clock the revels ended. The occasion was fittingly closed by a lively if unharmonious version of "Die Gieger," led by Mr. George Porter in the hall. Such evenings are few and far between and our sincere thanks are due to the Ball Committee, and in particular to Mr. Con Molloy, for the immense amount of work which they so willingly undertook, and we must congratulate them on a result which surpassed all expectations.

## AT THE BALL



"On the floor"



"Cutting the cake"



## VAGOTOMY

By E. G. TUCKWELL, F.R.C.S.

THE failure of gastrojejunostomy and the more formidable nature of gastric resection for the treatment of duodenal ulcer has long stimulated research for alternative surgical treatment. Dragstedt (1945) suggested division of the vagus nerves as a rational and comparatively simple procedure. He has performed a large number of vagotomies for peptic ulceration and reports very favourably on this treatment.

Stimulation of the vagus nerves causes secretion of acid gastric juice. Continued stimulation of the vagus nerves, such as occurs in susceptible individuals will produce a profuse and persistent gastric secretion containing a large quantity of hydrochloric acid. That hydrochloric acid is an agent maintaining activity of peptic ulceration is fairly well established and in certain cases it may actually be the initiating factor. These conditions are probably due entirely to the action of hydrochloric acid on the mucous membrane, they are:—ulceration of the jejunum after gastroenterostomy or certain partial gastrectomies; ulceration of the ileus in the neighbourhood of heteroptic gastric mucosa, such as sometimes occurs in the Meckel's diverticulum; and the ulceration of the oesophagus, which may result from regurgitation of gastric contents through the cardiac sphincter. However, as the gastric mucosa and the mucosa of the first part of the duodenum are normally subjected to the action of hydrochloric acid, it is probable that some other factor, such as a trauma, initiates ulceration in these areas.

Section of the vagus nerves is unlikely to prevent acute gastric or duodenal ulceration, although it should probably prevent these ulcers becoming chronic. At the same time cessation of spasmodic contractions of the stomach is likely to lessen the amount of trauma which may occur to the mucous membrane.

Many authors have written praising vagotomy for the treatment of peptic ulcers. They all admit its unpleasant sequelae, but tend to make light of them in view of the healing of the ulcerated area (Orr and Johnson, 1947).

However, although complete section of the vagus nerves will produce achlorhydria to vagus stimulation, there is evidence that this state of affairs is not permanent and a final

assessment of the clinical results of this treatment for duodenal ulcer must wait a few more years. (Vanzant, 1931; Moore et al, 1947).

The operative approach to the vagus nerves may be carried out through the chest or through the abdomen and diaphragm. Anatomical considerations were said to favour the thoracic operation, but more detailed dissection of the vagus nerves and the oesophagus shows that over 90% of all human beings are amenable to complete vagotomy from the abdomen through the oesophageal hiatus of the diaphragm. This operation of abdominal vagotomy has the advantage over the thoracic operation in that the lesion of the stomach or duodenum can be inspected and the operation itself is less likely to cause unpleasant complications.

The vagus nerves usually descend one in front and one behind the oesophagus as palpable and visible cords, which can easily be resected for a length of one to two inches. At the same time small communicating branches must be removed for the success of the operation. It is essential that the division of the nerves be absolutely complete and probably, in order to prevent regeneration, a sufficient length must be excised. Clinical proof that the division of the nerves is complete may be obtained from the result of the insulin test meal; this test is simply performed by injecting 15 units of insulin into a vein and estimating the acidity of the gastric contents as in a normal test meal, the hypoglycaemia stimulates the vagal connections in the hypothalamus so that, if any fibres of the nerves are intact, acid is secreted into the stomach. Following the operation there is atony of the stomach and intestines, which tends to recover during the next few days, the tone of the intestinal muscles being maintained by the intrinsic plexus. During those few days, however, the stomach may become very distended and stretched, producing discomfort, retching and vomiting and, if the stomach is allowed to dilate, danger to life. It is the usual practice, therefore, to maintain suction on the stomach for four or five days after the operation in order to prevent its distension.

In spite of this precaution there are numerous cases reported in the literature where emergency gastrojejunostomy has had

to be performed. Since this danger of gastric retention is so very real, it is obvious that the operation of vagotomy should not be the sole treatment in cases of duodenal ulcers which have any degree of pyloric stenosis. Furthermore, one must remember that a chronic duodenal ulcer is likely to produce some stenosis when it heals and that gastric retention might develop some months after an apparently successful vagotomy. After this operation gastrojejunostomy is unlikely to be followed by jejunal ulceration, but it is not a satisfactory way of draining the stomach and its routine use would diminish the value of this form of treatment.

With regard to gastric ulcers, although many of them will heal after vagotomy, the chronic ulcer is so often penetrating into the pancreas that its complete healing is very doubtful and the risk, although admittedly small, of carcinoma must always be remembered.

As a general rule we find that those surgeons with wide experience in this type of treatment debar vagotomy for the treatment of gastric ulcers. In the treatment of anastomotic ulcers after adequate partial gastrectomy vagotomy has an undoubted place. I believe that further gastric resection should be done, if exploration shows that the stomach remnant is large, but the performance of vagotomy at the same time is an added safeguard against recurrence of the ulcer and, since there is no pyloric sphincter, distension of the stomach with its unpleasant after-effects are therefore likely to be minimal. Other unpleasant sequelae of vagotomy are distension of the abdomen and diarrhoea, which may be persistent for some months, although certain cases are reported to respond very well to chemotherapy.

To summarise, section of the vagus nerves of the lower end of the oesophagus will abolish the neurogenic secretion of acid into the stomach and allow healing of peptic ulcers; whether this is permanent or not remains to be seen during the next few years. The side effects of the operation may be unpleasant and may be severe enough to

demand further operative procedure, such as gastroenterostomy, pyloroplasty, or even subsequent partial gastrectomy. The procedure is of undoubted value in the treatment of anastomotic ulcers, particularly those in which an apparently adequate amount of stomach has been removed at the previous operation, but its use with gastric ulcers may be dangerous owing to the presence of an undiagnosed carcinoma or of a chronic perforation into the pancreas. Most authors agree that the ideal patient for vagotomy is the young person, with recurring duodenal ulceration but with little or no scarring and deformity of the pylorus. It should not be used in the presence of active bleeding as the ulcer will take some time to heal and during that time bleeding is liable to continue. At the present moment vagotomy is still a human physiological experiment, and as such its wholesale performance should be confined to a few centres where large numbers can be done and carefully followed up. Only in this way can final assessment be made. If vagotomy is to be accompanied by further surgical procedure in a great number of cases I do not think that it will ever replace partial gastrectomy for the treatment of ulcer. It has been suggested that vagotomy with excision of the pylorus or pyloroplasty will cure almost all duodenal ulcers but the severity of this operation would be almost as great as the standard partial gastrectomy and would still be accompanied by the unpleasant side effects of vagotomy. Now that partial gastrectomy is a comparatively safe operation and surgeons have learnt that in order to be successful it must be extensive the results of treatment of chronic duodenal ulcer are satisfactory and the post-operative unpleasant sequelae are diminishing.

### REFERENCES:

- <sup>1</sup>Dragstedt, L. R., and Schafer, P.W. *Surgery* 17, 742. (1945).
- <sup>2</sup>Moore, F. D.; Chapman, W. P.; Milford, D. S. and Jones, C. M. *J. Amer. Med. Ass.* 133, 741. (1947).
- <sup>3</sup>Orr, I. M. and Johnson, H. D. *Lancet* (11) 84. (1947).
- <sup>4</sup>Vanzant, F. R. *Amer. J. Physiol.* 99, 375. (1931).

### THE JOURNAL

*Contributions for the JOURNAL should reach the Editor by the first Tuesday of the month for inclusion in the ensuing issue.*

## ROBERT GOOCH

By WILFRED SHAW, M.D., F.R.C.S., F.R.C.O.G.

SOME time ago, when visiting the Muniment Room, I was greatly struck by a fine oil painting of Robert Gooch, by Linnell. The picture had been presented to the hospital in 1938 by Miss Mary Grace Latham. The merits of the painting have been appreciated by the hospital authorities, and Robert Gooch's picture now hangs in the Clerk's office.

Robert Gooch was appointed joint Lecturer in Midwifery with Andrew Thynne, at St. Bartholomew's Hospital, in 1812. Thynne was the first member of the staff elected as a specialist in midwifery, but he was not regarded as a satisfactory teacher. Gooch held office until shortly before his death in 1830. Those who know Sir Thomas Moore's history of the hospital will remember Gooch's vivid description of Nelson visiting the wounded sailors landed at Yarmouth after the battle of Copenhagen. Gooch had been born in Yarmouth in 1784 and at the time was working as a surgeon's apprentice. He graduated at Edinburgh and became a general practitioner at Croydon. He decided to specialise in midwifery and gynaecology and started practising in London in 1811. He was appointed to the staff of the Westminster Lying-in Hospital and to the staff of the City of London Lying-in Hospital. Gooch suffered from poor health throughout the greater part of his career and, like his first wife, died from tuberculosis. He translated from the German Golis' book on acute hydrocephalus, a copy of which is in the library with an inscription which is presumably in the handwriting of the author. He wrote pamphlets, and shortly before his death published "Diseases of Women and Children."

Gooch is almost completely forgotten, for he has left behind nothing of permanent value. His contemporary reputation was very great indeed, for he was regarded as the outstanding obstetrician and gynaecologist of his generation, and MacMichael, in 1830, included Gooch amongst the first eighteen of British physicians, ranking him with Linacre, Caius, Harvey, Sydenham and Jenner. Gooch's reputation in literary circles was also great. He was a friend of Southey, the poet laureate, and Ferguson, in his 1859 edition of Gooch's "Diseases of Women" records that Southey and Sir Walter

Scott regarded Gooch as one of the most remarkable men of his time. Gooch practised from Berners Street, and the demand for his services was so great that he had to turn patients away.

It may therefore be of some interest to attempt to explain how this great reputation was made. Gooch had no family influence, but at Edinburgh, became friendly with Henry Southey and Knighton, and the Edinburgh associations helped him in practice when he started in London. Otherwise, the position he reached was entirely due to his own abilities. At Edinburgh, he showed promise as a speaker in the debating society and already had developed strong literary interests. The first important step in his career was when he moved from Croydon to specialise in midwifery in London. It is remarkable that at the age of twenty-eight, only one year after leaving general practice he was elected to the staffs of the Westminster Lying-in Hospital and of St. Bartholomew's Hospital. He admitted that he was nervous about his appointment at St. Bartholomew's, for he did not believe that he had sufficient theoretical knowledge. Moreover, at the time, the Bart's appointment had no particular prestige. There is ample evidence that Gooch had a dynamic personality, with wonderful powers of expression both in conversation and in prose, so that early in his career his lectures became famous throughout London. His wide reading and gift for languages made him conversant with contemporary medical thought. His translation of Golis, published in 1821, illustrates his energy and vitality. The book is interesting to read today, for acute hydrocephalus in the time of Golis comprised such conditions as meningitis and abscess of the brain. The most important source of information about Gooch's clinical skill is his book—"Diseases of Women and Children." The paper on the contagiousness of the plague is, without doubt, the best of Gooch's publications, written graphically in faultless English. His conclusions were irrevocable and its influence persisted throughout the nineteenth century. His papers on puerperal sepsis were important because Gooch differentiated between the fatal cases with rigors and peritonitis and such favourable types of case as congestion of the breasts on the third

and fourth days. Clinical thermometers were not available, nor was there any bacteriology, and the resources available to Gooch in the way of treatment were painfully limited to blood letting, purgation and opium. Gooch was also interested in insanity, but his comments are not constructive. "The Diagnosis of Pregnancy," is a most interesting chapter, and it is more than possible that the great stress placed upon it by the midwifery lecturers at Bart's is traditional from the time of Gooch. The very great clinical ability of Gooch is patent to all who study this chapter. Even modern authors cannot approach such passages as this—"Another circumstance likely to bias him is the respectability of the patient; but this, too, must be disregarded. Single women sometimes become pregnant in all ranks of life, not only among the low, but among the high; and not only among these, but in the middle ranks." The case of Joanna Southcott happened in Gooch's time, and this "aged and virgin prophetess" as Gooch calls her, persuaded numerous competent medical men that she was pregnant, yet at autopsy the uterus was smaller than normal.

Gooch had a great reputation for removing fibroid polypi. He used an ingenious instrument modified from one devised by Niessen. It consisted of two long silver tubes through which a piece of whipcord was threaded. The tubes were introduced into the vagina so that their upper ends came into contact with the pedicle, and when the tubes were rotated around the polypus the whipcord formed a noose which could be tied. The tubes were left in situ and kept together by means of rings fitted to a rod. The ligature could be tightened by rotating the rods around a longitudinal axis. In due course the polypus sloughed away. Gooch must have had very great experience of this type of case and

records a large number of successful cases. Gooch pointed out that the great danger of the operation was when part of the uterus was included in the ligature as it might very well be if the uterus were chronically inverted, owing to the risk of peritonitis. Gooch took great care to distinguish between the polypoidal form of carcinoma of the cervix and a fibroid polypus. He placed great emphasis on what he called the irritable uterus and devotes a chapter to an effort to describe a new syndrome and indeed a new disease. Today the effort seems unconvincing, although it is possible that Gooch included cases of endometriosis under the term irritable uterus. In his chapter on uterine haemorrhages, Gooch emphasises the method of bimanual compression to control post-partum haemorrhage, and he also used the method of pouring cold icy water over the abdomen with good effect. He describes the use of la Doux's method of packing the vagina with handkerchiefs soaked in vinegar. He resuscitated his patients with brandy and water, and biscuits and bread soaked in brandy.

In all his clinical descriptions there is a remarkable ability for graphic description—"The blood burst out with prodigious impetuosity"—a remarkably accurate picture of post partum haemorrhage.

It cannot be said that originality is to be found in any of Gooch's writings, but there is a clear picture of a cultured intellectual with wide interests and considerable clinical ability. His influence upon his contemporaries was in great measure due to his personality. As is the case of many older members of the staff, the great work performed in the services of the hospital—both to patients and in the instruction of students—is unrecorded, but the work must have been very great indeed.

## CORRESPONDENCE

### RAHERE'S FOUNDATION

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

I learnt quite recently that the English translation made in 1400 of the "Liber fundacionis ecclesie Sancti Bartholomei Londoniarum pertinentis prioratui eiusdem in Weste Snythfelde" which was written about 1170 has been published by the Early English Text Society, price 10/-. This gives the account of the foundation of the monastery by Rahere and although written in Middle English is fairly easy to read. It was

originally published by Norman Moore in the Bart's Reports in 1885, and I am sure that very few members of the hospital have ever read it.

It has occurred to me that this fact may have missed the attention of some of your readers and that it may be of interest to them.

I remain,

Yours sincerely,

GEORGE GRAHAM.

149, Harley Street,  
London, W.1.  
1st February, 1949.

### PORTRAIT OF ABERNETHY

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

With reference to the announcement in your December Number about this Portrait (see Plate 1), which he found in a shop in Cheltenham, described as "An Unknown Gentleman of the School of Raeburn," Mr. Whittaker has kindly presented his Engraving by Charles Turner, A.R.A. (see Plate 2), on hearing that the Portrait now belongs to the Medical College.

The Portrait was painted by Charles William Pegler, who lived in London, and exhibited fifteen portraits between 1823 and 1833 at the Royal Academy, including this portrait of John Abernethy in 1828, No. 173.

As regards the differences between the Portrait and the Engraving which you mention, the pose of the sitter is identical in both, the differences being that the sides of the chair are brocaded in the painting whereas they are in canework in the Engraving, and there are slight differences in the background. Instances are known of an engraver not following the original exactly. Mr. Adams of the National Portrait Gallery, and Mr. Vallance of Messrs. Holder who recently cleaned the Portrait for me, are confident that it was done in this case. I think this is a likely explanation though it does not rule out the possibility that Pegler painted other similar Portraits. He painted a smaller version which was recently presented to The Royal College of Surgeons, by Mr. H. B. Willett, son of Alfred Willett of Bart.'s, and a descendant by marriage of Abernethy.

Every effort has been made to obtain from the dealer at Cheltenham the previous history of the Portrait but so far without success. He tells me that it had been in storage there for over thirty years and was sold at a small auction about three years ago. I wonder if any of your readers in Cheltenham attended this auction or if the Portrait is known to them. Is it the Portrait by Pegler which Mr. Thornton tells me the Warburton Family possessed at the death of Abernethy?

In addition to the Pegler Portrait now the property of the Medical College, the Hospital has in its possession the well-known Portrait of Abernethy by Sir Thomas Lawrence, P.R.A., which was exhibited at the Royal Academy in 1820, No. 115, and presented to the Governors by Abernethy's pupils in 1820, the Portrait painted by James Northcote, R.A., in 1819 and presented by Miss Mabel Warburton, a descendant of Abernethy (was this presented in mistake for the Pegler Portrait?); a Marble Bust by William Groves which was exhibited at the Royal Academy in 1837, No. 1210, and presented by Mrs. Abernethy; and a Marble Bust by R. M. Siever exhibited at The Royal Academy in 1828, No. 1175.

Yours faithfully,

Sir ALEC MARTIN.

*Spencer House,*  
*St. James Place, S.W.1. January 11th, 1949.*

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

Since the presentation by Miss Mabel Warburton of the Northcote painting to the Hospital, I have doubted its authenticity as representing John

Abernethy. This doubt was strengthened when no trace of Northcote having painted Abernethy could be found, and it was significant that in 1819 (the date borne by the Northcote) he painted "the father of Dr. John Warburton." It then occurred to me that a mistake had been made by the storage firm which had sent the portrait to the Hospital at Miss Warburton's request. Miss Warburton has now confirmed that she had two pictures in storage, and that the firm was instructed to send the Abernethy portrait to the Hospital, and to dispose of the other. The wrong portrait was sent.

The Northcote now in the Hospital represents the father of the Dr. John Warburton who married John Abernethy's daughter Anne. The portrait recently presented to the Medical College by Sir Alec and Lady Martin is the Pegler portrait that William Clift records as being in the possession of Dr. John Warburton at the time of Abernethy's death (Plate 1). It was disposed of by the storage firm, and came into the hands of the dealer from whom it was recently acquired.

The portrait at the Royal College of Surgeons is a copy of the original Pegler, and was probably made for Elinor, another of Abernethy's daughters, possibly by Pegler himself, but not showing the same care, in the treatment of the hair for example. Elinor Abernethy married Sir George Borrowes, and their daughter married Alfred Willett, a son of whom, Mr. H. B. Willett, presented the portrait to the Royal College of Surgeons.

This brief explanation is offered in order to clarify a situation presenting several problems, which have been solved with the co-operation of Mr. C. K. Adams of the National Portrait Gallery, Sir Alec Martin, and finally Miss Mabel Warburton, who was able to confirm a theory that led to numerous enquiries over an extensive period.

I am, Sir,

Yours faithfully,

JOHN L. THORNTON

(*Librarian.*)

*The Library,*  
*St. Bartholomew's Hospital.*  
*29th January, 1949.*

### THE IPSWICH AND COLCHESTER RAHERE CLUB

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

Nine old Bart.'s students met for dinner at the George Hotel, Colchester, on January 8th, under the chairmanship of Dr. Penry Rowland, and propose to form an Ipswich and Colchester Rahere Club to meet annually for a dinner, the next meeting being provisionally planned for October 1st, 1949, at Ipswich. Will all Bart.'s men in the County of Suffolk and the northern half of Essex who inadvertently failed to receive notices of the first meeting please write to Dr. W. Radcliffe, "Ten Acres," Wivenhoe, Colchester.

Yours sincerely,

WALTER RADCLIFFE.

*Ten Acres,*  
*Wivenhoe,*  
*Essex.*  
*9th January, 1949.*

### PORTRAITS OF ABERNETHY

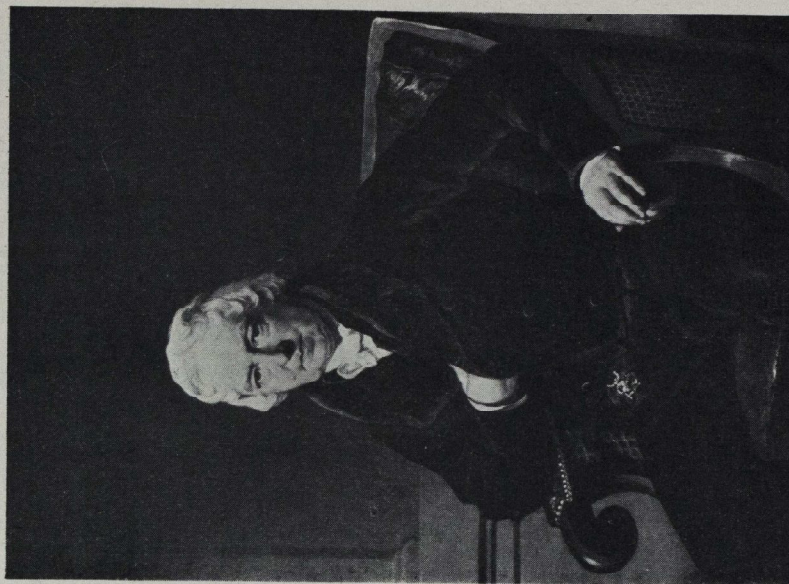


Plate II

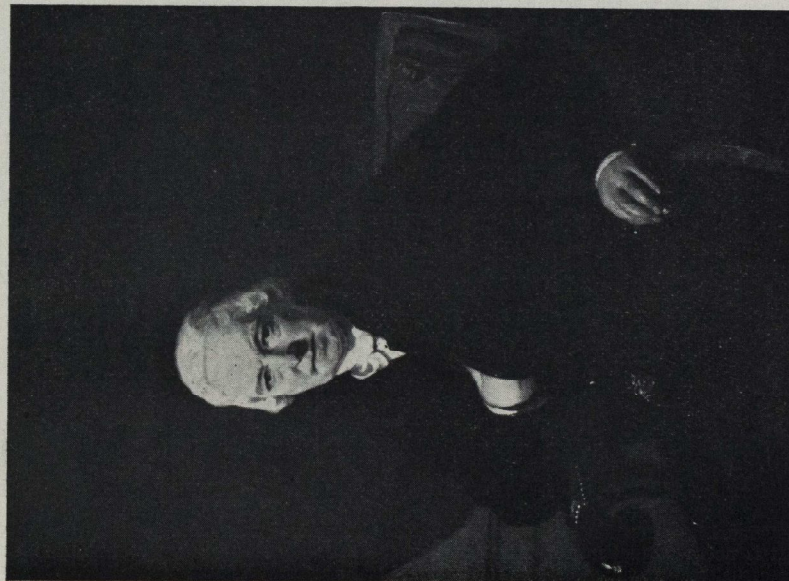


Plate I

### THE EMPIRE MEDICAL ADVISORY BUREAU

(The following letter has been received by the "Journal" and may be of interest to readers both at home and overseas.—Editor.)

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

The Empire Medical Advisory Bureau is the outcome of a strong feeling by the Council of the British Medical Association that more should be done by the medical profession in this country to welcome overseas medical men and women, particularly those from the Dominions and Colonies, and to assist them in feeling at home here. The medical associations affiliated to the B.M.A. and the overseas branches and divisions of the B.M.A. warmly welcomed the scheme and, after the necessary preliminary organisation, the Bureau was officially opened at B.M.A. House by Lord Addison (Lord Privy Seal) on 13th July, 1948.

The Council of the B.M.A. has allotted the funds and appointed a Committee of Management to organise and develop the Bureau. Sir Hugh Lett, immediate Past President of the B.M.A., who has been one of the prime movers in the project, is Chairman of this Committee and also of the Advisory Committee which has been formed and which is representative of Government Departments and Societies interested in the welfare of overseas visitors during their stay in this country for postgraduate or other purposes.

One of the main objects of the Bureau is to welcome the new arrival and in those cases where doctors let us know of their impending arrival, the Port Health Officers have been glad to meet and welcome our friends and pass on any urgent messages re accommodation.

Most of our visitors are attracted to this country primarily by the wealth of post graduate facilities available and a second main function of the Bureau is to inform the visitor of these and to put him in touch with the post graduate organisations and authorities who can meet his needs. The far-seeing visitor, however, makes written enquiries from his homeland or is advised and recommended by his local post-graduate committee, where this exists, so that he has a place reserved for him for his particular course of instruction on arrival. In this work the Bureau does not attempt to duplicate or cut across the function of the many post-graduate organisations, but is a marshalling yard of advice and information. The visitor who wishes to see something of the latest medical or surgical techniques is put in touch with the appropriate experts and casual visits to hospitals and other institutions are arranged.

### THE ETERNAL LANDLADY

By DAVID CARRICK

"WOMAN keeping inn, boarding-house, or lodgings, also woman having tenants." In this prosaic, cold fashion, the Oxford dictionary describes a member of the race of beings with whom practically every student is well acquainted.

It is not a romantic description, and, to the casual reader without cognizance of the

The difficult problem of finding somewhere to live within one's means is a pressing one for most overseas visitors and the Bureau maintains a register of hotels and lodgings and is always glad to hear of offers of "board and lodging" suitable for our overseas friends and their families.

Private hospitality is often welcomed by our visitors, who are glad to see something of home life in our country, particularly during the vacations between courses, and several doctors have notified us of their wish to entertain our visitors in this manner.

The Bureau arranges "At Homes" periodically and so far more than three hundred doctors and wives have been able to attend and meet friends from their own countries or other parts of the Empire and senior members of the profession of this country.

A wide range of general information is available at the Bureau and enquiries from overseas deal with rationing, cost of living, petrol allowances and so forth, whilst visitors already in the country seek help on such things as the inoculation of infants, medical or dental treatment, travel and theatres.

We may summarize by saying that the Bureau seeks to provide one place and one person to whom the medical man from the Dominions and Colonies can come for advice on the numerous medical and personal matters, the solution of which will go a long way to making a visit to this country both pleasant and profitable.

Yours faithfully,

H. A. SANDIFORD.  
(Medical Director.)

B.M.A. House,  
Tavistock Square,  
London, W.C.1.  
10th December, 1948.

### ART EXHIBITION

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

An Exhibition of works of art, including oils, water colours, gouache, photographs and plastics, will be held concurrent with the Bartholomew Fair next autumn. I should be grateful if I might use the medium of your pages to bring this to the attention of Bart's men, past and present.

Further details will be announced later.

Yours faithfully,

MICHAEL CLARKE-WILLIAMS.

The Abernethian Room,  
St. Bartholomew's Hospital.  
1st February, 1949.

species, one which leaves too much to the imagination. Few poets have sung her praises; only a handful of authors have spoken of her charms, and the great majority have not even deigned to mention her. Yet she remains a most important member of society, holding a unique position in her tiny Feudal domain.

It would be an exaggeration to say that she has not changed at all with the passing years. The alteration in the financial state of the Nation, coupled with the shortage of houses, has had the effect of increased charges and a growth in the power that she holds over her subjects, the lodgers. But, on the whole, a study of the few last-century authors who honoured her with mention, reveals that her main characteristics are much the same.

Even in Dickens's day she had a strange desire to be paid for her rooms, as Bob Sawyer discovered, but owing to the relative ease with which alternative accommodation could be obtained, the length of time allowed to elapse before stern measures were taken was very much greater. I cannot see many present-day students being permitted to get "a quarter and a month" in arrears without some argument on the subject. Nevertheless, the fact that "Missis" Raddle did, at the end of that period, complain quite bitterly, places her in a more genuine light than the proprietress of 221B, Baker Street.

If ever a woman suffered, it was Mrs. Hudson, landlady to the remarkable Holmes and the slow-witted Watson. Although, according to the Doctor, she was paid handsomely for the large airy sitting-room and the two bed-rooms, there must have been times when, despite the financial loss it would have entailed, she must have thought of giving notice to her erratic tenants.

The constant stream of visitors must have been very irritating, though the vexation caused by continuous journeys to the front door was, to some extent, alleviated by the extraordinary variety of the callers. High-ranking noblemen were by no means uncommon; foreign kings, heavily disguised, appeared now and again: there were Prime ministers and Foreign secretaries sandwiched between violent men who thought nothing of pushing the poor woman roughly aside before bending her fire-irons in half so as to demonstrate their virility, and engineers with their thumbs missing; beautiful young ladies, veiled or otherwise, were ten-a-penny. Telegraph boys practically lived on her door step, there was little hope of the hapless woman keeping that clean for long. She could never be sure of even recognising her main lodger, and it must have been exceedingly difficult to ascertain the number of people actually living in the house as it was not unusual for Holmes to creep in as a silent Chinaman and to leave as a noisy, drunken

old woman. Even nightfall, which brought with it some slight slackening in the ringing of the door-bell, was not entirely restful owing to the unearthly wailings of a violin from some part of the house.

All this was bad enough, but how many house-proud women would put up with a man who "kept his cigars in the coal-scuttle, his tobacco in the toe-end of a Persian slipper, his unanswered correspondence transfixed by a jack-knife into the very centre of the wooden mantelpiece"; or a man who would sometimes "sit in an armchair, with his hair-trigger and a hundred Boxer cartridges, and proceed to adorn the opposite wall with a patriotic V.R. done in bullet-pocks"? And when, if ever, could his room be tidied? When he was out on a case, the place was sure to be littered with criminal relics of a dangerous nature: and when at home, he was certain to be either drooping around under the influence of cocaine, or busily concocting vile-smelling chemicals whose odour pervaded the whole house.

Yet the extraordinary thing is that, far from giving him notice, she actually helped him on occasions to avoid assassination through the agency of air-gun bullets by creeping around on the floor and moving a cardboard effigy of him every now and again. I certainly wish that I could meet such an efficient and reasonable body, though I dare say that I would not be able to meet the fees that such devotion to duty must have demanded.

To return to reality, and to the present day, it must be admitted that there is no such thing as a landlady. At least, none of these good souls give themselves such a name and would be insulted if somebody was audacious enough to do so. There would appear to be something slightly lowering, a trifle *infra dig*, about the appellation. All the ones I have ever met (which is quite a few) have always "come down in the world" or are doing it because "they don't like being idle"; no though of financial gain has ever entered their benign heads. In all fairness, this applies more to the town than the seaside variety.

The sea-side landlady is very conservative. Her rooms are of a strictly standard fashion. The pictures on the walls are, for the most part, faded prints of a bygone age: "Bubbles" and "The Stolen Kiss" are amongst the most popular; although one

does, now and again, come across a more pathetic type such as "The Doctor" or "The Passing Cloud." Variety is occasionally added to these galleries by the inclusion of Daguerrotypes of long-forgotten relatives who regard one either with reprobation or amiability verging on the imbecilic. Then there are the religious ones with caricatures of angels and painstakingly worked samplers assuring one that "Charity Never Fails." Such assertions as the latter, although inspiring to the observer, might be more aptly placed in the hostess's parlour than in her victim's bed-room.

But it is the mantelpiece that attracts the greatest attention. The remarkable china dogs; the souvenirs from Margate; the pseudo-marble clocks whose flamboyant design scarcely makes up for the uselessness of their insides; the weirdly shaped vases full of pins and broken studs; the completely unidentifiable things . . . the list goes on for ever. I have never seen the majority of these objects d'art anywhere else than in these apartments, and I can only suppose that there must be some strange firm which deals exclusively with a single type of client.

Of the Town version of the species, it is difficult to say which is preferable, the strong silent type or the chatty ones. Probably the latter, because when a person confines her opinion of one to her thoughts, the atmosphere can become very troubled, particularly if you are doing the same thing; the thought waves get hostile to each other somehow. The chatty ones, however, can also be very tiresome at times. I have a friend who, in the normal way, is of a very cheerful disposition, this being natural in a demonstrator of chemistry. But he assures me that once, when he was in digs in Manchester, I would have hardly recognised him for his dolorous countenance.

It seems that his landlady was a woman much given to conversation of a rather morbid nature. It was of her late husband that she used to tell, and she never tired of recounting the story of his last illness, laying particular stress on the final hour and giving powerful verbal displays of his dying moans, finishing up with a particularly clever and awe-inspiring imitation of a death rattle.

This used to happen about once a week, particularly if he had a friend to supper, and in time it began to tell on his nerves; so he went away for a holiday. When he returned, Mrs. B. was in a great state. Apparently the cat had died, and she lost no time in

recounting *its* last hour with the final pitiful mew and squeaks; she must have been practising it for days, so perfect was the pantomime. My friend left soon afterwards because he noticed that one of the canaries was looking poorly and he felt that he could not stand three recitations a week. He says that he has always been particularly careful, ever since, in enquiring about the state of health of his prospective landlady's relatives and pets before clinching the deal.

Another singular thing in connection with these good ladies is the fact that, come what may, the lodger immediately previous to oneself was always a very nice young man. Although rarely said, it is generally implied that the likelihood of one being able to approach the niceness of the other is extremely remote. Besides, this legendary lodger always paid far in excess of what was demanded; he was so generous.

I heard all about one of these gentlemen, one day, when searching for rooms in the Brixton area. The place I had in mind was not situated in a very salubrious district, but the rent was fair and the house was in decent walking distance of the Oval, a useful position in the summer time.

I went in and met the lady. She was a plump, jolly-looking individual, not at all the sort that one would suspect of having had a hard life nor of being an unfortunate valetudinarian. Poor woman: how wrong I was! She was often poorly, she said, a state of affairs that prevented her from ever doing any cooking for her lodgers. They could do it for themselves, though, or they could eat out, whichever they preferred. Housework wasn't in her line either: "Hi'm not use to 'ard work," she said, "we halways 'ad a maid when me 'ubby was a hoffer in the Force."

I said that I was afraid that it would not quite do for me, and she said No, she hardly expected that it would. Would I like a cup of tea?

The cup of tea was followed by a conversation (of a rather one-sided nature, in which I was only expected to say "Yes," "No," "Really?" or "Well I never!"), at appropriate intervals) which lasted four hours. Having divined that I was a medical student, she launched forth into a thrilling diatribe concerning all the diseases she had had since May, 1935. It was an impressive list. Apart from the fact that she had been deprived of fifteen ribs, there had been approximately seven major and thirty-three minor

ailments during those twelve years. All the diseases had been accompanied by complications of a horrible and grotesque nature.

The word "complication" put her in mind of her husband who, so she said, had been a very bad man. He used to drink, she said, and would never stay at home and talk to her; he also preferred the company of another woman, a thing that she found difficult to understand.

I supposed that he was dead, but I was mistaken.

"Dead!" she expostulated, "not 'im; I chucked 'im out. I didn't mind 'im drinking; I didn't mind 'im fooling about with other women, but when 'e came 'ome one night drunk *and* with a woman, I said to 'im: 'This is the last straw, Percy, out you go!' and out 'e went."

She showed me a photograph of him. He was a reasonable looking man, perhaps a trifle timid, dressed in the uniform of the Fire Brigade. He hardly looked evil, but appearances are often deceptive; uniform does a lot for some people. Then she showed me photographs of all her relatives, none of whom she liked, they were a "scrounging bunch" so I was led to believe. But the *piece de resistance* came with the last likeness which was that of her late lodger: a very nice young man.

### STUDENTS' UNION COUNCIL

The following points of interest were discussed at the S.U. Council meetings in January and February.

#### Guy's Social Evening.

A return invitation to a "Social Evening" at Bart.'s has been extended to Guy's, and will be held on Friday, February 11th. The programme includes a tour of the Hospital and College, various medical, surgical and other demonstrations; an informal quiz; tea, dinner and a dance.

Six representatives from each year, at a cost of 3s 6d. per head, will attend from Bart.'s, as well as a number of women students and nurses.

#### S.U. Accounts.

The Dean has granted the wish of the Council to audit the S.U. accounts on July 31st of each year. This will allow them to be posted and inspected by all students well before the A.G.M. in November.

#### Catering Company.

The Catering Company have now appointed a Chef in the Hospital Refectory. A great improvement in the food, both in taste and presentation, is already noticeable. More changes are yet to come.

#### Telephone in Women's C.R.—Charterhouse.

A telephone has been ordered, and is expected to be fitted in a matter of weeks—definitely less than a month.

#### Bar in A.R.

The possibility of having a bar in the A.R. has been thoroughly investigated from all points of view, and found on many counts to be impracticable.

#### Chess Set.

In response to a request in the "Suggestions Book," a chess set has now been acquired for use in the A.R. Its conditions of use are set out in notices posted in the C.R. and A.R.

#### Newspapers and Periodicals.

The question of newspapers and periodicals is being looked into by a sub-committee with a view to discussing the journals purchased, their numbers, and whether or not the women shall have a separate supply to their own C.R.s, and additional magazines.

Lines inspired by the fiddler playing in a Chelsea Pub,  
or

### WHITMANIA

By M. HALLIDAY EVANS.

I rejoice in the manly sweep of your arm, my friend, my comrade, my new-found bosom companion.

My analytical eye discerns the play of muscle fibres beneath your coat sleeve.  
I strip away your coat sleeve with my analytical eye and lay bare your shoulder  
That I may more perfectly feast my eyes on—what? A pimple?  
A subcutaneous eruption marring the perfect, wholesome virility of your shoulder?  
I hasten to replace your coat sleeve.

The pimple,  
Gives rise to a slight but perceptibly disconcerting feeling  
Of intestinal discomfort. In a word,  
I feel a bit sick.

I will concentrate instead on watching your supple, pregnant bow.  
I follow its movements as it glides swiftly over the E string.  
I follow its movements as it glides swiftly over the A string.  
I follow its movements as it glides swiftly over the D string.  
I follow its movements as it glides swiftly over the G string.  
There are only four strings on a violin.

I watch the rise and the fall: the to and the fro: the ascent and the dip,  
and I find

The strong rhythm of life in its movement.

I consider it symbolic  
that the gut of a cat stroked by the hair of a horse  
Should produce such bold clear tones. At least,  
The others may not be aware, I  
Am aware of the boldness and clearness inherent in  
The God-forsaken squeak you make, you drunken wretch, you!  
Not that I reprove your heady carousal.  
I feel a bit whistled myself.

I lose myself in the sweep of your bow. You are not aware of the fact, but I  
Am your bow. It is me whom you drag over the strings.  
Over the E string.

Over the—but I observe that a fellow Bart.'s Man has severed your A string with the  
neck of a bottle. However

I feel the remaining strings pulsate in turn beneath me.  
I am sensitive to every compression and rarefaction.  
Faster and faster sweep me over the strings!

I exult in the motion, in the—STOP!  
My nose is caught beneath the D string and the G string!  
Oh my nose! My aquiline, dominant, assertive, most masculine feature  
Caught between two chords of quivering cat-gut!  
The shame of it! What will my nine stout comrades think?  
Nine glistening bodies rhythmically moving as the sea breathes.  
Nine noses, superb, entire. Eighteen nostrils  
(I am confident of my arithmetic)

Intact,  
And I, the tenth, come noseless.  
Yet I rejoice, giving my nose gladly that my music may kindle the hearts  
Of broad-shouldered, red-blooded, long-drinking, hard-swearing, hot-loving Men  
Whose solemn task on earth it is to arrange  
Displays of afferent branchials in sordid Bio. Labs.

Yes, let them hear the music sprung from me!  
(Their girl friends, too, may listen if they like)  
Me vibrant; me presto agitato; me molto vivace; me treble fortissimo ad nauseam.

### BOOK REVIEWS

**STAMMERING. ITS NATURE, CAUSE AND TREATMENT**, by Kate Emil-Behnke. 1947. pp. 97. William and Norgate. Price 6s.

In this slim volume the author deals with a vast and controversial subject. The nature of stammering, she states, is a disturbance of breathing. Surely that is a manifestation, and not the essence of the disorder? Its cause is "a shock to the sympathetic nervous system." But if one regards stammering as neurogenic, it is hardly justifiable to leave the cranial nerves and the brain out of the picture. Treatment consists in "re-education of the muscles used in speech in conjunction with treatment of the nervous factors." The primary emotional factors, as well as the secondary emotional symptoms are recognised by the author, but an elaborate programme of breathing exercises, lip and tongue exercises and voice training looms large. It cannot be doubted that Miss Behnke has been successful with stammerers, but this must be attributed to a strong personality *en rapport* with those who turned to her for aid, rather than to her theories and the Behnke Method of respiratory and muscular re-education. On p. 72 she reiterates that "the muscles of breathing are involuntary," yet on p. 77 she urges the stammerer to "bring his diaphragm to a high pitch of control"! To the expert this book offers nothing new; the less well informed may find it misleading; the stammerer who turns to it for a guide to self-cure is likely to be disappointed.

**CLINICAL ENDOCRINOLOGY**, by L. Martin and M. Hynes. J. & A. Churchill Ltd., London, 1948, pp. 222. Price 15s.

This is an admirable book, written from the standpoint of the general physician rather than that of the experimental physiologist. It gives a balanced account of the biochemistry and known function of the endocrine glands, together with the disease states associated with their dysfunction (diabetes mellitus excluded); it deals very adequately with treatment and includes useful bibliographies after each section.

The paper, printing and photographs are excellent, but the X-rays should in future editions be reproduced as negatives. Occasional mistakes have escaped correction such as "administration of desoxycorticosterone . . . increases the serum potassium." (p. 120).

This book will prove of great value to the general practitioner and the more seriously minded student.

A. D. M-F.

**AIDS TO MALE GENITO URINARY NURSING**, by John Sayers. 1st Edition, 1948. pp. xii + 130. Baillière Tindall & Cox. Price 5s.

Truly an aid to the understanding of this special branch of nursing, this book gives much information which is difficult to obtain elsewhere. It is to be particularly recommended for its illustrations, especially those of apparatus.

**MEDICINE AND SCIENCE IN POSTAGE STAMPS** by W. J. Bishop and N. M. Matheson. Harvey and Blythe Ltd., pp. 82. 32 pages of illustrations. Price 7s. 6d.

This book would appear to be the first to cover the whole subject of medical philately, although many articles have appeared in the journals in the past covering certain aspects of it. For the subject is far more extensive than one might at first imagine, it may conveniently be subdivided into four main sections. Firstly, portraits of medical men, not only those commemorated for their contributions to medicine such as Robert Koch, but also those men who have achieved fame in other spheres like Georges Clemenceau and Anton Tchekhov. Secondly, views of hospitals and other scientific institutions. Thirdly, stamps issued in connection with Red Cross, tuberculosis, maternity and child welfare funds. And lastly, a miscellaneous group including medical symbolism. Thus the subject is obviously wide in its scope and it allows for considerable personal choice as to who is and who is not connected with medicine, and it requires much research into the lives of other famous men depicted on stamps to discover those whom the late Lord Moyrihan so aptly described as "runts from medicine." Mr. Bishop and Dr. Matheson have compiled a veritable *vade mecum* upon this subject, including a first class section of illustrations and a catalogue of the stamps that they would include in a collection of the philately of medicine.

M. J. C-W.

**DISEASES OF THE NOSE AND THROAT** by St. Clair Thomson and Negus. Cassell & Co. Ltd., London, 1948, pp. xix + 1,004. Price 70/-.

All otolaryngologists will welcome the new edition of "Diseases of the Nose and Throat" by St. Clair Thomson and Negus. For many years this work has been firmly established as the classical textbook and work of reference for practising laryngologists and rhinologists throughout the English-speaking world. With the death of St. Clair Thomson in 1943, the task of bringing this book fully up to date has been worthily undertaken by his collaborator and colleague at King's College Hospital, V. E. Negus. Owing to the long interval that has elapsed since the previous edition, extensive revision had become necessary. The new material of the intervening years has been carefully sifted, and valuable additions have been made, particularly on such subjects as treatment with chemo-therapy and antibiotics, nasal allergy, sinusitis in children and infections of the parapharyngeal space, to mention only some of the new subjects incorporated. By carefully pruning some of the chapters which have less importance to the modern laryngologist, such as the sections on syphilis and atrophic rhinitis, the book has remained substantially the same in size. A number of older illustrations, which had outlived their value, have been discarded and new

ones substituted. The high literary standard set by St. Clair Thomson has been fully maintained and the work remains a masterly presentation of the diseases of the nose and throat. The publishers are to be congratulated on the excellence of the production, which fully compares with their pre-war standards. This book will once again achieve world-wide popularity as the most authoritative textbook of laryngology and otology in the English language.

J. C. H.

**BROMPTON HOSPITAL REPORTS—Vol. XVI**  
—1947, pp. 248. Price 10s.

This volume, as usual, contains articles published recently by members of the staff in other Journals.

It contains the last article written by the late Tudor Edwards, which deals with constrictive pericarditis and includes a study of twenty cases.

Oswald Tubbs contributes an article upon superior vena caval obstruction. Three cases are described, demonstrating the remarkably slight radiological changes in cases of this type.

There is a long article by N. R. Barrett upon the treatment of pulmonary hydatid disease and an interesting description of broncho-pulmonary abnormalities by A. F. Foster Carter.

Details of breathing exercises, which have been developed at the hospital over the past twenty years, are set out in full for the first time in a report from the Physiotherapy Department.

W. O.

**AIDS TO PRACTICAL NURSING**, by Marjorie Houghton. Baillière, Tindall & Cox. pp. viii + 364. Price 5s.

This book is too well known to student nurses to need description, and this new edition has only minor changes. When the next edition is planned, this statement on page 336 should surely be removed:—" . . . many of the patients requiring lifting are already sitting up in bed with the knees flexed over a bolster."

**MODERN METHODS OF MENTAL TREATMENT**. A Guide for Nurses by J. W. Fisher, M.R.C.S., L.R.C.P., D.P.H., D.P.M. Staples Press. Price 6s.

The author gives the mental nurse instruction in all branches of therapy she is likely to meet, and some she is unlikely to need, such as the way to "soften up" subjects for mass hypnotism. He says in his opening chapter on sedation, "You want above all peace and quietness in a mental hospital." The "you" refers presumably to the staff and not the patients. The account of leucotomy is a sensible one.

**AIDS TO BIOLOGY**, by K. G. Neill. 2nd Edition. 1948, pp. viii + 279. Baillière, Tindall & Cox. Price 6s.

This useful primer in biology does not strictly deal with the first M.B. Syllabus, but emphasises rather the principles of biology and the fundamentals of physiology. For this reason it is useful as a foundation for more detailed examination work.

**AIDS TO ORGANIC CHEMISTRY**, by Stanley F. Smith. Third Edition, 1948, pp. viii + 127. Baillière, Tindall & Cox. Price 4s. 6d.

Whilst by no means a complete text book, this member of the Aids Series presents in concise and simple form all the organic chemistry which is required for an understanding of biochemistry.

**AN INTRODUCTION TO SURGERY**, by Rutherford Morison and C. F. M. Saint. 4th Edition, 1948. John Wright & Sons, Bristol. pp. 243. Price 42s.

Rutherford Morison is dead, but a number of his famous aphorisms still gleam in the fourth edition of his book, which has been prepared by Professor Saint. The aim of the book is to impart the general principals of surgery. These are stated clearly enough, and exemplified variously. Some of the methods of treatment advocated sound archaic; the photographic illustrations are melodramatic; there are 16 diagrams of the omentum acting the "abdominal policeman," and 9 of spontaneous cure of cholelithiasis.

The book is well made, and expensive.

**THE MODERN MANAGEMENT OF GASTRIC AND DUODENAL ULCER**. Edited by F. Croxton Deller, M.D., M.R.C.P. E. & S. Livingstone Ltd. Price 20s.

The management of patients with peptic ulceration now involves so many separate departments that this intelligent and comprehensive review of the subject is welcome.

This monograph contains sections on pathology, dietetics, medicine, radiology and anaesthesia. It is a practical guide to treatment and stresses the need for co-operation between the various departments.

There is a section on vagotomy which is up to date and sensible, and the whole book is clearly written and easily read.

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**ST. BARTHOLOMEW'S FAIR**

By CON MOLLOY.

In the early autumn of this year, the Bartholomew Fair is to be revived by the Students' Union and for two days the Charterhouse grounds will be given over to fun and merriment.

The purpose of this note is to give a brief resumé of the history of the Bartholomew Fair and to encourage people to make suggestions of things to be done in the Fair now being planned.

The Fair was founded by Rahere and was from the very first connected with the Church. In the Charter of 1133 the privileges and possessions of the Priory were confirmed by Henry I:—"I grant also my firm peace to all persons coming to and returning from the Fair which is wont to be celebrated in that place at the Feast of St. Bartholomew . . ." The royal servants were also forbidden to "implead" or to exact dues upon those going to or from the Fair.

At first the Fair was a gathering of pilgrims and worshippers who came to see miracles performed upon St. Bartholomew's Day. Later there developed two Fairs. One was held inside Priory's bounds, and consisted chiefly of the "booths and standings of the Clothiers of all England and the Drapers of London." Leather, pewter and live cattle were also sold. The outer Fair was possibly composed of the mere pleasure givers and pleasure

seekers who attended on the company of worshippers and traders then attracted to the Fair.

In the first centuries of its existence the Bartholomew Fair was one of the great annual markets of the nation and the chief Cloth Fair of England.

As the Fair prospered, the emphasis upon the pursuit of pleasure became more marked. Later the Priory ceased to hold any interest in it and over the years trading became much diminished. By the seventeenth century the Fair had degenerated into what was little more than a riot of amusement.

In 1827, the Corporation of London, which had for many years been disturbed by the vice and dissolution brought into the City by the Fair, bought up the rights and, in 1855 completely suppressed it.

In the Octo-centenary celebrations of the Hospital in 1923, the Fair was revived as a spectacle, and in 1939 the last Bartholomew Fair was held in the Hospital Square to raise funds for the Hospital.

Much interesting information may be had from the "Memoirs of Bartholomew Fair," by Henry Morley (in the Library) and in Ben Jonson's "Bartholomew Fair," a vivid description of the entertainment, intentional and accidental, of the early seventeenth century Fair is given.

**EXAMINATION RESULTS**

**UNIVERSITY OF OXFORD**

**2nd B.M. EXAMINATION**

**Medicine, Surgery and Midwifery.**  
Glossop, M. W.

Michaelmas Term, 1948

**UNIVERSITY OF LONDON**

**M.D. EXAMINATION**

**Branch I (Medicine)**  
Borrelli, V. M.

Garrod, O. Jordan, J. W.  
**Special First Examination for Medical Degrees**

December, 1948.

Adam, R. M. Carrick, D. J. E. L. Cuthbert, R.  
Baker, A. S. Clarke, D. J. A. Fieldus, P. L.  
Brazenor, E. L. F. Cochrane, J. G. Hellings-Evans,  
B. McC.

December, 1948.  
Rimmer, A. H. M.  
Roberts, T. M. F.  
Wilson, D. M.

The following External Candidates have completed exemption from  
Andrewes, D. A. Fisher, F. M. Hill, E. J.  
Dunger, G. T. Gorsky, A. J. Jones, B. S.

First Medical:  
King, P. A. H.  
Shaw, D. M.

The following Higher School Candidates have qualified for exemption from  
Davies, M. B. France, G. Matheson, P.  
Fletcher, L. O. A. Keet, S. J.

from First Medical  
Southgate, B. A.

**CONJOINT BOARD**

**FINAL EXAMINATION**

**Pathology**

Batt, B. J. Facer, J. L. Jowett, J. H. G.  
Bennett, J. F. Farrar, E. B. Morris, V. C.  
Crook, R. A. Griffiths, A. W. Morley, D. F.  
Dawson, W. G. Jackson, P. G. Rees, J. D.

Jowett, J. H. G.  
Morris, V. C.  
Morley, D. F.  
Rees, J. D.

**January, 1949**

Simpson, E. A. D. W.  
Smyly, D. P.  
Wallis, F. P.

**Medicine**

Bennett, J. F. Jenkins, A. V. Millard, J. L.  
Goodrich, P. M. Mellotte, G. H. C. Reiss, B. B.

Jenkins, A. V.  
Mellotte, G. H. C.

Millard, J. L.  
Reiss, B. B.

Shattock, F. M.  
Stanley, H. W.

**Surgery**

Charles, D. Dawson, W. G. Graham-Stewart  
Clifford, W. E. Evans, C. M. W. Orr Hughes, K.  
Coombs, G. A. Freier, S. J. C.

Dawson, W. G.  
Evans, C. M. W.  
Freier, S. J. C.

Graham-Stewart  
Orr Hughes, K.

Struthers, R. A.  
Taylor, G. R.

**Midwifery**

Abraham, R. J. D.  
Badoo, M. A.  
Baker, A. M.  
Carter, F. G. T.  
Coombs, G. A.  
Davies, W. B.  
Davies, W. H. G.

Dickerson, R. P. G.  
Eve, J. R.  
Facer, J. L.  
Farrar, E. B.  
Griffiths, J. D.  
Hacking, S.  
Jones, N.

Latham, J. W.  
Mason-Walshaw,  
K. R.  
Menon, J. A.  
Milligan, J. L.  
Montfort, F. G.  
Raines, R. J. H.

Reiss, B. B.  
Rohan, R. F.  
Simpson, E. A. D. W.  
Thomas, D. H. C.  
Thomas, W. C. T.  
Widdicombe, J. G.

The following students have completed the examination for the Diplomas **M.R.C.S., L.R.C.P.:**  
Bennett, J. F. Graham-Stewart, J. C. Millard, J. L. Stanley, H. W.  
Clifford, W. E. Orr-Hughes, K. Taylor, C. B.  
Coombs, G. A. Jenkins, A. V. Shattock, F. M.

**ROYAL COLLEGE OF SURGEONS**

Subject to the approval of the Council of the R.C.S. at a meeting held on December 9th, 1948, the following are entitled to the Diploma of Fellow:—

Ahluwalia, P.  
Andrew, J.  
Campbell, D. H.  
Clarke, E. P.  
Cohen, L. B.

Courtice, B. H.  
Davies, J. A. L.  
Grant, R. N.  
Gregory, T. S. S.  
Hadfield, G. J.

**R.C.P AND R.C.S**

Diploma of Tropical Medicine and Hygiene  
Harold, J. T.

August, 1948

**SOCIETY OF APOTHECARIES****FINAL EXAMINATION**

November, 1948

**Surgery**

Dibb, F. R. F.

**Midwifery**

Whittall, J. D.

The following Candidate, having completed the Final Examination, is granted the Diploma of the Society:—

Whittall, J. D.

**RECENT PAPERS BY BART'S MEN**

ANDREWES, C. H. The natural history of the common cold. *Lancet*, Jan. 8, 1949, pp. 71-5.  
— Prophylaxis of virus infections. *Brit. Med. J.*, Dec. 11, 1948, pp. 1007-9.

BETT, W. R. A chapter of scientific progress. *Med. Bookman and Hist.*, 2, Oct.-Nov., 1948, pp. 399-401.

— Sir Robert William Philip (1857-1939). *NAPT Bull.*, 11, Dec., 1948, p. 185.

\*CAVE, A. J. E. Intra-aveolar foreign body in an orang. *Brit. Dent. J.*, 85, Nov. 19, 1948, p. 234.

COHEN, E. LIPMAN. Cryotherapy for rosacea. *Post-Grad Med. J.*, 24, Dec., 1948, pp. 656-9.

\*CURETON, R. J. R. Squamous cell carcinoma occurring in asbestosis of the lung. *Brit. J. Cancer*, 2, Sept., 1948, pp. 249-53.

\*DALE, Sir HENRY. Physiological basis of neuromuscular disorders. *Brit. Med. J.*, Nov. 20, 1948, pp. 289-92.

\*DALRYMPLE-CHAMPNEYS, Sir WELDON. A study of the epidemiological aspects of undulant fever in this country. *Public Health*, 62, Sept., 1948.

\*DESMARIS, M. H. L., and others. Muscle histology in rheumatic and control cases: a study of one hundred and nineteen biopsy specimens. *Ann. Rheum. Dis.*, 7, Sept., 1948, pp. 132-41.

DISCOMBE, G. The quantitative description of the fragility of the erythrocyte, and its application to the study of acholuric jaundice. *J. Path and Bact.*, 60, April, 1948, pp. 315-22.

FIELD, E. J. (and J. B. BRIERLEY). The lymphatic drainage of the spinal nerve roots in the rabbit. *J. Anat.*, 82, Oct., 1948, pp. 198-206.

\*FINZI, N. S. Million-volt x-ray research at St. Bartholomew's Hospital. *Proc. Roy. Soc. Med.*, 41, Oct., 1948, pp. 719-20.

\*FLETCHER, C. M. Instructions for the patient with dyspepsia. *Practitioner*, 162, Jan., 1949, pp. 51-60.

GARROD, L. P. See Scowen, E. F., and —

\*GIBB, W. E. Paracentesis in pyopericardium. *Lancet*, Dec. 4, 1948, pp. 891-2.

GREEN, B. See McKenna, R. M. B., and —

\*HARRIDGE, H., (and L. C. THOMPSON). A method of investigating eye movements. *J. Physiol.*, 107, Sept., 1948, p. 25P.

\*HORDER, Lord. The vocation of medicine. *Lancet*, Nov. 6, 1948, pp. 715-7.

\*INNES, G. S. The million-volt x-ray plant: its development and application. *Proc. Roy. Soc. Med.*, 41, Oct., 1948, pp. 691-703.

JACKSON, C. A. Amethocaine hydrochloride. *Brit. Med. J.*, Jan. 15, 1949, pp. 99-101.

\*JEWESBURY, E. C. O. Principles of electroencephalography. *St. Thom. Hosp. Gaz.*, 46, Dec., 1948, pp. 194-203.

\*JONES, ARTHUR. Clinical reactions and injuries in supervoltage therapy. *Proc. Roy. Soc. Med.*, 41, Oct., 1948, pp. 703-9.

JONES, F. AVERY, (R. DOLL and —). Environmental factors in the etiology of peptic ulcer. *Practitioner*, 162, Jan., 1949, pp. 44-50.

\*JONES, P. F., and SHOOTER, R. A. Procaine penicillin: effect of single daily injections. *Brit. Med. J.*, Nov. 27, 1948, pp. 933-4.

KENNAWAY, Sir ERNEST L. The racial and social incidence of cancer of the uterus. *Brit. J. Cancer*, 2, Sept., 1948, pp. 177-212.

KERSLEY, G. D. See Desmarais, M. H. L., and others.

KINMONTH, J. B. Thrombo-angitis obliterans. *Lancet*, Nov. 6, 1948, pp. 717-9.

MCKENNA, R. M. B., and GREEN, B. ?Pityriasis rubra pilaris. ?Darier's Disease. *Brit. J. Derm and Syph.*, 60, Oct., 1948, pp. 338-41.

\*MAINGOT, RODNEY. Surgery of peptic ulcer. *Ann. Roy. Coll. Surg. Eng.*, 3, Nov., 1948, pp. 248-65.

\*O'CONNELL, JOHN E. A. The causative lesion in sciatica: its diagnosis and modern treatment. *Med. Press*, Dec. 22, 1948, pp. 531-4.

OLDFIELD, JOSIAH. Science and the Bible. I-III. *Med. World*, 69, Oct. 8-15, 1948, pp. 207-8, 239-42, 272-3.

\*PHILPS, SEYMOUR. Scleral resection in the treatment of retinal detachment. *Brit. J. Ophth.*, 32, Nov., 1948, pp. 811-8.

\*ROCHE, A. E. Increased frequency of micturition. *Med. Press*, 220, Oct. 13, 1948, pp. 298-300.

\*SCOWEN, E. F. and GARROD, L. P. The streptomycin-sulphadiazine treatment of undulant fever. *Brit. Med. J.*, Dec. 25, 1948, pp. 1099-1101.

SHOOTER, R. A. See Jones, P. F. and —.

\*WALKER, A. J. Caecal faecolith. *Brit. J. Surg.*, 36, July, 1948, pp. 55-8.

\*WILLIAMS, I. G. Million-volt x-ray therapy. *Proc. Roy. Soc. Med.*, 41, Oct., 1948, pp. 709-19.

WORMALL, A. Contributions of chemistry to the problems of immunology. *Brit. Med. Bull.*, 5, iv-v, 1948, pp. 333-7.

\*Reprint received and herewith acknowledged. Please address this material to the Librarian.

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tryptophane	0.3%	1.0%
phenylalanine	0.9%	2.9%
cystine	0.3%	1.0%
methionine	0.5%	1.6%
threonine	1.2%	4.0%
leucine	2.1%	7.0%
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"ON LANGUAGES"

EVER since the curse of God fell upon the tower of Babel, converting its aspiring builders into an unintelligible rabble, the lack of a universal tongue has nullified the efforts of man to achieve a stable world—for understanding is the first demand of friendship. In the middle ages this diversity of speech was of little consequence, for then the scholar, always in a great minority, did in fact possess a medium of common exchange in the form of Latin, however adulterated it may have been, whereby he could exchange his views and knowledge in the certainty of being understood by his contemporaries in other lands. For the mass of the people, however, who existed in small and closed communities the need for such intercourse did not arise since they placed no reliance upon, nor indeed saw the need of, co-operation between such communities. Such a limited state of affairs, however, could not last and with the growth of civilisation as we know it today, the inevitable demand for closer co-operation has brought with it an ever more insistent demand for understanding. This demand, however, has not been answered; the continually widening scope of society has carried in its wake intolerance and confusion, the barrier of language has always proved too great for our ineffectual strivings.

In the muddle which constitutes international relations of today the need for exchange of ideals and principles is of paramount importance, and this is true also in every branch of learning and knowledge. The lack of international exchange which exists in the medical world today is due not to any desire of medical society to remain isolated from contemporary thought in other parts of the world, but rather to the

inability of its members either to read or write in any tongue but their own. The advantage which the scholar of the Middle Ages possessed in having at his disposal a language in which he could express his feeling to his fellows of similar status is lost to us. True it is that to some extent the nomenclature of the various sciences is based upon a common principle, but this does little to relieve the gloom which hides not only the knowledge and dissemination of contemporary medicine, but also the very customs and philosophies of one people from another. In the past history of education, Latin or Greek were, because of their universal application, a *sine qua non* in the curriculum of school and university. Unfortunately the complexity of our present society, and the diversity of its demands upon us, have left but little time for acquiring or receiving any similar course of instruction; it is being increasingly left to the individual industry of the pupil, a factor of naturally small proportions in a schoolboy, to acquire a working knowledge of any language but his own and even this, in many schools, is taught with but doubtful competence.

It is a fact that only after leaving school does one begin to appreciate how important is education and how great were the chances missed; but by then the average individual is in no position to return to his studies in order to fill the gaps in his knowledge. An article recently published in the B.M.J. entitled '*Languages in the services of Modern Medicine*,' quotes a passage mentioned by Lock in his '*Some thoughts concerning Education*.' "One can scarce burden children too much with the knowledge of Languages," it reads, and a little further on,

"They are useful to men of all conditions." It continues to impress upon the reader that the only time to teach such a subject is during youth, when "... those on whom the child depends have Authority enough to keep him close to a long continued Application." On reflection, therefore, it is indeed depressing that with necessity of languages in the dissemination of knowledge, so little attention is paid to the teaching and learning of these subjects in the medical schools of this country. True enough the medical student is more than overburdened by the quantity of knowledge which he is expected to possess on qualifying, but at the same time there must exist some scope for the teaching of languages in such establishments. The value of French and German both as keys to medical literature and as aid to the study of other languages is emphasised by the article mentioned earlier. It is true that in this respect the overwhelming predominance of English as a language throughout the world does, to some extent, supply the want of a common tongue. This, however, is but a one way service, for as a result of the well-known inability of the English speaking nations to learn any language but their own, such literature as is published in a foreign tongue remains virtually a closed book unless an intermediate can be found to act as interpreter. In itself the need for such a provision constitutes a considerable obstacle, for such information is by definition second hand and thereby depends upon the ability and discretion of the interpreter—an unsatisfactory, though unavoidable, condition.

The author of the article, in making a careful analysis of foreign journals which are available to the reader in the Manchester

Medical Library, shows that no Journals in German, Spanish or Portuguese are indexed though certainly the latter two possess today a flourishing medical literature; our own library lists none. This sparsity of foreign literature is due not to inadequate library policies but rather to the woefully small demand created by the users of such libraries; a sad reflection on the linguistic accomplishments of the medical community. In America the pre-clinical training of a student includes, in the curriculum, the compulsory study of at least two languages. This, however, is not to advocate the adoption of a similar regime in this country where the pre-medical training period should supply the need in this direction but it does show that the American medical schools do appreciate the important place which such a study holds in the world-wide spread of medical knowledge.

Before the war voluntary German classes were held in this hospital for any student who wished to attend and occasionally lectures were given on the same subject. The resumption of such a practice cannot be too strongly advocated.

It has been suggested that the Brackenbury Scholarship should include a paper in either French or German, and in the opinion of this Journal such a step should be taken, with the provision, however, that such a paper should be of a voluntary nature though at the same time bearing weight with the examiner in the final result. The Brackenbury Scholar is eminently one on whom the future of Medicine might be expected to depend; surely then it is not unreasonable to ask that he should be able to maintain himself with his contemporaries overseas?

#### ABERNETHIAN SOCIETY

April 28th—Professor A. C. Frazer, M.D., D.Sc., M.R.C.P. "Problems of normal and abnormal fat absorption in man."

#### ELEVENTH DECENNIAL CLUB

The next meeting of the Eleventh Decennial Club will be held at Frascati's Restaurant, Oxford Street, on Friday, May 6th, at 7.0 for 7.30 p.m. Dr. E. B. Brooke will be in the Chair. Details can be obtained from the Hon. Secretary, Wilfred Shaw, 109, Harley Street, W.1.

## HEAT STROKE IN IRAK

By W. V. CRUDEN, M.B., B.S.

THERE was more than one problem that faced Adam and Eve in the Garden of Eden. For they were living, according to tradition, in one of the hottest spots in the world—Southern Mesopotamia—where the tent temperature sometimes reaches 135° F. and where the problem of the regulation of body heat is at its acutest.

Ever since the Mongol invasion the country has been a huge expanse of brown mud—dry and hot in the summer, paralytically sticky and squelchy in the winter rains. "Mespot" has indeed been aptly described by a British Tommy as "miles and miles and miles of d... all"! It is in this country that Heat Exhaustion and Heat Stroke are a perpetual menace.

In earlier days, before the country became a desert, the heat may not have been as intense as it is now, but there is plenty of evidence to show that even then it was a very hot spot, and "the shadow of a great rock in a weary land" symbolises the immense value placed upon any shelter from the sun's rays. The native Iraqi of to-day knows the sun for what it is—man's greatest enemy, and he realises that a drink of water can be the most precious experience of the day. He occupies the heated mid-day hours with the siesta—that cessation of work and period of repose which the British soldier nicknamed "Egyptian P.T." If he has to move he ambles about slowly, keeping instinctively in the shade whenever possible. It is probable, too, that his flowing robes have some effect in diminishing the danger of excessive heat.

The European, on the other hand, has not this age-long knowledge of tropical heat and cannot easily adapt himself to it. "Mad dogs and Englishmen lie out in the mid-day sun." British troops in two world wars learnt at heavy cost of the dangers of the climate. The summer of 1917 was exceptionally hot and there were some 9,000 heat casualties in our troops. In the last war there were fewer cases because the danger was better known and understood, but even so there were many deaths and much suffering especially amongst unacclimatised troops.

One cannot better describe the terrific despotism of the sun in these lands than by quoting a few sentences from Doughty's "Arabia Deserta."

"... The summer's night at end, the sun stands up as a crown of hostile flames from that huge covert of inhospitable bergs; the desert day dawns not little and little, but it is noontide in an hour. The sun, entering as a tyrant upon the waste landscape, darts upon us a torment of fiery beams, not to be remitted till the far-off evening. No matins here of birds; not a rock partridge-cock, calling with blithesome chuckle over the extreme waterless desolation. Grave is that giddy heat upon the crown of the head; the ears tingle with a flickering shrillness, a subtle crepitation it seems, in the glassiness of this sun-stricken nature: the hot sand-blink is in the eyes, and there is little refreshment to find in the tents' shelter; the worsted booths leak to this fiery rain of sunny light... This silent air burning about us, we endure breathless till the asr (mid-afternoon) when the dazing Arabs in the tents revive after their heavy hours. The lingering day draws down to the sun-setting; the herdsmen, weary of the sun, come again with the cattle, to taste in their menzils the first sweetness of mirth and repose. The day is done, and there rises the nightly freshness of this purest mountain air: and then to the cheerful song and the cup at the common fire. The moon rises ruddy from that solemn obscurity of jebel like a mighty beacon: and the morrow will be as this day, days deadly drowned in the sun of the summer wilderness."

No wonder, indeed, that Hell is hot to the Semite!

How is the body temperature regulated in these tropical conditions? How is it kept down to 98° F. when the air around is 135° F.? Let us examine the normal mechanism of control, which is perhaps directed by a thermostatic centre in the hypothalamus. Temperature regulation is a balance between heat production on the one hand, and heat loss on the other, and we must consider each of these factors in turn.

First, as regards heat production, heat is necessarily produced in the body as the result of every basal metabolic process. The slightest activity raises the metabolism and therefore the body heat—such a simple act as moving about a room will raise metabolism 20%; eating raises it another 10%; moderate work raises it still more, whilst violent exercise may increase metabolism 16 times above its basal rate. Over activity of thyroid and adrenal glands increases metabolism; this effect is also produced by febrile illnesses—for instance Pneumonia with a body T 105° F. causes no less than a 50% rise in body metabolism; and this of course will, like a vicious circle, tend still further to raise the body temperature. Thus the body, like an internal combustion engine, is itself

perpetually generating a varying amount of heat. This is clearly a good thing in cold climates where our problem is that of keeping the body sufficiently warm. But when the outside air is extremely hot, as it is in Iraq, this internally generated body heat is greatly increased by the hot external air which surrounds it like a Turkish bath, and the combined effects of internal and external heat produce the danger of the person being cooked, alive—or dead. In such circumstances the problem of controlling the body temperature is literally a matter of life and death. How is such a miracle accomplished?

In order to understand this we have to study the second factor in temperature control, namely heat loss. In temperate climates this occurs through conduction, convection, radiation and evaporation, but when the outside air temperature is higher than the body temperature, the first three of these—conduction, convection and radiation—are abolished . . . and indeed they are reversed. So that the sole means left to bring about heat loss is evaporation, and a man's life indeed depends upon his sweat glands.

The balance of heat production and heat loss, as we said, is all important. Heat makes a man tired. He therefore works less. It dulls his appetite and he therefore eats less . . . and both these effects lower his metabolism and therefore his heat production. On the other hand the atmosphere stimulates the temperature sense organs in the skin, the skin vascularity is reflexly increased and the sweat glands are urged to greater activity. The insensible sweat is reinforced by sensible sweat, and how "sensible" that sweat is, only those who have lived in a perpetual and all enveloping bath of perspiration, can know. The effect, of course, of this severe sweating with its loss of water and salt, is to make one extremely thirsty. Moreover, the loss of fluid produces a marked concentration and scantiness of urine (with the consequent dangers of crystaluria and calculus formation) and the stools become hard, dry and constipated. Finally the loss of salt, which tends to form a thin crust over the skin and which can sometimes be seen with the naked eye and easily tasted by licking oneself, tends, to produce cramps. (I wonder whether this phenomenon had anything to do with the fate of Lot's wife?)

With all these factors at work it is obvious that there may be many causes for the break-

down of the body's heat regulation mechanism. In a hot climate any form of excessive heat production by the body, be it overwork, overeating, alcoholism or hyperthyroidism will tend to upset the body's equilibrium. Particularly is this the case with febrile infections which are so rife in these parts—(malaria, dysentery and sandfly fever, for instance). Obviously fatigue, starvation and unnecessary exposure to the sun are dangerous. On the other hand, heat loss by evaporation may be upset by many factors; humid atmospheres, tight clothing, or the covering of large areas of the body with bandages or ointments, will obviously interfere with its function. If the sweat glands are defective from congenital anhidrosis, atropine paralysis or extensive skin disease, (such as an acute exfoliative dermatitis) body temperature cannot be controlled and heat stroke is likely. We may, in these cases, attempt to replace the deficient sweat by covering the body with water or wet clothes and allowing this substitute for sweat to evaporate and cool the skin, but we must, of course, perpetually renew our water covering for anything but the most transient relief. Finally this tremendous loss of body fluid, unless replaced by copious drinks of saline water, leads to the dangers of dehydration, haemoconcentration, altered body chemistry and cramps. In such climates 8 pints daily is the minimum intake and as much as 20 pints may be necessary for comfort.

These notes are based on experiences in Iraq in the summer of 1942 and attendance at a Heat Stroke course in Baghdad in 1943. I was stationed near Basrah in the summer of 1942 and during July, August and September, when PAIFORCE was being built up, troopships packed with men were steaming up the sultry Persian Gulf and disembarking hosts of troops in this strategic port. Naturally there were many heat casualties from these ships. Non-acclimatisation, overcrowding and sea-sickness in the Persian Gulf—which is one of the hottest waterways in the world—all played their part. Here is a typical story . . . During the voyage to Iraq there was much seasickness in a monsoon. The cooks also were sick and there was a disorganisation of feeding arrangements and no extra salt issue. The intense heat and high humidity in the Persian Gulf had their effect. The ship docked in the evening—the men remained between decks till 4 a.m. then marched to the railway station and entrained in goods waggons. On arrival

at the Camp area they had to draw and pitch their own tents having had no food since the previous day. One unit, supposed to be self-contained, landed without cookers or rations. There were 100 cases of Effects of Heat, with 12 deaths.

There is only space to describe three distinct syndromes—*Heat Exhaustion; The Subacute Effects of Heat and Acute Heat Stroke*. Of course, mixed types and gradations of symptoms occur, but it is as well to describe the three well defined groups.

*Heat Exhaustion* is the commonest syndrome, and it is usually not serious. Its outstanding feature is circulatory failure or shock. The patient complains of weakness, headache, nausea, giddiness and staggering which may culminate in a faint. The temperature may be raised at the onset but is usually normal or subnormal. The skin is pale and clammy, the pupils dilated, the pulse weak and rapid and the blood pressure low. Urinary chlorides are reduced and cramps may occur. The patient, however, remains rational and the prognosis is good. One must distinguish the condition from algid malaria, seasickness, hypoglycaemia and even fright. Treatment is that of shock, with copious drinks, and salt is given until the urinary chlorides become normal. Even if the temperature is subnormal, the patients should remain in an artificially cooled atmosphere and be carefully watched lest they go on to the heat stage. So much, in brief, for *Heat Exhaustion*. It was a condition which commonly recurred in susceptible patients. I remember one man who had about 7 attacks and was finally evacuated out of the Country.

The second syndrome has been called *the Subacute Effects of Heat*. It is a serious illness, for the onset is insidious, and an increasing derangement of body chemistry occurs in an apyrexial stage which lasts a week (or even as long as three weeks), and it culminates, if untreated, in the final catastrophe of hyperpyrexia and death. At onset the commonest complaints are lassitude and headache. Digestive upsets occur and particularly important are the mental symptoms. These include insomnia, dullness, irritability, restlessness and a disrespectful and insubordinate attitude to those in authority. Cramps, twitching and frequency of micturition occur. An indication that all is not well with the heat regulating mechanism may be shown by a slight mid-day rise of the otherwise normal or subnormal temperature to

99° or 100°. Now at this stage rest in a cool place may abate the symptoms, but they recur on re-exposure to heat. Anyway, with or without remission, the patient's condition steadily deteriorates. Persistent vomiting and falling blood pressure are bad signs. Dehydration and haemoconcentration occur, the blood urea rises, and the scanty urine may contain albumen, casts and acetone: it is deficient in chlorides. All these are signs of gross upset of body chemistry. Finally the temperature begins to rise and the extremely dangerous Pyrexial stage is at hand. It is often ushered in by increased mental symptoms which may be maniacal in severity. The temperature shoots up rapidly to 105°, 109°, 112° and coma sets in. The picture now is truly terrible. The skin is hot, dry, gritty and inelastic; the face sunken, and the coma is often accompanied by pareses. A terminal circulatory failure and bronchopneumonia occur. As in cholera, rigor mortis is immediate. The chief findings at post mortem are widespread venous engorgement and minute haemorrhages in all organs, and oedema is marked in all cases.

This final phase of hyperpyrexia is more difficult to treat than the pyrexia of acute Heat Stroke (which has yet to be described) for it has been preceded by a long illness which has already gravely disturbed the body chemistry before the final onset of hyperpyrexia. The diagnosis, too, in all stages of the illness, is difficult, especially if the effects of heat are not uppermost in one's mind. For instance, the early mental symptoms may be mistaken for what the Army terms "b-mindedness" and the poor unfortunate finds himself incarcerated in the guard room or mental ward, or worse still punished with fatigue duties (which are surely guaranteed to produce the maximum amount of harm in the minimum amount of time). Again, during the early stages all sorts of diagnoses are possible, and whilst investigations for malaria and dysentery, for meningitis and for that well-known character the "P.U.O." are proceeding in Hospital, valuable time may be lost. Perhaps the greatest difficulties are encountered when heat effects complicate other diseases, and it not infrequently happens that the findings of malarial parasites in the blood is considered the whole story when in reality the major trouble is heat effects. It is in these later cases—Heat Effects plus acute infections—that the prognosis is at its gravest.

The third Syndrome to be described is *Acute Heat Stroke*—a sudden and dramatic failure of the heat regulating mechanism. There may perhaps be mild prodromal symptoms (like those previously described) for a day or two, and there is usually suppression of sweating, but very frequently the attack comes "out of the blue" and the patient whilst at work is smitten unconscious with hyperpyrexia. This fearful tragedy must have been in the Psalmist's mind when he wrote . . . "the sun shall not smite thee by day," and when Isaiah says "neither shall the heat nor sun smite them." There is, moreover the following pathetic little story in 2 Kings 4, which is considered by the pundits to be a description of acute heat stroke: ". . . And when the child was grown, it fell on a day that he went out to his father to the reapers. And he said unto his father, my head, my head. And he said to a lad, carry him to his mother. And when he had taken him and brought him to his mother, he sat on her knees till noon, and then died . . ."

This acute heat stroke resembles acute alcoholism. The face is congested, the eyes suffused, the pulse full and bounding, the respirations stertorous, and the patient is delirious, stuporose, or in coma. There is, however, one pathognomic sign—the skin is so hot to the touch that one instinctively removes one's hand from the patient's body. The rectal temperature registers anything up to 112° — and even 115° has been recorded before death. Recovery from a temperature of 112° has been seen twice in Iraq when treatment was immediate. Thus hyperpyrexia is obviously a first-class medical emergency. Any delay in cooling is dangerous. I well remember one tall young fellow in Basrah who was admitted with a T 110° and was comatose, or semi-comatose, for two days. He recovered eventually, but he was a pathetic sight, shuffling about the ward with the mentality of a small child. He had been "cooked" too long!

Diagnosis is easier than in the Subacute type though any severe acute fever may simulate the condition. Perhaps one should especially mention meningitis, apical pneumonia, sandfly fever, fulminating typhoid and typhus, and cerebral haemorrhage. The chief problem, of course, is *cerebral malaria*, and if in doubt the patient is treated as having both diseases, with heat stroke as the first priority. Cooling, therefore, is commenced as soon as the ther-

момeter emerges from the patient's rectum, and continues whilst the first blood smear and intravenous quinine are effected. These two conditions are uppermost in one's mind in hyperpyrexial states.

There is only space for a few final words on treatment. Obviously prophylaxis is all important, and education, especially of the unacclimatised, is necessary. The avoidance of over-exposure and overwork during the mid-day heat is important. Suitable clothing should be provided. Most important is a plentiful water supply, preferably kept cool in chaguls or Persian Hubs and with a daily salt ration. Alcohol should be reserved for the cooler evening. There should be a careful vetting of personnel, and those unsuited to the climate—the poor sweaters, the hyperthyroids and the chronically ill, should be removed to more temperate climes.

Prodromal signs of Heat Effects should be noted and severe illness can often be prevented by timely rest in a cool atmosphere. Various methods for artificially cooling the air were devised—one of the most successful being the camel-thorn cooler. In this, camel-thorn was packed very lightly in a suitable wooden frame and water was allowed to trickle over it. By placing the frame at right angles to the prevailing wind the air was cooled as it passed through the camel-thorn, and with a suitable exit for the air at the other end a temperature of 70° could be expected under favourable circumstances.

When removal to Hospital was necessary it was sometimes wiser to delay the journey till the cool of the evening, for the interior of the ambulances became like a furnace at mid-day. In 1943 in Iraq ambulances were being furnished with Cuss-Cuss-tatis (where the air passed through a stream of water before reaching the patient). But it was sometimes advisable when travelling with the wind to turn back on one's tracks and go away from the Hospital for a time to allow the breeze to blow through the Cuss-Cuss-tati and so provide intervals of cooling for the interior of the vehicle.

On reaching Hospital the cases were admitted immediately to the Cooled Heat-Stroke Centre, and hyperpyrexia was at once reduced by spraying with ice cold water, cold sponging and fanning. In the very humid atmospheres around Basrah evaporation was inoperative and immersion in an ice cold bath was sometimes necessary. Obviously

these means were drastic and required careful control by frequent rectal temperatures. Cooling was discontinued as soon as a safe level was reached . . . for instance, 109° was reduced to 104°, or 106° down to 102°. Further reduction might obviously lead to a dangerous collapse. Thereafter further cooling was reserved for any further rise of temperature. Iced enemas and antipyretic drugs should not be used. Venesection, oxygen and circulatory stimulants were often required, whilst quinine has already been mentioned. Intravenous fluids were controlled by estimation of fluid balance, and when the patient recovered consciousness iced drinks and saline were given plentifully. Convalescence often was protracted, and if the patient was not evacuated to a cooler climate it was advisable to test his tolerance to heat by exposure outside the Hospital be-

fore returning him to the rigours of the Climate.

In conclusion it is interesting to consider once more that this dangerous climate has been the environment in which civilisation started (for the primitive Indus Valley civilisation grew up in a somewhat similar heat), and that the misty figures of early Genesis, that Abraham, Nebuchadnezzar and Daniel, to say nothing of Sinbad the Sailor and Ali Baba, were all subject to the hazards of the heat, and that perhaps Alexander the Great died in Babylon because there was no Heat Stroke Centre to assuage his fever.

#### REFERENCES.

- Leonard Woolley. 1930. "The Sumerians."  
Seton Lloyd. 1942. "Ruined Cities of Iraq."  
Lipscomb, F. M. 1943. "Baghdad Lectures on Heat Stroke."  
Samson Wright. "Applied Physiology."

## "PAST HISTORY"



She found a pot of Ergot,  
And drained it to the dregs;  
A lovely case, the best I've seen—  
I cut off both her legs.

(Author unknown)

## RETIREMENT OF MISS HELEN DEY



The retirement of our Matron, Miss Helen Dey, is a matter of real regret to the staff of St. Bartholomew's Hospital.

In the first world war she joined the Q.A.I.M.N.S.R. and was one of the first to be sent to France in August, 1914. Pressure of work was heavy, hours were long, but she was always cheerful, giving encouragement to others. A natural energy and vitality sustained a mind with real heart behind it enabling her to give of her best. Her high ideals and devotion to duty were an inspiration to all her colleagues. During the war she was awarded the Royal Red Cross in recognition of her work and was mentioned three times in dispatches. Miss Dey transferred to the regular service and remained a member until 1921. During that time she held many responsible posts. Her work was of a high order and it was clear that she would make her mark and reach a high position in the Nursing profession.

In 1921 Miss Dey was in the U.S.A. working for five years at the Receiving Hospital, Detroit. There the Medical Superintendent paid her very high tribute, stating that they had never had anyone with such outstanding ability. There she was for some time Supervisor of the Out-Patient Department and later Assistant Superintendent of Nurses and was instrumental in bringing about certain improvements in the Hospital. Miss Dey was held in great respect

and affection by the many with whom she came in contact, and her charming personality made her a wonderful ambassador.

On her return to England she was appointed Assistant Matron of the General Infirmary at Leeds.

It was in March, 1927, that she took up her appointment as Matron and Superintendent of Nursing at St. Bartholomew's Hospital and it will be agreed by all that it was indeed a lucky day for "Bart's". Hers was the distinction of being the first St. Bartholomew's Nurse to be Matron since the formation of its School of Nursing, and she could not have started her responsible work at a more vital time. The State Registration Act for Nurses had only just started to function and the increasing shortage of nurses was causing much anxiety. It might be supposed that the post of Matron at a major hospital would satisfy the ambition of most—but not Miss Dey; it is true to say that she has been active in all movements which aim at maintaining a high standard of nursing wherever that skill is required.

To give briefly a complete picture of her activities is impossible. Prominent among them are her work as an elected member of the General Nursing Council, and of the Council of the Royal College of Nursing. She is also president of the Association of Hospital Matrons, a member of the Whitley Council for Nurses and Midwives and of the Advisory Committee on Sister Tutors' Courses and Diplomas of the University of London. Other activities include service on the National Advisory Committee of the Ministry of Labour and National Service, on the Advisory Nursing Board of H.M. Prisons, on the Army Nursing Board and on the National Council of Nurses. All this makes no mention of her exacting war work as Sector Matron with its problems of many hospitals in addition to her own. For her work in this capacity she was awarded the C.B.E. in the New Year Honours of 1946.

It is perhaps difficult to realize how great has been her contribution to the profession in achieving so much for the welfare of both nurses and patients. The standard of nursing and the traditions of our Hospital have never been higher in spite of all the difficulties and vicissitudes of the war. Her deep understanding of human nature and

particularly her thoughtful consideration for those in trouble have made her much beloved.

The concluding words of the list of duties of the Matron of St. Bartholomew's Hospital as laid down in 1813, are these . . .

*"always remembering that as you fulfil your duty, so will you not only become respectable but also highly esteemed."* We can end with no greater tribute of our affection and respect for her than by saying that she has indeed become "respectable and highly esteemed."

## APPOINTMENTS

Miss J. M. Loveridge has been appointed to succeed Miss Dey as Matron to the Hospital.

Dr. Gordon Ostlere has been appointed an Assistant Editor, British Medical Journal.

## THE ORDRE OF THE HOSPITAL OF ST. BARTHOLOMEW'S IN WESTSMYTHFIELDE IN LONDON

By G. C. R. MORRIS

This is the title of a book, published in 1552, which describes the organisation of the hospital soon after its second foundation. Rahere's foundation lasted from 1123 to the dissolution of the monasteries in 1545, and that of King Henry VIII from 1547 to the National Health Act of 1948; so it may be interesting to recall how the hospital has been governed for the past four centuries.

The Preface explains that in 1547 the hospital possessed only so much "household implements and stuff . . . as sufficed three or four Harlots then lying in child-bed," and the efforts of the citizens of London to restore it were greatly hindered by "the wickedness of report," which had "grown to such rankness" that it threatened both the repute and the work of the hospital — "where in the mean season notwithstanding, there have been healed of the Pocks, Fistulae, filthy Blains and Sores, to the number of eight hundred, and thence safe delivered, that other having need might enter in their room. Beside eight score and twelve that have there forsaken this life, in their intolerable miseries and griefs, which else might have died, and stunk in the eyes and noses of the City." So it seemed good to the Lord Mayor to publish this "Order of the Hospital," that all might judge the adequacy of the arrangements, and perhaps suggest improvements. If, in particular, anyone thought we had more than enough money for "an hundred sore and diseased," the author points out that we are anxious to accommodate as many as one thousand. Finally, he trusts that this account will be a good example to other "Almoysners and Houses of Almoise, known either by the name of hospital, or Savoy."

First, then, there are twelve Governors, appointed by the Lord Mayor, and renewed by the election of half their number every second year. They comprise:—

The President, who is "chief ruler and governor . . . under the Lord Mayor";

The Treasurer, who has all the treasure, rents and benefactions in his charge, and reports to the Governors on October 20 each year; his account book, with the other books and journals, is checked by four Governors acting as Auditors; and he has to present himself for questioning on November 2, when he hands over to the newly elected Treasurer;

Four Surveyors, who have "the view of all the lands and leases pertaining unto this house"; they meet every other Wednesday, and are replaced by two new ones chosen at the Feast of St. Michael;

Four Almoners, who have to come every Monday at least to see that every Officer is doing his duty. "Ye shall also diligently enquire if the Chirurgeons of this house do their duty toward the poor without corruption or partiality, and calling them before you, ye shall enquire what number there were healed that week, and the same deliver, and reward, according to your discretions." They are to admit new patients, to keep an inventory of Utensils, etc., to suggest alterations for the benefit of the poor, and "ye shall also see unto the keeping sweet of the poor, and in your proper persons visit them once every Week at the least, and to see that their service of bread, meat, and drink be truly and faithfully delivered unto them";

Two Scrutiners, whose task it is to enquire for and to record bequests and gifts—"ye shall in every place where you shall have

occasion to come in the company of good, virtuous, and wealthy men, to the uttermost of your power, commend and set forth the good order of this house, and how rightly the goods given to the poor are here bestowed, to the encouragement of other to extend their charity thereunto”;

All these are charged “to attend only upon the needful doings of this house, with such a loving and careful diligence, as shall become the faithful Ministers of God, whom ye chiefly in this vocation are appointed to serve,” and are offered a Heavenly reward for their labours, typified by the words at the end of the Treasurer's Charge:—“And in recompense of your pains, ye shall be assured of the mercies laid up for you in the promises and blood of Jesu Christ our Saviour.”

Next, there are seven kinds of Officer, “continuabile or removable, as the governors shall find cause”;

The Renter is to collect all rents and hand them to the Treasurer; and to keep four books, each with numbered pages and a Calendar in the front, namely:—a Repertory Book of the Foundation, Charters, Deeds, Leases, etc.; a Book of Survey for alterations in rents and for repairs; a Book of Accounts, for all expenditure and income, and also for a list of patients, their diseases, occupations, cures and deaths; and a Journal, for general matters and the decisions of the Governors (this is the most valuable of the extant hospital records, and has been kept from October, 1549, with only one short gap, to the present day);

The Hospitaller's office “is chiefly and most principally to visit the poor in their extremes and sicknesses, and to minister unto them the most wholesome and necessary doctrine of God's comfortable word, as well by reading and preaching as also by ministering the Sacrament of the Holy Communion at times convenient . . . also whensoever any poor person shall be here presented or sued for, to be admitted into this house, you shall receive the same presentation, calling unto you two of the Chirurgions of this house, to view and examine the disease of the said person, whether it be curable or not curable.” He also has to supervise the distribution of food to the patients, the safe keeping of their valuables, and their discharge when cured;

The Steward and Butler are to provide food as instructed by the Almoners, and attend when it is served to the poor. “Ye shall have to do in none other man's office in this house but only with your own in

manner as is above described. But, if ye shall perceive at any time, any thing done by any officer or other person of this house, that shall be unprofitable thereto, or that may be occasion of any disorder, or shall engender slander to the same: that ye then declare the thing to some one or two of the Governors of this house, and to none other person, nor farther to meddle therein.” This admonition, in much the same form, has been repeated ever since after each Officer's charge.

The Matron has to receive the sick from the Hospitaller, and bestow them in the appropriate places. She has charge of the Sisters to see that they do their duty by the poor—in making the beds, keeping the wards clean, and purifying the unclean clothes—and to ensure that they do not leave the women's ward after seven o'clock in the evening (nine in summer). The same Sister is to remain no longer with the same patient than needful cause shall require. When the Sisters are not busy they are to be set to spinning, or some other occupation that will preserve them from idleness and be profitable to the poor, the Matron receiving the flax from the Governors, and returning it, spun, to be sent to the weavers. “Also ye shall suffer no poor person of this house to sit and drink within your house at no time, neither shall ye so send them drink into their wards, that thereby drunkenness might be used and continued among them, but as much as in you shall lie, ye shall exhort them to virtue and temperance, declaring this house to be appointed for the harbour and succour of the dear members of Christ's body, and not of drunkards and unthankful persons”;

The Sisters' charge is “in all things to declare and show yourselves gentle, diligent, and obedient to the Matron of this house, who is appointed and authorised to be your chief governess and ruler. Ye shall also faithfully and charitably serve, and help the poor in all their griefs and diseases, as well by keeping them sweet and clean, as in giving them their meats and drinks, after the most honest and comfortable manner. Also ye shall use unto them good and honest talk, such as may comfort and amend them, and utterly to avoid all light, wanton, and foolish words, gestures and manners, using your selves unto them with all sobriety and discretion. And above all things see that ye avoid, abhor and detest scolding, and drunkenness, as most pestilent and filthy vicés. Ye shall not haunt or resort to any manner of person out of this house, except

ye be licensed by the Matron, neither shall ye suffer any light person to haunt or use unto you, neither any dishonest person, either man or woman, and so much as in you shall lie, ye shall avoid and shun the conversation and company of all men”;

The Porter is to keep the gate; to watch for pilfering, for men going into the women's ward, or women into the men's, and for suspicious people loitering about; to shut the wards at seven; and to punish in the stocks (at the second offence) any patient who is a swearer, or lacks reverence to God, or contemns the Matron, or refuses to go to bed;

The Beadles attend the Governors, and at other times patrol the City for “any person infected with any loathly grief or disease, which shall fortune to lie in any notable place of this City, to the annoyance and infection of the passers by, and slander of this house,” and for any discharged patients begging, or shamming disease, and for any sturdy beggar or vagabond; all these they are to warn off or lock up.

“There are also as in a kind by themselves, three Chirurgions in the wages of the Hospital, giving daily attendance upon the cures of the poor. . . Your charge is faithfully and truly to the uttermost of your knowledge and cunning, to help to cure the griefs and diseases of the poor of this Hospital, setting aside all favour, affection, gain, or lucre”; to take no gift or reward from patients or friends without first informing the Almoners; “also we utterly forbid and command you, that ye by no colour pester or burden this house with any sick or diseased person, for the curing of which person ye before have received a sum or sums of money, upon pain to be dismissed this house.”

After the charge of the Visitor of Newgate, there follows a detailed estimate of the hospital's annual expenditure, in which the known charges reach a total of nearly eight hundred pounds, including a salary of twenty pounds for each Chirurgion, and two pence per person per day for the diets of the poor.

The spiritual needs of the poor are filled by daily services:—“At the hour of eight of the Clock in the morning, and four of the clock at the afternoon, throughout the whole year, there shall a bell be rung the space of half a quarter of an hour, and immediately upon the ceasing of the bell, the poor lying in their beds that cannot arise, and kneeling on their knees, that can arise, in every ward, as their beds stand, they shall by course as many as

can read, begin these prayers following. And after that the party whose course it shall be hath begun, all the rest in that ward shall follow and answer upon pain to be dismissed out of the house. And thrice in the week, that is to say, Sunday, Wednesday and Friday, they shall say the litany in manner and form as it is in the end of this book.” The details of the services are followed by a long Prayer of Thanksgiving, which has to be learnt by heart and repeated “by the poor that are cured in the Hospital, at the time of their delivery from thence, upon their knees in the Hall before the Hospitaller, and two Masters of this House at the least.” The book concludes with a sample of the Passport given to each patient on discharge, together with clothes and money according to his need.

How far the hospital was conducted according to these admirable rules we cannot be quite certain; but the gracious and charitable spirit behind them can be expected to persist in spite of any changes in administration imposed by the Government of the day.

#### BIBLIOGRAPHY.

A bibliographical note of the book is included in Sir D'Arcy Power's “Selected is a black-letter octavo signed A-18, printed in London by Richard Grafton, printer to King Edward VI and Deputy Treasurer of the Hospital in 1551. The copy in the Hospital Archives, the acquisition of which was described by Mr. Geoffrey Keynes in this Journal (vol. 44, 1937-8, p. 216), lacks the last three leaves, which contain the Prayer of Thanksgiving, the Passport, and the colophon. Complete copies are to be found in the British Museum (see Sir Norman Moore's “History of St. Bartholomew's Hospital,” 1918, vol. 2, p. 164), the Bodleian, the Folger Library in Washington, and the Pepsysian Library at Magdalene College, Cambridge.

This edition was reproduced in 1888 by the Early English Text Society in their reprint of Thomas Vicary's “The Anatomie of The Bodie of Man” (appendix xvi, p. 289).

A second edition was printed in 1652 by James Flesher, printer to the City of London, as a small quarto with the title “Orders and Ordinances, for The Better Government of the Hospitall of Bartholomew the Less,” signed A-F1, to which two other 16th century pamphlets, on Orphans and on the Customs of London, were attached. The spelling and punctuation of this edition are

altered, and the Daily Services are entirely omitted. The hospital possesses a good copy of this book, which is not so rare as the first. It was reprinted in Strype's edition of

Stow (1720, vol. 2, book 6, appendix, p. 51), and twice by W. Marrant Baker in the St. Bartholomew's Hospital Reports (1884, vol. 20), and as a separate volume in 1885.

## CORRESPONDENCE

### AN ACT COMPARABLE TO THE GREATER FOLLIES OF HISTORY

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

I think the latter part of the February Editorial needs some comment both with regard to the views concerning Medical Education and also concerning the N.H.S.

In connection with Medical Education the writer says, "it is becoming more and more expensive and therefore available to fewer and fewer of his (Mr. Bevan's) future bondsmen." The fact is at the moment all the Medical Schools in the country are more than full and for every student accepted many are being turned down. Naturally I deprecate that economic factors play a great part in deciding whether or not a certain man or woman shall take up medicine. However, this is not preventing the maximum of doctors being trained at the present day as is possible in the available Medical Schools.

The difficulty, however, lies in the shortage of Medical Schools; and I would suggest that many good and big hospitals in London and the provinces are suitable for clinical teaching. What are needed are, on the one hand, experienced teachers both in clinical and preclinical subjects, difficult, though I'm sure, not impossible to procure; and on the other hand, lecture theatres and Anatomy and Physiology buildings (for 2nd M.B. subjects) near the proposed teaching hospitals. Although it affects priorities in the building programme I feel this rearrangement would not substantially alter the number of houses built.

The financial problem of students is quite another question. In future I suggest students thought suitable for a medical education should be given full economic stability during their period of training. The writer's desire for a liberal education obviously should be fulfilled. Is not the present attitude of cramming elementary sciences and so narrowing the general education due to so many prospective students being forced to get scholarships and exhibitions to augment their scanty funds and so be able to study medicine? I refuse to accept the hypothesis that in the future, because medical training is becoming more and more expensive, it is therefore only available for fewer and fewer.

With regard to the emotional attitude expressed on the N.H.S. I assume it was agreed that a health service at some time was necessary. The disagreement is over the type and timing of the N.H.S. Nearly every measure of progressive legislature has been opposed by many on the ground that the timing is not opportune. If we waited for the very best time for such measures we would find that it would never arrive. In the case of the working of the N.H.S. it is unfortunate that the Editorial writer's apparent personal antipathy to Mr. Bevan should

stop him from taking even a relatively objective attitude to the N.H.S.

I will cite a few examples of what the N.H.S. has achieved in an essentially practical form, which can be easily assessed, during the first six months of its life.

A. From its inception till November 23rd of the same year, 2,357,000 pairs of spectacles were prescribed to patients. It was estimated that the demand in a year would be from 3 to 4 million. This points to the fact that many people needing spectacles in the past did not obtain them for economic or other reasons. Less than 10 per cent. of them seeing doctors with regard to obtaining spectacles were found not to need them.

B. From July 5th till mid-December, 1948, 1,877,000 dental treatments were completed, 40 per cent. of which were for the provision of dentures. Accurate figures for the pre-N.H.S. period are not available but it appears obvious that very many people were in need of dentures and conservative treatment prior to July and did not get the treatment necessary.

C. Anybody benefiting from Electrical Hearing Aids can now have them and this has obviously improved enormously the happiness and occupational usefulness of many.

Are the supply of Spectacles, Dentures and Hearing Aids to those in need of them, many of whom could not afford them at all and many more could only do so at great personal sacrifice, "a great act of folly"?

Ninety-five per cent. of the population have registered under the N.H.S. They could if they wished not take advantage of the scheme and would only be out of pocket 10d. per week, which is the share allocated to the N.H.S. A considerable section of the 95 per cent. could afford to lose the benefit of the 10d. per week and continue to seek medical and dental advice and treatment privately. Obviously the writer of the Editorial is in a small minority in thinking it a great act of folly.

It is constructive criticism and suggestions of improvement that are necessary both to improve the selection and retaining of doctors and also improve the working of the N.H.S. and not biased and destructive criticism.

Yours faithfully,

J. D. B. ANDREWS.

The Abernethian Room,  
St. Bartholomew's Hospital,  
February 5th, 1949.

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

Your Editorial in the Bart.'s Journal, February, 1949, entitled "Education," very rightly draws attention to the position of the medical student today who is inclined, on account of a crowded curriculum, to regard medicine, first and last, as a

science. Let me say at once that it has been my experience in contacts with many professional men that Bart.'s men have invariably been the best of colleagues, with a sense of the meaning of their vocation.

As a fresher in 1911, with many others our introduction to Bart.'s and medicine took place in the Abernethian room where we were addressed by a member of the senior staff. We were told what it meant to be a Bart.'s man and what would be expected of us when fully equipped and let loose among the public. Does the same thing happen today at Bart.'s? Do other hospitals start their students off on the right foot? Do teachers still stop now and again and remember that inspiration and example is part of their job? The crowding of the clinical canvas, the rush tactics of modern medicine and mass medicine must be leaving little time for thought and poise. The qualified, yet incomplete doctor, then enters a career of hard work and in too many cases ethics, of which he knew very little, fades as time goes on.

In addition to coaching the new student, in order to try and get his mind thinking on the right lines, there should be a lecture or two at some period which deals with history, tradition, codes of honour and ethics in its widest sense. It should not be difficult to insist that all intending medical students should possess a short, interesting and well-written book designed to assist them hereafter. In this way we are more likely to try and work as a team of men and women with loyalty and decency. How well the need for such a brotherhood can be seen at this present moment, when jealousies, scrambling and shouting for position is rife, exaggerated in a large degree by the unhealthy Health Act.

I suggest strongly and very seriously that the single reason for the present plight of our past great, old and honourable profession, is due to lack of unity—that division of our ranks is essentially due to lack of moral background. I do not believe that the disgraceful and humiliating daily occurrences, inspired by the politician, would have been tolerated for a moment by an older past generation—men of character who realised their position and worth and were more in touch with tradition and codes of honour. I hope that I and many of my contemporaries will not forget our Bart.'s education and the inspiration of many great teachers, that it will continue to serve us well and that we may try and pass it on to others.

Lord Horder has so rightly remarked that the medical profession is old and lasting and the politician small and transient. To this must be added an understandable ignorance of our complex affairs. Ignorant power has for the moment, and perhaps for a long time to come, defeated a body of professional men who have, in too many places, lacked in moral fibre. Loyalty and understanding in our ranks would make us unassailable from any quarter, however powerful.

If the present young student is going to continue being taught that medicine is only a science, then the day is not far off when there will, without opposition, gradually emerge a whole time salaried, regimented, sapless medical civil service which interpreted means a low standard of medicine.

This gap in the curriculum is obvious and serious and should be filled at the earliest possible moment. Some of the seeds sown must fall on good ground.

Yours faithfully,

W. ETHERINGTON-WILSON.

Cumberland House,  
Warren Road, Torquay.  
February 9th, 1949.

### THE WALES RAHERE SOCIETY

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

The Annual Dinner of the "Rahere Society (Wales)," was held at the Park Hotel, Cardiff, on January 25th, 1949. Dr. Colston Williams, the President, was in the chair. There were 60 guests present, the guest of honour being Professor Paterson Ross, Director of the Surgical Unit, St. Bartholomew's Hospital.

The toast of "Bart.'s" was proposed by the President, to which Professor Paterson Ross replied. The toast of the City of Cardiff was proposed by Dr. Ivor Davies and Alderman R. G. Robinson, J.P. Lord Mayor, replied. Mr. Melbourne Thomas proposed the toast of the guests and Professor Gilbert Strachan responded. A most enjoyable evening was spent.

The Rahere Society, Wales, now have three honorary members, Sir Milsom Rees, Dr. C. F. Harris, Dean of Bart.'s, and Professor Paterson Ross. It is hoped to increase the Society to about one hundred members. The officers elected for next year are:—Dr. Frederick Campbell, President; Mr. Melbourne Thomas, Vice-President; Dr. Emrys Harries, Hon. Secretary.

Will all "Bart.'s" men in Wales who have not yet been contacted please communicate with the hon. secretary, The Residence, City Isolation Hospital, Canton, Cardiff.

Yours faithfully,

EMRYS HARRIES,  
Hon. Secretary.

City Isolation Hospital,  
Canton, Cardiff.  
February 12th, 1949.

### TENTH DECENNIAL CLUB

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

What has come to the Tenth Decennial Club? I know we were the Orphans of the 1914 Storm and Death; ordinary civil death, was unkind to us in the thirties, but some of us survive with memories of some very pleasant dinners. Are we really too old and too shattered to meet again? Or have my fellow members met and I not heard of it?

Should this meet the eye of other "tens" who still feel young enough to dine, I hope they will write to you and say so. If nothing better came of it they might at least draw a secretarial epitaph.

Yours faithfully,

LINDSEY W. BATTEN.

12 Lyndhurst Road,  
Hampstead N.W.3.  
10th January, 1949.

## PATHOLOGY AT BART'S IN THE NINETEENTH CENTURY

By ERNEST H. SHAW, M.R.C.P.

SINCE I am now over eighty years of age, and first entered the service of St. Bartholomew's at the age of ten, my memory of the hospital is probably the longest of anyone now living. It has been suggested to me that some of my recollections of distant days may be of interest and should be placed on record.

In 1878 my father was cloak-room attendant, and I helped him with the work of receiving and giving out students' hats and coats. The cloakroom was then next door to the Anatomy Department, and by looking through a key-hole I could see the dissecting room and bodies which I called "skeletons" on the tables. My father deprived me of this fascinating and terrifying spectacle by blocking up the key-hole.

A year later a vacancy occurred in the Library, and I started on my first regular job at the age of 11 years and 2 months.

The Library of those days was a temporary iron building by the old college in Little Britain. Dr. Norman Moore was then the Warden of the College, and I collected the key of the Library from his house.

Mr. Mark Morris was the Steward, and I used to take the illustrated and the other papers to his house by the Little Britain Gate every Saturday and collect them on Monday. For this little service he gave me a new 2/- piece every Christmas. The librarian of that time was Mr. Thomas Godart; he was also a medical artist, and a large number of his paintings are preserved in the Museum, including a series illustrating diseases of the tongue originally made for Mr. Butlin. He also did engravings in wood and stone, the latter being used for illustrations to Mr. Luther Holden's book on Osteology. He left the library about 1882, continued his work in London as a medical artist for five years, and then went to Australia.

I can remember only one member of the clinical staff of those days, Mr. Callender, a big bearded man and stern; I was rather afraid of him. Another large bearded figure of those days whom I recollect clearly was Mr. W. G. Grace. I discovered who he was in after years.

The year 1880 saw the opening of the new building which includes the present library and museum. The ceremony was performed by the Prince and Princess of Wales (after-

wards King Edward VII and Queen Alexandra), and my first glimpse of royalty was while standing with other servants at the foot of the main staircase and watching them coming down. Another memorable occasion about this time was a visit to the library by Mr. Luther Holden just after his retirement: all the students present gave him a great reception. He was a lovable man, and I can recall him well—a big cheery man with a white beard and a pleasant smile. The library was the scene of a less commendable episode about 1882, on the day of the Lord Mayor's show. The windows were open and students and guests watched the procession pass. Then the people outside in Smithfield began to chaff the students and of course they replied. The end of it was that the crowd started pelting the students with horse dung. When the windows were closed I helped those inside to clear up the mess.

In 1884 I was transferred to the Museum and this was the beginning for me of the study of pathology, which was to occupy the rest of my life. The Museum was already in its present spacious quarters, and the shelves were fairly well filled with specimens transferred from the old quarters near the Anatomy Department. One of my duties was to collect specimens from the post-mortem room, then situated in a corner beyond the Dispensary between it and the Christ's Hospital wall. I well remember my first visit; it took some time for me to get used to the sights one encountered in such a place. I little thought that in after years I should be making post-mortems myself. After 1886 the specimens were brought to the Museum by a porter. Uniformed porters also carried specimens to the Museum from the operating theatre. On one occasion the tin which contained a large vesical calculus was dropped and the stone fell out on the gravel of the square. The man hunted about, found what he thought was the calculus and delivered it to my room. We thought it looked rather odd and eventually realised that the "calculus" was just a large pebble. The term "box carrier" applied to such porters and was first used of the man who accompanied a surgeon to the ward carrying a box of catheters from which they were selected as required; this, needless to say, was before the days of asepsis.

The head attendant in the Museum when I first went there was named Pickering; he left in 1886 and I succeeded him. The Curator during my first five years was Mr. D'Arcy Power; he was a good-looking man with a fair moustache, always kind and pleasant and I enjoyed working for him. During that time he added about 500 specimens to the collection. The yearly show on October 1st was an impressive one, and my time during August and September was fully occupied in mounting the specimens in jars and numbering them. Macerated bone specimens and plaster casts were included; I learned how to make these casts, and made a large number from various patients in the wards, particularly of limb deformities for M. Walsham, who was in charge of the Orthopedic Department.

Another member of the staff with whom I had a great deal to do was Mr. Anthony Bowlby, who, when Mr. D'Arcy Power succeeded him as Museum Curator, became Surgical Registrar. He gave a weekly demonstration on Friday mornings of morbid anatomical material from the operating theatre and post-mortem room; this I had preserved and took down for him to a classroom in the basement in metal bowls. His visits to my room to look over specimens occurred on most days of the week and often friends or students accompanied him. I used to watch and listen to him, and so began my interest in pathology. I owe a great deal to his teaching. His descriptions were brief, clear and easily followed; the same terseness and accuracy of description characterized his book on surgical pathology. I also helped him with the indexing of notes of cases in the wards, and with compiling the statistical talks for his annual report as Registrar. When he was writing his Jacksonian Prize Essay on diseases and injuries of nerves I even visited former patients in the neighbourhood for him to get after-histories. These were days when if you wanted anything done you had to do it yourself or get anyone who happened to be available to do it, whether it was part of their regular job or not. Many years were to pass before anyone even thought of a Follow-up Department. Another vivid memory of Mr. Bowlby was his going about with a pistol in his hand when acting as Starter at the Annual athletic sports, then held at Stamford Bridge; I was also an official on these occasions, but with the more humble duty of selling programmes. Afterwards Bart.'s acquired its own ground

at Winchmore Hill through the efforts of Mr. Bruce Clarke. My recollection of this is limited to one visit in 1906 when I played in a cricket match between the junior staff and servants; at this stage of my career I was Mr. Bruce Clarke's house surgeon.

Mr. Bowlby was also responsible for all histological diagnosis. Sections were cut by students (Surgical Pathological clerks retain some of these duties and were still sometimes known as "cutters" even until 1920) and examined by the Surgical Registrar once a week. Mr. Bowlby was succeeded in this duty by Mr. C. B. Lackwood in 1891, and it was not until 1893 that the hospital appointed its first Pathologist, Kanthack.

My work in the Museum brought me into contact with every member of the active clinical staff, and with some of those who had retired. I remember seeing Sir James Paget during some of his later visits. I used to take Museum specimens down for the lectures of Sir William Savory, and recollect that for the last one he gave, the theatre was packed with students and members of the staff. I was told that it was just an ordinary lecture given in the usual way. He was a fine looking man, very quiet and rather reserved. Later it was my fortune to take a parcel of his treasures to his home in Hanover Square. These were the contents of his drawer in the old museum, where each member of the staff used such a drawer as a locker. The tradition that each member of the clinical staff was entitled to some space of his own, either in the Museum, or much later in the present Pathology Department, where he could keep specimens, continued for another forty years. Visits from Sir Thomas Smith and Mr. Marrant Baker were frequent; their object being to examine specimens which they had removed at operations. Those of Mr. Baker were sometimes epitheliomatous tongues, removed with the aid of an 'Ecraseur,' in which he was anxious to see that he had excised the growth sufficiently widely. Most of the staff of those days were tall and striking men, another such was Mr. John Langton, who was interested in herniae and Surgeon to the Truss Society. I remember helping him in the dissecting room with some frozen parts of the pelvic region; when these were frozen hard I sawed through them, so obtaining slabs showing the inguinal canal in different planes. These were hardened in methylated spirit for subsequent examination.



I first recollect Mr. Howard Marsh as a teacher of anatomy in the eighties; when he became Lecturer on Surgery I had to provide his museum specimens, and since he lectured at 9 o'clock very punctually and came to the Museum to select his specimens beforehand, I had to be there in good time. He was gruff but very kind. He afterwards became Lecturer in Surgery at Cambridge University, and Mr. Edgar Willett, then Museum Curator, selected specimens from the "Stock-pot" in my work-room, which I packed and delivered to Mr. Marsh at the railway station on the evening of his departure to Cambridge. I had the same duty to perform some years earlier when Mr. Alfred Willett held this position; in this way quite a number of specimens were supplied for use at Cambridge. It would be interesting to know whether any of them are still there—whether, in fact, a candidate from Bart.'s in the Final Cambridge M.B. may even now sometimes be shown a specimen which originally came from his own hospital.

Mr. Alfred Willett was the donor of the horse, whose skeleton stood on the ground floor of the Museum for many years, (it was removed about 25 years ago). This animal, an old carriage horse from his place in the country, arrived in a horsebox at Cannon St. station one evening, where it was met by Mr. Edgar Willett with several friends and myself. The horse-box was not in a position where it could be unloaded at Cannon St. and the train was reversed and taken into Charing Cross, whence the horse with its escort proceeded to Bart.'s. Here it was taken to the dissecting room, and strung up to the iron star-case leading to the gallery. The first attempt to end its life, made by pouring prussic acid into its mouth, had no apparent effect on the poor beast, and a large amputation knife had to be used to cut its throat. Then began the cutting up, and a mess it was. After removing as much as possible of the soft parts, we took the whole lot up to my room, and put it in the macerating tank. It was new getting well into the early morning hours and I spent the rest of the night in my work-room. Unfortunately the job of preparing and erecting the skeleton was too big for us, and so the whole business had eventually to be handed over to Mr. Marl at the Royal College of Surgeons' Museum.

In the 'eighties it was an interesting sight to watch the carriages of various members of the staff drive into the Square. They were of

all kinds, open and closed, and with one or two horses. I remember two in particular, a small, green one-horse carriage belonging to Mr. Butlin, and a large, open carriage and pair used by Dr. Gee. These vehicles waited in a ground behind the "Martha" block. I also remember seeing Mr. Butlin visit the hospital on horse-back. The first member of the staff to use a motor-car was Mr. Lockwood. This was in about 1899. It was an open red car, and I went in it to many of his private operations to cut frozen sections for him. I also performed this service for Mr. Butlin, for whom I had been cutting sections in the ordinary way since the early nineties. It was under his guidance that I first learned to "spot" malignant disease. He was always interested in morbid anatomy, and a frequent visitor to the museum in even earlier days for the purpose of examining his operation specimens; many of these were tongues and growths of the larynx.

For years after I went to the Museum all material for histological section was frozen; the method of paraffin embedding was not introduced until the middle nineties. After hardening in Müller's fluid the piece of tissue was immersed in gum solution, and frozen by means of an ice and salt mixture. I used to fetch the ice from the fishmongers (Sweetings). Sections were cut with a razor mounted on a sliding carrier with three legs, one of which could be lowered by turning the screw at its head. In these days museum specimens were more in spirit. It was after the appointment of Dr. Kanthack as pathologist that formalin came into use for their preservation, and a paper which I wrote with him "The use of Formalin for the Preservation of Museum Specimens" by A. A. Kanthack and E. H. Shaw, read before the Pathological Society of London, November 3rd, 1896, is the first English account of this process.

The present Pathology Department was built in 1908. Where was the pathological work done until then? What is now the Morbid Histology Laboratory was the Physiology Department and Biology was also housed in some of the rooms, destroyed by a bomb in 1940, adjoining the Museum. Pathological work began, of course, in the Museum and its preparation rooms; its main extension was to what is now called the Practical Surgery Room, next to the present Morbid Histology Laboratory. This room was, in fact, for a good many years the Pathology Department. Bacteriological work

began in 1891, when Dr. Klein joined the staff. He was given a room at the top of the Museum block. Various other people had rooms or parts of rooms in this building. Sir Lauder Brunton, for instance, had a laboratory next to the Curator's room in which he pursued the study of pharmaceutical chemistry.

A memory I have of Dr. Kanthack was his examining a nodule on the skin of the face of a student, and finding leprosy bacilli. I remember it so well, for the young man burst into tears when told of the nature of his disease. He was a native of India.

Kanthack was largely instrumental in launching me on the second stage of my career. He was appointed to Cambridge, and in October, 1897, I went there with him as assistant in the University Department of Pathology. Stubbings, who will be known to many Cambridge men of later days, was

## THE "BART'S" FAIR

It is now possible to give more information about the Fair, which is being organised by the Students' Union to raise funds for the Union.

The Fair will be held in the Medical College Grounds on September 22nd and 23rd and will be open from 11.30 a.m. until 7.30 p.m. on each day; the opening ceremony being performed at 12.30 p.m. on September 22nd. Permission has been received from the Treasurer and Almoners of the Hospital to use the title of "Bart.'s Fair."

The Medical College Council has generously placed the Charterhouse Site at the disposal of the Students' Union and permission has also been obtained from the Charterhouse Trust for the use of the Cloisters in Charterhouse Square.

All Clubs of the Hospital have been

## BARTS—GUYS SOCIAL

On Friday, February 11th, a return visit to this hospital was paid by 50 students from Guy's hospital. A conducted tour of the hospital had been organised including a visit to the 1,000,000 volt X-ray machine in the Mozelle-Sassoon Department. A medical demonstration by Dr. Scowen, a surgical demonstration by the professional unit, and a demonstration of radioactivity by Professor Wormald were part of the programme. Tea was served in the Great Hall and later in the

junior to me. Kanthack died little more than a year later, and left me enough money to help me to start reading medicine. I returned to Bart.'s in 1899 as half-time Museum attendant under Sir Frederick Andrewes, a position which I retained until nearly the time of my qualification at the age of 38 in 1905. During this period all the sections of museum specimens were cut by my niece at my home in New Cross.

I became a house surgeon at Bart.'s, then pathologist, casualty officer and Registrar at the Metropolitan Hospital, and finally pathologist to the Great Northern Hospital, where the rest of my life has been spent. I think I may say that I have enjoyed some reputation for rapid histological diagnosis at operations, and even up to the present time I have used the same type of microtome for cutting frozen sections as that which was used for all purposes when I first did histological work more than sixty years ago.

approached to provide some form of entertainment on the central grass plot at Charterhouse Square and it is hoped to provide a continuous programme of entertainment throughout both days of the Fair, with their support.

The Metropolitan Police Band has promised to attend and will provide music during the lunch hour and late afternoon.

M. J. Clarke-Williams has undertaken the organising of an Art Exhibition and all persons interested in contributing are asked to contact him.

The Organising Committee are anxious that the Fair should be a complete success and would like any practical suggestions forwarded to them, as well as individual offers of support from students, upon whom the whole success of this venture depends.

evening a twenty-question contest and a general knowledge quiz between teams from the two hospitals took place. Soon after, dinner was served in the refectory and the evening ended with a dance at Charterhouse Square.

It was indeed pleasant to entertain such genial visitors and we trust that the Guy's representatives enjoyed their visit as much as we did their company.

## AN UNUSUAL SPACE OCCUPYING INTERCRANIAL LESION

By A. B. HAIGH, M.B., B.S.

THE following case is of interest both as regards the pathology of the lesion, and the slight nature of the symptoms and signs associated with it.

The patient, a farmer aged 60, was admitted to the Neuro-surgical Department on the 5th May, 1948.

### History.

The history was that, apart from a blow on the right temporal region 18 years previously, the patient was quite well until 8 months prior to admission. This blow was not followed by unconsciousness or any untoward symptoms. He admitted that he might have received many others while under the influence of alcohol.

However, 8 months before admission he began to notice headaches in the right half of the head and nuchal region. These were throbbing in character lasting anything between half an hour and 2-3 days. They occurred up to three times a week. They seemed to be produced by any slight knock on the head or lying on his right side. They had improved slightly over the 3 weeks immediately prior to admission.

Two months before admission he had first noticed a swelling in the right temporal region which had increased in size at first, but, he thought, had since become smaller.

There were no other symptoms. There had been no vomiting, nor visual impairment and no defect of hearing or speech. He had noticed no paraesthesiae or weakness of his limbs. While the past and family history revealed nothing relevant the patient admitted that he had been accustomed to taking much spirits. He attributed the presence of the swelling on his head to alcohol, and as a result for some weeks had ceased to drink.

On examination, the patient was a very alert and astute old man, though plethoric and overweight.

In the anterior part of the right temporal fossa there was a roughly circular swelling, about 2½ ins. in diameter. The surface was smooth and convex and at its centre was about ½ in. above the surrounding scalp. The edges were ill-defined. It lay beneath the temporal muscle and was entirely non-mobile. There was no pulsation or bruit. Neurological examination was entirely negative. There was slight cardiac hyper-

trophy and the blood pressure was 210/112. There was no evidence of cardiac failure. The Wassermann reaction was negative.

### X-ray.

X-rays of the skull showed a 6 cm. area of bone erosion in the right temporal fossa. The bone in this area was greatly thinned and crossed by a few trabeculations. It was bounded by a margin of dense bone. This was not one smooth curve, but consisted of a series of arcs, linked together with their convexities outward, so as to give a scalloped appearance.

### Pre-operative diagnosis.

It was thought that this tumour was an osteoclastoma, a dermoid, or an epidermoid, of the skull. It was considered that exploration of the lesion was indicated.

### Operation. 12.5.48.

Under anaesthesia, the tumour became clearly pulsatile, the overlying temporal muscle making it impossible to say whether the pulsation was expansile or transmitted.

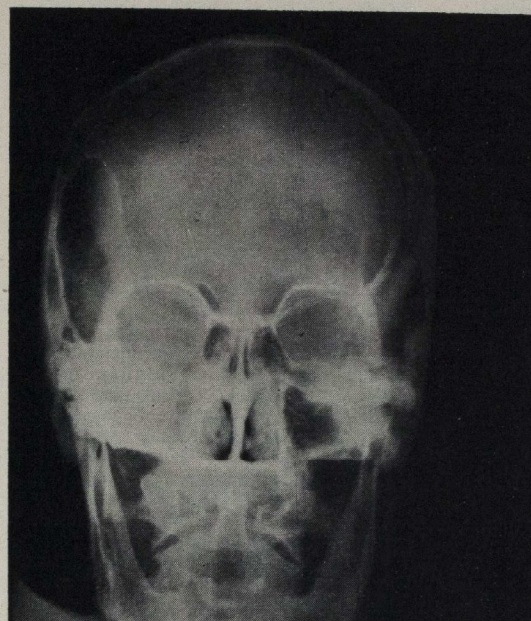
The lesion was approached through a right temporal flap; the temporal muscle being separated from the skull by cutting diathermy, and turned down with the scalp.

As this was being done, two parts of the tumour were exposed, where they had eroded the outer table of the skull completely. The anterior of the two was a well-defined cyst about 3 cms. in diameter. The posterior was a low elevation with temporal muscle fibres adherent to it.

The anterior projection of the tumour was aspirated and dark green fluid obtained.

A burr hole was then made in the greatly thinned skull above this portion. The bone here was outer table only, the inner having been completely and extensively eroded to give rise to the scalloped appearance. As the removal of this thinned bone proceeded, it was seen that the two prominences were continuous with a large cystic tumour lying extradurally, on the floor of the middle fossa. The tumour could be separated from the dura by gentle blunt dissection. It measured 7 cms. antero-posteriorly by 7 cms. supero-inferiorly.

The blunt dissection was pursued far medially towards the mid-line. The dura had been depressed to a depth of 5½ cms. from the inner surface of the skull. Furthermore,



A-P view.



Rt. lateral view.

at this deepest point, the dura had been penetrated over an area 3 cms. x 2 cms. and a prolongation of the tumour continued for a further 1½ cms. medially, where it was embedded in the right temporal lobe. The intracranial extent of the tumour, therefore, measured 7 cms. in all three planes. It was removed completely.

The rent in the dura was repaired with temporal fascia, and an attempt made to obliterate the large dead space by suturing the dura to the pericranium. A drain was placed in the space, and the temporal muscle sutured. The scalp was then sutured in two layers after the insertion of a sub-galeal drain. The patient's condition remained excellent throughout the operation.

Post operatively, apart from some initial restlessness, the patient made satisfactory progress and was allowed out of bed on the 5th day. The wound healed perfectly and the decompression was flat and pulsating. He was discharged 2 weeks after the operation.

#### Examination of the tumour.

The tumour was dull grey in colour with a smooth surface. It was roughly spherical in shape with three elevations; the superficial one, which had emerged anteriorly; the deep intradural projection; and a small posterior one.

The contents consisted firstly, of the dark green fluid, which contained some red cells, and some "degenerated unrecognisable cells." Secondly, the bulk consisted in its semi-solid content which was amorphous, yellow and greasy. This contained 16% of cholesterol and 12% of fatty acids by weight.

The tumour wall was 1.5 mm. thick and consisted mainly of thick fibrous tissue impregnated with haemosiderin. There were also cholesterol crystals surrounded by macrophages and foreign-body giant cells. There were numerous small recent haemorrhages.

Most unfortunately, the lining of the tumour had been destroyed, probably by haemorrhage, and there was no epithelial or neoplastic tissue remaining.

#### Discussion.

A consideration of the literature leads to the conclusion that this was a case of diploic epidermoid. The behaviour of the lesion was sufficiently typical for the diagnosis to be made even in the absence of exact histological confirmation.

Epidermoids were first described by Cruveilhier in 1829. He called them

"Tumeurs Perlées," because their surface had a sheen like mother-of-pearl.

Mahoney<sup>1</sup> analysed 142 cases of verified epidermoid, which, in 1936, was the total in the whole of the literature. He found that 112 were intracranial, 23 were diploic, and 7 intraspinal.

The intracranial tumours arise in the mid-line anywhere on the base of the brain from the anterior perforated space to the foramen magnum. Their favourite site is beneath the pons and medulla extending out into the cerebello-pontine angle (Bailey<sup>2</sup>).

The rest of the discussion will be restricted to the even rarer diploic type.

King<sup>3</sup> in 1939, described seven cases of epidermoid tumour, three of them diploic. He states that in the latter the x-rays appearances are absolutely typical, and should enable an exact pre-operative diagnosis to be made. These appearances were first described by Cushing<sup>4</sup>. He notes the erosion of the inner table to a greater extent than the outer; with the dense, clearly defined and scalloped border. It is interesting that the case described by Cushing bears, an extraordinary similarity to that described here.

The bony defect was in an almost identical situation on the left side. The patient had noticed a very small defect in the left parieto-temporal region for 4½ years, this had recently begun to pulsate. For 3 months he had had very slight weakness of the left foot, and nuchal pain. The tumour was 9.0 cms. in diameter and had caused very great compression of the brain in the left temporo-parietal region. There was no erosion of the dura. The existence of the very slight homolateral signs in Cushing's case is of interest, in that it shows a similarity in behaviour to subdural haematomata, which are also slowly growing compressive lesions.

The extensive bony erosion caused by these tumours must be largely due to the pulsation transmitted to them from the brain. In one case described by King, the epidermoid had eroded the orbital roof and opened the ethmoid sinuses.

They also illustrate the slight nature of the signs produced by large, slowly growing compressive lesions as compared with those that infiltrate brain tissue.

Cushing emphasizes that the removal must be performed without incising the capsule. If the tumour were opened extensively, complete excision of the capsule would be almost impossible.

The typical pathology of the tumour was described by Bailey. Of their appearance he says—"The surface is smooth, silky, with irregular pea-sized or larger elevations, and peels away readily from the surroundings." The lustrous mother-of-pearl appearance is best seen in the intracranial epidermoids (Cushing).

In the case described here, both the fluid and the semi-solid contents appear to have been quite typical.

Characteristically, the capsule is about 1 mm. thick, and histology shows it to be in three layers. The outer consists of a cellular connective tissue with a few scattered fusiform or stellate fibroblasts.

The middle layer is stratified squamous epithelium 4 to 20 cells thick. The outer cells are flattened and without nuclei. The inner cells are more cuboidal in shape with well preserved nuclei and intracellular bridges. Special staining shows keratohyalin granules.

The inner layer consists of cornified epithelium which is cast off to form the contents of the tumour.

Rowbotham<sup>5</sup> describes two diploic epidermoids, both with characteristic x-ray appearances, and discusses the origin of epidermoid tumours. He mentions two hypotheses. The first is that primitive epidermal ectoderm is included within the skull, when the lateral mass sends in mesodermal elements to separate the embryonic skin from the developing central nervous system. This is the view that is generally held.

The second hypothesis is that primitive neural ectoderm becomes separated from its proper "organisers," and reverts to epidermal ectoderm.

In support of the second theory, Rowbotham states that he examined over a hundred random sections of the skull, and found no epidermal cell rests. But in view of the extreme rarity of these tumours, it would perhaps have been surprising if he had.

Finally, to consider the alternative diagnoses in the case presented; that of traumatic blood cyst is quite untenable, as it is inconceivable that this lesion could have caused such bone or dural erosion or grown to such a massive size. The contents were not those of a traumatic cyst.

Intracranial dermoids do occur, but diploic dermoids are excessively rare. Dermoid cysts almost always contain hair, bone or teeth.

Osteoclastoma of the skull usually only expands the diploe and seldom erodes them. No neoplastic giant-cells were found.

#### Summary.

A large cranial tumour is described. It is thought to have arisen in the diploe of the skull; and over years, have spread through the cranium, both externally and internally. The complete absence of neurological signs is of interest.

The tumour is considered to be a diploic epidermoid and these lesions are discussed.

The differential diagnosis is also considered.

I am very grateful to Mr. J. E. A. O'Connell, at whose suggestion this paper was written, for his help and encouragement in its preparation.

The photographs of the x-rays were made by the Photographic Department of the Hospital.

#### BIBLIOGRAPHY

- <sup>1</sup>Mahony, W. Die Epidermoide des Zentralnervensystems. Ztschr. F. D. Ges. Neurol. U. Psychiat. 155, 416, 1936.
- <sup>2</sup>Bailey, Percival. Cruveilhier's Tumeurs Perlées. Surg. Gynec. Obst. 31, 390, Oct. 1920.
- <sup>3</sup>King, J. E. J. Extradural Diploic and Intradural Epidermoid Tumours. Annals of Surgery, Vol. 109, No. 5, 1939.
- <sup>4</sup>Cushing, Harvey. A Large Epidermal Cholesteatoma of the Parieto-Temporal Region. Deforming the Left Hemisphere Without Cerebral Symptoms. Surg. Gynec. Obst. 34, 557, May, 1922.
- <sup>5</sup>Rowbotham, G. F. Epidermoids Arising in the Diploe of the Bones of the Skull. British Journal of Surgery. Vol. XXVI. No. 103, Jan., 1939.

#### SPORT

January 29th v. Old Cranleighans.

RESULT: Won 11—0.

February 2nd v. Fighter Command.

RESULT: Won 17—6.

J. L. C.

February 5th, v. Nuneaton

RESULT: Lost by 10 Points to 8.

Played on a hard, frosty ground, Bart's did well to hold a strong Nuneaton side to a close game. Within five minutes Bart's had lost A. M. Baker

#### R. U. F. C.

January 8th v. Old Rutlishians.

RESULT: Won 10—6.

January 12th v. Reading University

RESULT: Won 27—16.

January 15th v. Aldershot Services.

RESULT: Lost 5—24.

January 26th v. St. George's Hospital

RESULT: Won 39—0.

(full back) with an injured shoulder and Nuneaton had scored a goal. Thereafter, with Holland deputising at full back, the depleted Bart's pack battled nobly against heavy opposition but Nuneaton were always slightly superior at forward. However, Wynne-Jones, at scrum-half, nullified this advantage by effectively "squashing" his opposite number. K. Jones (wing forward) was largely responsible for forcing the Nuneaton fly-half on to the defensive and thus foiled many movements. The defence was good for the most part but a bad lapse in the centre enabled Nuneaton to score one more goal.

Bart's scored through K. Jones following up a forward rush, this being converted by Third who also landed a good penalty goal.

#### 2nd Round Inter-Hospital Rugby Cup

February 10th, v. St. Mary's Hospital

RESULT: LOST BY 5 POINTS TO 16.

From the opening few minutes of the game it was obvious that the ruthless superiority of the Mary's three-quarters, enhanced as it was by Sullivan's delightful positioning at full-back, boded ill for Bart's.

The first half was exasperating to watch. Time and again the Mary's centre broke through a pitiable defence, and but for Moyes and his co-forwards, the score must have been astronomical. One can truthfully say we were fortunate that lemons were taken with a score of only 8-0 in Mary's favour.

Early in the second half the ubiquitous Dick battled his way over the opposition's line and then converted his own try. Our bruised hopes peeped out again; the more so when John flattened the corner post in a most heartening attempt to level the score.

But a penalty under our posts came at quite definitely the wrong moment and after Beatson had made sure of the three points Bart's seemed to be a beaten side. Sullivan, by a fine solo run of 50 yards, added another try, which the ever-faithful Beatson again converted.

Murphy made several good runs for Bart's, without being able to score, although once or twice he and his supporters had cruel luck.

As it was Mary's won most meritoriously, Bart's were not disgraced; there is always another field and another day.

J. D.W.T.

#### February 12th, v. Middlesex Hospital

RESULT: LOST BY 33 POINTS TO 3.

Coming only 2 days after a gruelling cup match it was a tired Bart's side which took the field for this game.

The first half produced some good rugby, especially at forward with the Bart's pack holding their opponents and getting a fair share of the ball. However, the backs were weak and could make little of their chances.

After the interval, Middlesex were soon on their stride with their backs running well; they met with little opposition from the Bart's back division and scored repeatedly. The forwards hung on to the end but the backs never looked dangerous in defence or attack.

#### February 23rd, v. Woolwich Garrison

RESULT: WON BY 28 POINTS TO 8.

Bart's enjoyed a marked superiority in all departments and had a comfortable win by 2 goals, 1 penalty goal and 5 tries to a goal and a try.

With the pack in a lively mood, Bart's were soon in front through a try by Murphy who ended a good movement by running in from 25 yards. Poor handling by the Hospital backs spoilt many promising movements but with the pack well on top, Bart's never looked like losing. Moyes hooked well to give the backs plenty of chances from set scrums and in the loose John and Stephens were outstandingly well backed up by Norbury and K. Johns. The three-quarters moved well but the handling was suspect at times. Tries were scored by Stephens (2), John (2), Murphy, Bailey and Norbury; John kicked a penalty goal.

#### February 26th, v. Oxford University Greyhounds

RESULT: LOST BY 16 POINTS TO 8.

Though beaten by 2 goals and 2 tries (16 points) to 1 goal and 1 try (8 points), Bart's played well against a strong Greyhounds side at Oxford.

They started off in earnest and carried the play well into the Greyhounds' half. Receiving the ball from a loose scrum Corbet soon dodged his way through for an unconverted try.

For the rest of the half the Greyhounds were on the attack. Thanks to two beautiful cross-kicks, a breakaway by the scrum-half and good kicking by Duff, they led 13-3 at half-time.

The second half was keenly contested. The home side obtained one more try. From the kick-off a defender dropped the ball. Third, who played very well throughout, pounced on it in a flash: he dribbled and ran 35 yards to score a fine opportunist try. He converted it himself.

#### A. F. C.

All matches this year were played in anticipation of the Hospitals Cup to be played on February 23rd against Mary's.

We had previously beaten them in November on our ground 4-3 with an under full-strength team. We, therefore, hoped with our additional players to beat the holders and so pave the way to the Final again.

But it was not so to be. The matches this year showed us that we, as a team, had not reached form. Several successes, however, were recorded, notably in beating the Old Cholmeleians 2-1 and drawing with a strong Corinthian-Casuals team 2-2.

Hospital feeling was high as February 23rd arrived. Just previously both our Cup Rugby sides had lost to Mary's. In faith, then, we ordered two coaches to take the team and supporters to our opponents' ground at Teddington.

Our hopes were amply justified for we received voracious support from members of the hospital and nursing staff and also from the Rugby Club. The latter deemed their voices inadequate for this vital occasion and brought all sorts of musical instruments with them to swell the chorus.

And now to the game. We fielded the strongest side we could. Mary's seemed weaker on paper except for their captain, D. Kelleher (Irish international) and G. Sullivan (Welsh Trialist). We opened the attack and soon Grassby sent across a shot at goal which was miss-kicked by their right back into the goal. One up. Soon, however, Mary's replied with a high drop shot from their right wing and we were level again. And so the battle went on, with Bart's always slightly on top.

We changed over equal, 1-1. Soon after half-time Mangan beat the Mary's goalkeeper from a

break away but the referee ruled the goal off-side. Mangan was not to be so easily beaten, however, and soon after taking a nice pass from Gilks, on the turn, gave the goalkeeper no chance.

This odd goal lead was maintained until the fatal moment of the game arrived 15 minutes from the end.

Wright, in intercepting a pass from the Mary's right wing, deflected the ball with his arm. He was inside the area. Two Mary's players appealed for a penalty. The referee hesitated, and without confidence gave the decision.

Sullivan made no mistake about it. A No. 9 gave Cox no chance.

The Bart's team seemed stunned by this event and never recovered. Kelleher made sure of the issue with a close shot just before time.

It seemed unfortunate that the game should end like this but everyone agreed that it was a most enjoyable tussle.

Before closing mention must be made of the Bart's defence which was very sound and particularly Cairns and Batey who masked superbly the activities of Kelleher and Sullivan.

Team: W. H. A. C. Cox; T. S. Cookson, J. A. S. Amos; J. D. Cairns, I. S. Batey, A. N. H. Wright; G. Grassby, T. A. Duffy (Capt.), J. Adams, M. K. Mangan, J. M. L. Gilks.

#### HOCKEY CLUB

##### 1st Round Inter-Hospital Hockey Cup

January 29th, v. Middlesex Hospital

RESULT: WON BY 5 GOALS TO 2.

The game opened briskly under dry, fast conditions and our forwards must have put the Middlesex defence off their stroke because Batterham and Khurshid had both scored goals by the time your reporter arrived at Foxbury.

Thereafter the opposition gathered themselves together and made a determined onslaught on our goal keeping the ball well up.

However, our defenders kept their heads and, eventually cleared the ball allowing the forwards to break through to the Middlesex goal and force

#### SELECTED WRITINGS OF WILLIAM

CLOWES, 1544-1604. Edited, with an introduction and notes by F. N. L. Poynter. pp. 179. Harvey & Blythe, Ltd., London, 1948. Price 15s.

Among the many prominent surgeons who have graced the staff of this Hospital, William Clowes should receive primary consideration. Elizabethan surgery was dominated largely by quacks, and the few honest students of the craft who contributed to the development of surgery deserve full recognition. The writings of William Clowes were popular and significant, but few copies have survived to modern times. Mr. Poynter conceived the excellent idea of selecting extracts from Clowes's works contained in the Wellcome Historical Medical Museum, and making them available to a wider public. His book contains an introductory section consisting of a brief outline of Elizabethan surgery, and biographical details of William Clowes; a bibliographical note with information on his writings, and the locations of surviving copies; notes (which are personally preferred at the foot of the page); a biographical index of

a short corner. We failed to take advantage of this and the Middlesex forwards again took command of the ball. By half-time they had brought the score to 2-1.

In the second half the play remained open and brisk. The standard of hockey, true to cup form, was more vigorous than tactical. On the whole, we were slower in attack than the Middlesex forwards but when in the circle we followed up shots with great success.

On the right wing Godden broke through on more than one occasion spattering the goal posts with hard drives and forcing a succession of corners. Batterham was the chief goal-getter and scored twice more through persistent hard shooting and following-up.

The backs, aided by Hicks's inspired goal-keeping, kept the opposition well in hand allowing them to score only once in the second half and that off a corner. Nehta was especially outstanding amongst all the backs and used his remarkable ball control to great effect.

The halves slaved gallantly and by their ubiquity kept the forwards well supplied whilst starving the Middlesex of opportunities.

The final score, 5-2, was a fair reflection of the afternoon's play. The side this year is vigorous, containing many new players and should do very well when it has learnt to play with greater cohesion.

J. W. P.

Team: W. Hicks; J. B. Dossetor, N. Nehta; J. Ainley-Walker, A. E. Griffiths, A. Clappen; J. W. Mellows, G. Hirst (Capt.), N. Khurshid, J. Batterham, J. Godden.

#### RIFLE CLUB

The officers of the rifle club for 1949 are as follows:—

President—Mr. H. J. Burrows; Vice-Presidents—Dr. G. Canti, Mr. N. A. Jory, Dr. G. E. C. Francis; Clinical Hon. Secretary—D. C. Morgan; Pre-clinical Hon. Secretary—B. D. Lascelles; Hon. Treasurer—M. C. Hall.

#### BOOK REVIEWS

persons mentioned by Clowes in his text, and a short bibliography.

This book is beautifully produced in a limited edition, includes eight plates (the frontispiece representing a unique portrait of William Clowes), and does ample justice to the text. It is not only a contribution to the history of surgery, but to the history of the Elizabethan period, and does credit to the Editor and the publishers. The association of William Clowes with this Hospital emphasizes the fact that this book should become the personal property of Bart's men, particularly if they can appreciate bibliographically well-produced volumes.

J. L. T.

A SYNOPSIS OF PHYSIOLOGY, by A. Rendle Short, C. L. G. Pratt and C. C. N. Vass. 4th Edition, pp. 331 + xv. John Wright & Sons, Ltd., 1948. Price 20s.

The object of this book as laid down in the preface to the first edition is "to give a fairly full summary of modern physiology, particularly human physiology, in a small compass."

In no other book is this aim so nearly achieved, and we have no hesitation in recommending this book to those who, having completed a physiology course, wish to make a rapid survey of the subject.

Ten years have elapsed since the last edition, and this has necessitated the eradication and re-writing of some chapters. Others we recognise as old friends brought suitably up to date.

**THE DIAGNOSIS OF THE ACUTE ABDOMEN IN RHYME**, by Zeta. H. K. Lewis & Co. Ltd., pp. 93. Price 6s.

Descend, O Muse, and make thy earthly Home in This little book about th' Acute Abdomen. See here the Student whose laborious Days Are damned by massive Textbooks. Look, then praise

The Industry and Charity of "Zeta"  
Whose Book is short and sweet and writ in Metre.  
The toiling Student, ringed by Solid Facts  
Of Path. and Biochem. and even Acts  
Of Parliament, now turns with pleased Surprise  
To one who can be Funny to be Wise;  
Who writes as much as, no more, than he ought;  
His Volume, like the Student's time, is short.  
The Teacher and the Student know the Trick,  
A Jingle helps an awkward Fact to stick,  
And linger there beneath Cerebral Laminas  
Till brought to Light by Conjoint Board Examiners.  
Then, Muse, look forward to the happy time  
When all our teachers demonstrate in rhyme  
When all the Fire the English tongue affords

Will roll and echo thro' our Halls and Wards.  
What oldest Multip. but could hear with awe  
Her cysts described in iambic Ease by Shaw?  
Even the dulllest Student would absorb it  
In surgical Spenserian Verse from Corbett.  
If Ross should talk in Trochees there's no knowin'  
What purple Prosody will come from Scowen.  
So give three cheers for Zeta's Metrics  
Which yet may lighten the Burden of Surgery,  
Medicine, Pathology, Special Depts.  
(Assorted), Children and even possibly  
Gynaecology and Obstetrics.

**DISEASES OF THE EAR, NOSE & THROAT**, by D. G. Carruthers, 2nd Edition, pp. 244 + vi. John Wright & Sons, Ltd. 1948. Price 25s.

The need for a satisfactory students' text book of E.N.T. has long been felt and whilst this text is by no means perfect, it probably fills that role better than any other. Emphasis is always on fundamentals and the examination of each part is well written. The section of sinus radiology is worthy of note.

A few criticisms. Penicillin and Calciferol therapy do not receive the prominence due to them—there is no mention of the latter in the section on lupus vulgaris; the caption to Fig 16 informs us that the auditory canal can be straightened by drawing the pinna "downwards and backwards"! The production is of Messrs. Wrights usual high standard.

# ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

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### ANALGESIA IN CHILDBIRTH

Once more Mr. Bevan has raised high his banner of political chicanery by accusing Mr. Thornycroft's recent "Analgesia in Childbirth" Bill of being no more than a political stunt exploiting human pain. Quite rightly the reaction both in Parliament and the Press to this statement was a storm of protest, for surely this of all Bills is of a non-party issue; it was gratifying, therefore, that in spite of Mr. Bevan's protest, the Bill passed its second reading without further obstruction from either party.

The problem of analgesia in childbirth has always been an urgent, though neglected one. Recently, however, with the report by the sub-committee of the Medical Women's Federation published in the B.M.J., the great need for the general availability of analgesia in labour has been brought to the public eye. The results of their investigations showed that women doctors who had experienced childbirth were almost unanimously in favour of the relief of pain during parturition.

The opinion of such witnesses who can visualise the benefits offered by analgesia both from the maternal viewpoint and from the more detached medical aspect, must bear great weight with the critics of painless labour.

Ever since Sir James Simpson first advocated the use of anaesthesia and its pain-relieving qualities in the process of childbirth, his humanitarian conception of painless labour, has been fiercely contested by certain sections of the community with a variety of ill-founded arguments.

Before however one can dub any contention as "ill-founded" it is necessary first, to show that such arguments are in fact without

a logical basis, and it is therefore not out of place to recapitulate and attempt to answer them.

The application of anaesthesia to labour as conceived by Sir James Simpson was opposed initially by a great body of religious thought; it quoted blindly from the Bible in an attempt to show that the pain of childbirth is a visitation from the Almighty upon woman in punishment for Eve's sin in the Garden of Eden. It would be sinful and unnatural to relieve such pain they protested. The medical world, too, was of the opinion that painless birth would be unnatural. "Pain," they said, "in the process of parturition, is a desirable, salutary and conservative manifestation of the life force." Such bigoted dogma, however, could not stand before the advance of more rational thought which was taking place at that time and the final death blow to its arguments came when Queen Victoria consented to undergo labour with the assistance of chloroform. In point of fact the limited knowledge and technique which then existed made any general application of anaesthesia to such a common occurrence quite impracticable.

A more cogent argument against the use of analgesia was later developed by Eugène Marais, the South African naturalist, in his book "The Soul of the White Ant." He maintained that the pain of childbirth has a definite biological value. It is the stimulus of the maternal instinct. "We find," he says, "that birth pain is the key which unlocks the doors of mother love from the termite to the whale. Where birth pain is absent there is absolutely no mother love." This opinion he supported by experimental evidence from

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a herd of half wild kaffir buck. Apart from the startling generalisation of his statement, his argument attracted a number of followers, and is one which cannot be lightly ignored. His contention can however be answered in two ways. Firstly it is surely not legitimate to apply his observations of mother love in kaffir buck, assuming those observations to be correct, to the human mother, where instinct, which predominates in the animal, has become subordinated to reason. It is difficult to believe that a mother will love her child in direct ratio to the pain she suffers at its birth. Secondly, experience has shown that mothers who have undergone labour under painless conditions do not love them any the less for it. Moreover, it is not infrequently recorded that the mother-child relationship is disturbed by the resentment of the mother to her child arising from the agony of her ill-conducted labour. Normal birth is a physiological process, whilst pain is a manifestation of a pathological condition. Normal birth should be a relatively painless procedure. In the majority of cases, the young mother faces childbirth in an agony of apprehension. Labour, she has been told by her female friends, is invariably painful. She hears hair-raising tales, in many cases exaggerated for the benefit of the hearer, of the pain suffered during childbirth. With this background of fear, the onset of labour becomes a thing to be dreaded; it cannot be conceived as the greatest of all natural functions, which should give the mother the emotional significance of birth, accomplished not with pain and suffering, but with joy.

Grantly Dick Read has appreciated this psychological factor, and the methods which he teaches in his "Natural Childbirth"<sup>1</sup> and the "Revelation of Childbirth"<sup>2</sup> are aimed directly at overcoming this fear. There are still many opponents of his methods, but the mass of testimony which has accumulated, not only in this country but also in America, where his methods have been practised, in support of his work must be sufficient to

convince an unbiased mind of their efficacy.

The mother who is taught to expect a painless labour, and in fact to look forward to her confinement, does experience in the great majority of cases, an easy and satisfying labour. Eighty per cent. to 85 per cent. of normal births, states Read, can be achieved entirely free of pain, and this without the aid of analgesia.

As in all things, the dangers of a method lie in its extremes. Helen Deutsh says of obstetrics that it is a man made science and "... a masterpiece of masculine efficiency, but it deprives woman of her active participation in delivery and thus in a sense of her monopoly in this field." Her statement is true, but it is aimed principally at anaesthesia, and not analgesia. Read himself states: "Normal woman in labour should have no more pain than she is willing to bear, not able to bear, but willing to bear."

The place of analgesia in childbirth, should it be necessary, lies in establishing a mean which satisfies, as far as possible the sentiments expressed by both Deutsh and Read.

With the realisation in mind that pain in childbirth is both unnecessary and undesirable, it becomes evident that there is a pressing need for re-education in the mental approach to procreation of numerous practitioners who visualise pain as an integral and unavoidable part of the birth process, and an equal need for the improvement of the medical services at present available to the expectant mother.

Mr. Thorneycroft's Bill though not the whole answer to the problem is at least a very fair beginning, and though the introduction of such measures as it advocates will be a long task, it is one which should not be further delayed. Mr. Bevan's attitude to the Bill will not assist the promotion of such measures.

<sup>1</sup> Grantly Dick Read: "Natural Childbirth." 1933.

<sup>2</sup> Grantly Dick Read: "Revelation of Childbirth." 2nd Ed. 1943.

<sup>3</sup> Eugène Marais: "Soul of the White Ant." 1937.

### THE JOURNAL

Contributions must reach the Editor before the first Tuesday of the month for inclusion in the following number.

The Editor apologises for an error in the title of the article by A. B. Haigh which appeared in the April number. It should have read "An Unusual Space Occupying Intracranial Lesion."

## SOME ASPECTS OF PAIN

By V. C. MEDVEI, M.D., M.R.C.P.

JUST over a hundred years ago Johannes Mueller<sup>1</sup> made public his theory of the specific energy of nerves. This was the beginning of the scientific and experimental analysis of the senses and of pain. It made possible the sharp division of the pain "sense" and of the pain "emotion," with the result that at the beginning of the 20th century the sensory theory of pain was generally accepted. The traditional pleasure-pain theory regarding pain as an "emotional quale" — and dating back to Plato and Aristotle<sup>2</sup>, was put into the background. It would have been dropped completely by the pioneers of the pain-perception theory, had it not been for the quality of unpleasantness inherent in pain. In an endeavour to explain the latter away, Herbert Nichols<sup>3</sup>, one of the first psychologists who accepted the sensory theory, searched for the nerves of pleasure, and eventually declared that they are in the organs of sex and nutrition.

During the first half of the present century anatomists, physiologists, pathologists and clinicians succeeded in establishing the peripheral pathways of pain perception, in localising cerebral centres, and in interpreting the apparent non-adaptability of pain. But in spite of the magnificent work of men like Schiff, von Frey, Weir Mitchell, Henry Head, Charles Sherrington, O. Foerster, Thomas Lewis, Cushny, J. Morley, H. S. Gasser, R. Leriche and, more recently, H. G. Wolff and Henry Cohen<sup>4</sup>, the sensory theory has not proved sufficient to explain more than certain—though very important—aspects of pain. As Sherrington remarks in his "Foreword to 1947 Edition" of "The Integrative Action of the Nervous System" ... "In all those types of organism in which the physical and the psychical co-exist, each of the two achieves its aim only by reason of a contact utile between them. And this liaison can rank as the final and supreme integration completing its individual. But the problem of how that liaison is effected remains unsolved: it remains where Aristotle left it more than 2,000 years ago." And Leriche puts it thus: "Physical pain is not a simple fact of nervous impulses travelling over a nerve at a predetermined gait. It is the resultant of the conflict between the stimulus and the individual."

At present these two facets of pain, the perception and the emotion, appear accepted as being complementary. The study of the sensory mechanism has made such enormous strides, that it is perhaps advisable to rest for a moment and consider the other facet. This paper will deal with some—and only a few—aspects of pain as an emotional quale.

The practical importance of such a contemplation will become more obvious when the recent controversy is recalled on the question of pain in childbirth, ending—for the moment—with the "Report of the Subcommittee of the Medical Women's Federation" a few weeks ago. A hundred years ago a similar controversy existed, when anaesthesia was introduced into surgery. It may sound incredible that a surgeon declared "pain was a wise provision of nature, and patients ought to suffer pain while their surgeons were operating; they were all the better for it and recovered better." Even the discovery that according to Genesis, ii, 21, "And the LORD GOD caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs, and closed up the flesh instead thereof": did not finally decide this battle waged with invective, abuse and quotations from the Bible. It needed a royal gesture, Queen Victoria's painless labour under chloroform, to make anaesthesia acceptable.

In our days a neurologist of the eminence of F. M. Walshe writes on "Psychogenic Pain" as follows<sup>5</sup>: "In 'Psychogenic pain' none of these anatomical mechanisms or physiological processes is involved and the symptoms so named have no sensory quality to which the term pain can rightly be applied. They are not primary sensations but complex states of mind, emotionally toned ideas which would be more fittingly described as 'anguish,' 'grief,' 'distress,' or 'anxiety.' The subject of 'psychogenic pain' should rather be said to have a fixed idea or obsession about pain, or, alternatively to be using the word 'pain' figuratively because he cannot more adequately describe the distress of mind from which he suffers. Thus stated, the difference between physiogenic pain and psychogenic 'pain' should be clear." This does not seem to fit in with the most recent investigations on pain in phantom limbs, nor with certain observations on congenital in-

difference to painful stimuli (*Asymbolia for Pain*," Schilder and Stengel<sup>2</sup>; Ford and Wilkins<sup>3</sup>).

One of the arguments against the existence of psychogenic pain is, that pain cannot be felt in dreams. Although it is admitted that the pain of a toothache may be felt during sleep, the existence of a sudden pain in a dream, independently of any stimulus, is denied, and regarded as not sufficient to arouse a man from sleep. I believe, however, with Macdonald Critchley<sup>4</sup>, that during a dream we are able to suffer pain, just as we are able to feel, to hear, and have perfectly natural sensations of taste. As Critchley points out, "the memory of pain is notoriously short, and it is not surprising that on waking little or no recollection of the pain-sensations should remain." Further evidence for this is the fact that hypnosis can induce and increase pain sensation without any physical stimulus. Pain without the pain-feeling, the subjective experience of pain, could not exist. Finally, definite psycho-galvanic response could be shown in cases of pain induced by hypnosis (Levine<sup>5</sup>). Keele's method of distinguishing "psychogenic" from "physiogenic" pain was discussed elsewhere<sup>1</sup>.

The cognitive aspect of the quality of pain may, therefore, be separated from the affective aspect of the pain-feeling and of the emotion of unpleasantness for the sake of study and analysis. It has to be realised, however, that both are merely aspects of one and the same experience. Thus, in overwhelming pain the cognitive factor is minimal, because there is clouding of consciousness, and the sufferer is insensitive to his surroundings; deep visceral pain has hardly any qualifying sensation. In contrast, negligible pain causes no impairment of consciousness and no distraction from surroundings. As these surroundings include the patient's own body, on which the pain is experienced, such pain is detached from personality, is nearest to a pure sensation, and can be localised with exactitude.

Of other psychological processes accompanying pain, depression is one of the commonest in the case of protracted or recurrent pain, and is of particular interest. It is remarkable how rare is suicide because of intractable pain. During 1923 there were reported 391 cases of suicide in Chicago, but only 11 of them were said to be caused by protracted or recurrent suffering from pain

(quoted after Critchley): 10 of them were men. In Forbes Winslow's series of 7,190 cases, pain is not mentioned in a single case. Another investigator points out that more people commit suicide because of an incurable tinnitus than an intractable pain (Crichton Miller)<sup>4</sup>.

Whereas depression may be one of the mental effects of protracted pain, severe (psychogenic) pain does not usually accompany cases of a primary mental depressive state. In fact, the threshold for pain is often increased in such a state, and this has been held as an argument against the existence of psychogenic pain. But this increase of the pain threshold is usually only temporary, and is not present when neurasthenic or hypochondriacal traits dominate the picture.

Another point of interest and importance is that the pain of the thalamic syndrome (Déjerine and Roussy) may resemble some forms of hysterical pain. They are both out of proportion in intensity to a known stimulus, cannot be correctly localised, and are affective in character. In the thalamic syndrome, cutaneous and deep pain develops, after a stage of defect of sensation, which usually includes all forms. The pain is comprehensive in its distribution, but worst in the limbs, where it feels as if the foot or hand is being crushed and twisted. Otherwise, the pain is said to be stabbing, boring, burning, aching. The condition is exacerbated by cutaneous hyperalgesia, so that stroking or scratching can elicit the whole gamut of pain experience. Obviously, apprehension and dread of contact may lead to obsessional traits, lack of sleep, fatigue and exhaustion, to anxiety and to drug addiction. On the other hand, objective manifestations may exist in cases of hysterical pain, and pupillary dilatation, tachycardia and pallor can be caused by the mere memory of a painful experience.

That emotional factors influence the threshold for pain is well known. It becomes raised under the stress of battle, in anger and in pleasure, whereas fear, apprehension and introspection may lower it. Less well appreciated, although known, is the fact, that the threshold for other sensations may be unaltered; hence the man hit by a bullet notices it first when he sees blood flowing from the wound, or feels the warmth and dampness of the blood, he cannot see.

Racial factors have a great influence on sensitivity to pain and have been carefully

studied. Broadly speaking, civilised races are more sensitive than the uncivilised, but there are wide variations within both groups. A considerable lowering of pain-sensitivity is known in certain cases of hysteria. If consciousness in such a case is not impaired, its study is of particular interest, because of the similarity to ecstatic states of martyrs of all religions. Yet even in this field there is a wide range of differences. Stoic philosophies, teaching development of the spiritual part of life by the proper training of self-control and discipline are vastly different from certain types of ecstatic display of some flagellants, dervishes and fakirs. The stoic is equally indifferent to pain and to pleasure; in the case of some martyrs "divine happiness" (i.e., pleasure) may be experienced through the suffering of intense pain.

More difficult to explain are the feats of sadhus and fakirs, who lie on a bed of spikes, walk over glowing coals, eat glass and perform other acts of self-mutilation, often without the frenzy of religious orgy. J. H. Hunt, who studied them carefully<sup>6</sup>, concluded that it is their mental condition which is abnormal from that of Europeans; physically, their bodies react very much the same as ours under similar conditions.

On the other hand, it is well known that in migraine, for example, the mental and emotional background is equally important as the physical underlying condition and, in some cases, decisive. Similarly, Grantly Dick Read<sup>7</sup> has maintained for years that the pains of labour are caused by fear. The autonomic system, which controls the relaxation of the cervix, is connected with the thalamus, the seat of primitive emotions. Fear, which is one of them, may produce cortico-thalamic inhibition, and thus primary uterine inertia. Psychological training from the beginning of pregnancy may remove fear and enable complete relaxation at will and

diminution of pain, which can be "almost entirely" avoided in most cases of normal births. Read's method has been applied successfully by a number of reliable and expert observers. It should be stressed, however, that he agrees that pain in childbirth may occur, "and should be obliterated by other means (i.e., anaesthesia) when it cannot be avoided."

As a final remark on the mental aspect of pain, the rare records of "sympathetic" pain may be of interest. Critchley quotes examples from literature where the "victim's agonies are shared by a loved one." Certain South American Red Indian tribes express such a state symbolically by the husband taking to bed when the wife is in labour. Scientifically more impressive in this respect appear, however, pain experiences in identical twins, as mentioned by Sir Francis Galton as early as 1883.

I have no doubt that the study of pain in such twins will prove more fruitful for the knowledge and understanding of both aspects of pain than many experiments in the strictly limited physiological field of pain as a sensory perception; and the study of pain will remain one of the principal objects of medical research.

<sup>1</sup> Cit. after Medvei, Buckston Browne Prize Essay, 1948: "The Mental and Physical Effects of Pain." E. & S. Livingstone, Edinburgh, 1949. (In print.)

<sup>2</sup> Schilder, P. and Steugel, E. *Arch. Neurol and Psych.* (1931), 25, 598.

<sup>3</sup> Ford, F. R. and Wilkins, L. *Bull. Johns Hopkins Hosp.* (1938), 62, 448.

<sup>4</sup> Critchley, M. *Bristol Med.-Chir. Journal* (1935), 52, 191.

<sup>5</sup> Levine, M. *Johns Hopkins Hosp. Bull.* (1930), 331.

<sup>6</sup> Hunt, J. H. *St. Bartholomew's Hospital Journal* (1934-35), 42, 11, 31, 55.

<sup>7</sup> Read, G. D. *Natural Childbirth*, London, 1933. *Revelation of Childbirth*, London, 1943.

<sup>8</sup> Galton, Sir Francis. *Inquiries Into Human Faculty, etc.*, Ed. Everyman, p. 162, London, 1928.

## TWELFTH DECENNIAL CLUB

It is proposed to hold a meeting of this Club which incorporates those men who are now qualified who entered St. Bartholomew's Hospital between October, 1925, and October, 1935, on Friday, May 13th, at 6 p.m., at the Hall of the Society of Apothecaries, Water Lane, E.C.1.

All old Bart.'s men who are eligible for membership will be welcome whether or not they have already joined the club.

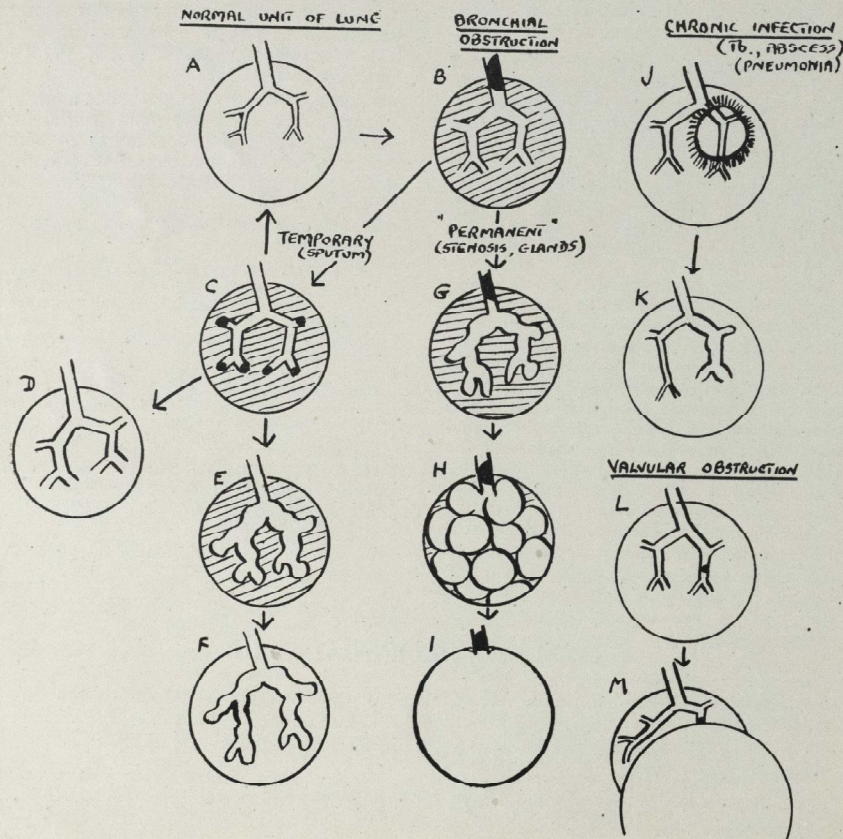
## THE DEVELOPMENT AND ASSESSMENT OF BRONCHIECTASIS

By N. C. OSWALD, M.D., M.R.C.P.

BRONCHIECTASIS denotes permanent or semi-permanent bronchial dilatation, which is liable to give rise to sputum, haemoptyses, and chronic pneumonia. The name is not altogether satisfactory as it lays too much emphasis upon the shape of the bronchial walls and takes no account of pulmonary changes between the bronchi which often are of considerably more clinical importance than

the defects in the bronchi. It may arise in at least four different ways, namely as a result of "permanent" bronchial obstruction, temporary bronchial obstruction, valvular bronchial obstruction, or chronic pulmonary infection. These mechanisms are shown in the diagram. (A) represents a normal unit of lung which may be either a whole lung, a lobe, or part of a lobe. When a bronchial

### STAGES IN THE DEVELOPMENT OF BRONCHIECTASIS



obstruction occurs, air behind the obstruction is absorbed with resulting collapse of the unit and cylindrical bronchial dilatation (B), the shaded lines indicating that the lung is collapsed. Should the obstruction be temporary, as by sputum, the distal negative pressure will tend to suck the sputum further into the lobe (C); this is the state of affairs in such conditions as post-operative atelectasis and atelectasis associated with whooping cough or bronchitis. If the sputum is dislodged quickly, the lung usually returns to its original state (A); if it is not, permanent changes may occur in the bronchial walls, so that when the lung does re-expand, the bronchi remain cylindrically dilated (D). Should the bronchi become severely infected before expansion occurs, saccular bronchiectasis results, which is an irreversible condition (E). Possible subsequent re-expansion (F) depends largely upon whether or not the alveoli between the affected bronchi are damaged.

Should the bronchial obstruction depicted in (B) be "permanent," as by an organic stenosis, pressure of glands from without or foreign body, the subsequent course depends upon the nature of the bacteria distal to the obstruction. If they are not pathogenic, benign atelectasis with some degree of cylindrical bronchial dilation may persist indefinitely. If pus-forming organisms are present, the bronchial tree is liable to be distended by pressure of the pus, quite apart from any destructive lesions of the bronchial walls that the infection may produce (G). In a few instances, the bronchial tree is grossly distended (H), or may even take on the appearance of a cyst (I).

When a portion of lung is the site of chronic infection, as in tuberculosis, lung abscess, or pneumonia, all the elements of the lung may be involved in the inflammatory process (J). The end result of this may be a patch of irregular bronchiectasis confined to the site of the original infection (K); this is commonly seen in chronic fibroid phthisis and as a complication of lung abscess. The importance of the mechanism in cases of pneumonia is very difficult to assess. So often patients suffering from bronchiectasis date their symptoms from an attack of pneumonia, but whether the bronchiectasis results mainly from the destructive effects of the pneumonia itself, or from bronchial obstruction and atelectasis due to sputum, must remain largely a matter for conjecture.

The fourth possible mechanism in the production of bronchial dilatation is by a valvular mechanism, whereby a partial bronchial occlusion allows the passage of more air along the bronchus during the phase of dilatation in inspiration than can escape during the phase of passive relaxation in expiration (L). In time, this results in cyst formation (M).

Thus, bronchiectasis is not a disease in itself, but a complication either of some form of bronchial obstruction, or of chronic pulmonary infection. The underlying cause should be sought in every case and treated where possible.

### CLINICAL ASSESSMENT.

The clinical assessment of any case of bronchiectasis naturally falls under six headings, namely—

(1) The daily quantity of sputum should be assessed. If it is more than two ounces, the case can be regarded as clinically "infected," due regard being paid to whether or not systematic postural drainage has been employed, as grossly infected cases can often have their sputum reduced to a trace by this method. It is as well to remember that the quantity of sputum expectorated is a fallacious guide to the state of the infected lung, as not infrequently patients producing little sputum are found to have large quantities of pus in their lungs at operation.

(2) Haemoptyses are uncommon in children, but increased in frequency and quantity with age. Once haemoptysis has occurred, and it occurs in the majority sooner or later, it is likely to be repeated.

(3) The number of attacks of pneumonia associated with the bronchiectasis should be determined.

(4) The anatomical extent of the disease should be estimated accurately by bronchograms outlining all the principal bronchi in both lungs. This is obviously essential in any case in which pulmonary resection is contemplated.

(5) The age is of considerable significance from the surgical standpoint. The ideal time for pulmonary resection is at about the age of ten, although good results with little in the way of complications and sequelae can be expected up to about the age of thirty-five. Beyond this age, pulmonary resection should be less lightly undertaken.

(6) The secondary effects of bronchiectasis, both local and general should be assessed. The local effects consist of



fibrosis, emphysema, chronic pneumonia and bronchitis. The general effects include chronic ill-health, stunting of growth and clubbing of the fingers.

The majority of cases of bronchiectasis have, perforce, to be treated medically, either because the disease is too extensive for pulmonary resection, or the patient is too old, or there are complications. Excellent clinical results are often obtained by prolonged postural drainage, which includes sleeping on a frame at night in the position most suitable for the promotion of bronchial drainage.

It is evident from the chart that cylindrical bronchiectasis may be reversible; it may be

taken as a general rule that cases of this sort should be treated medically for six months, particularly if there is associated atelectasis, as it is usually impossible to determine from a single film whether or not the bronchi have been permanently damaged.

Surgical resection, the only cure for established bronchiectasis, is an excellent form of treatment in the younger age groups when the anatomical extent of the disease is not too great. It is applied usually to cases troubled by either foul-smelling sputum, haemoptyses, or recurrent pneumonia, or any combination of these, which fail to respond to other forms of treatment. The mortality from the operation is negligible and the complications slight in carefully selected cases.

### A GREY ELEGY

Written in a London Fog.

The foghorn wails adieu to parting day,  
The jostling crowd gropes slowly down the Strand.  
The worker homewards plods his weary way,  
And grumbles in the darkness "What a land!"  
Now smarts the acrid vapour on the sight,  
And all the air a solemn stillness holds,  
Save that from taverns, far into the night,  
Escape the sounds of raucous coughs and colds.  
Save that from yonder mist-enthralled tower  
Great Ben doth force the traveller to complain,  
As far aloft he booms the passing hour,  
"Confound the fog, I've missed the blessed train."

G. J.

### THIRTEENTH DECENNIAL CLUB

The second meeting of the Thirteenth Decennial Club was held on the 3rd of December, 1948, in the Refectory at Charterhouse.

It was in some ways an unsatisfactory reunion. Members felt that the Refectory lacked convivial atmosphere, but it must be remembered that the Hall was lent by the Medical College, at this stage of the Club's growth an economic necessity.

The main complaint, however, concerned the inadequate catering—in insufficient food and expensive drinks, despite the fact that the previous year the caterers had appeared satisfactory. The Secretaries have sent a sharp letter to the Company and different arrangements will be made next year.

The meeting was redeemed by Prof. D'Silva, who took the chair and spoke with his usual charming dryness. He reminded members that this was not only the last Decennial Club to sport all-male membership, but the final one to be born "out of bondage."

It is hoped that next year members will not be deterred by the shortcomings of this last reunion, and will make the effort to meet again. Indeed, we understand in the old days men were known to return for meetings even from the wilds outside the Home Counties. But then, of course, we were all out of bondage.

## CORRESPONDENCE

### THE MORTAL LANDLADY

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

Your contributor David Carrick has again enlivened the columns of the JOURNAL, this time with a delightful account of the vagaries of The Eternal Landlady; joyously we read on, and can now classify our own as well as recognise each other's.

However, two points arise, both of which need amplification so, with the author's permission, I will proceed. And, Sir, if any of your readers are tired of studying under street lights on the Embankment, or are bored with roistering each night in a friendly tavern for want of a happy lodging life, they may take comfort from my words: indeed, I venture to hope they may cheer the luckless students who, speaking lightly of "Landlady Trouble," lift a curtain from their own drab world where they are being hounded, if not from district to district, from front-room to back, and from back-room to basement.

Firstly, where are the cheerful bodies who encourage their lodger's waywardness with kindly words and good advice? Mr. Carrick's final example is a monster who does not represent them fairly. We know of one, with crippled joints and aged partner—a charming Darby and Joan couple they make—who recently censured her lodger for becoming engaged to a lady he had only known for five months. "You haven't tried living with her," she asserted plaintively. The reply naturally included a query whether she ever practised her own advice. "You mean my husband and I?" she smiled. "We're not really married yet." Students are respectfully informed that these digs are not to let.

Secondly, the recognition of the different kinds of landlady is important, but careful selection may compensate for faulty treatment. In this as in any game there are rules to be followed. After arrival at new digs, the lodger is on his best behaviour, the landlady watches, cat-like for signs of bad behaviour. The first mistake is usually made by the landlady, who confuses her lodger's politeness with weakness and stupidity: she proceeds to progressive criticism and increasing complaints. The lodger continues to behave carefully, and avoids counter-criticism. Eventually, the lady makes a more serious mistake in the form of trivial or unsubstantial criticism. This is the moment for which the lodger has waited.

Instantly, he closes the door and counters with a simple question, "Madam, am I the worst lodger you have ever had?" or "Are you proposing to drive me out of my mind, or just into the street?" A negative reply is the lady's third mistake. The lodger presses his advantage, speaks rapidly for perhaps four minutes—the form of words is unimportant—then suggests that the lady should leave. It is important to ensure that this happens at once.

The lodger need not pack. He simply lights a coal fire, removes a representative selection of Landseer and Alma Tadema from his walls, rests his feet upon the mantlesheaf, and smokes freely. The prognosis is very good.

The next day he expresses gratitude for, but not surprise at, his early cup of tea. He does justice

to an excellent hot lunch served immediately upon his return from the hospital, and expresses approval of the fresh flowers in his room.

This concludes the game, and the players now live amicably under the same roof until the landlady dies or the student qualifies, whichever is the earlier.

I am, Sir,

Yours faithfully,

J. McO.

The Abernethian Room,  
St. Bartholomew's Hospital,  
16th March, 1949.

### SPECTACLES AND THE NATIONAL HEALTH SCHEME

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

I was interested to read the remarks of your correspondent, Mr. J. B. D. Andrews, about the enormous number of spectacles provided under the National Health Scheme. This, he says, points to the fact that many people needing spectacles in the past did not obtain them for economic or other reasons. I would like, if I may, to occupy a little of your space with a statement of fact about the provision of glasses under the N.H.S. and before it.

1 It is quite untrue to say that before July 5th, 1948, anybody was deprived of the benefits of spectacles for economic reasons. In those days an accurate pair of glasses was provided by the Hospital Opticians for the sum of 10s.—12s. Moreover, because the control of these glasses was in the hands of doctors who knew when glasses were necessary the execution of these orders was immediate and the patient received his glasses in a few days. If he could not afford this price the spectacles were presented to him through one of the charitable funds of the Hospital.

2 I am not in the least surprised that 2,357,000 pairs of spectacles were provided under the N.H.S. between July 5th and November 23rd, 1948. Most of these spectacles were obtained by walking into a shop and they were provided for every symptom concerning the eyes and many not even remotely associated with them. Because they cost the patient nothing, and because they were unnecessary in the first place, they were abandoned after a brief period without regret. But let it be remembered that each pair of glasses so prescribed cost the "State"—which is you and me and the other chap—£4. Moreover, the patient now has to wait anything up to six months before the glasses are delivered.

Glasses are only of benefit if they are necessary and the huge number provided under the N.H.S. is not in any way an indication that the public, before July 5th, 1948, went short of any spectacles which were needed.

Yours faithfully,

SEYMOUR PHILPS.

104, Harley Street,  
London, W.1.  
April 8th, 1949.

## SIR JAMES PAGET AND ST. BARTHOLOMEW'S HOSPITAL

By

JOHN L. THORNTON and GWENETH WHITTERIDGE, M.A., D.Phil.

*Based on a Demonstration to the Paget Club,  
June, 1948.*

JAMES PAGET was born at Yarmouth on January 11th, 1814, the son of Samuel Paget, a prominent ship owner, banker, brewer, "train-band" captain, and in 1817, Mayor of the town. Young James felt the call of the sea, and intended to enter the Navy, but after attending a private school, in March, 1830, was apprenticed to Charles Casterton, a surgeon in practice at Yarmouth. After 4½ years James proceeded to London, but had already become deeply interested in natural history, particularly botany. With his brother Charles he published *A sketch of the natural history of Yarmouth*, which appeared in November, 1834, priced at half-a-crown. James wrote later of the work involved in preparing the volume: "The knowledge was useless: the discipline of acquiring it was beyond price."

Paget entered Bart.'s at the beginning of October, 1834, when Lawrence, Stanley, Latham, Roupell, Farre, Wormald and Hue were teaching, and Burrows was a junior. The School had rapidly declined since the retirement of John Abernethy, but the Museum was good, being based on collections presented by Abernethy and Stanley, and there was a small library stowed away in a room next to the operating theatre.

In 1835, School examinations were held (having been inaugurated in 1834), and Paget entered for Medicine, Surgery, Chemistry and Botany, to emerge first in all four. His prize for Surgery consisted of the second edition of Astley Cooper's *Anatomy and surgical treatment of abdominal hernia*, 1827, which was presented to the Library by Sir Norman Moore in 1910. Also in his first year, James Paget discovered the *Trichina spiralis* in a subject in the dissecting room, and although Sir Richard Owen appears to have attempted to gain the honour of priority, Paget read a paper on the subject before the Abernethian Society on February 6th, 1835, an abstract being available in the Minutes of the Meetings of the Society. Owen's paper (*Trans. Zoo. Soc.*, 1835, i, pp. 315-24) is illustrated by reproductions of specimens first observed by Paget.

In his second year James Paget took Anatomy, Physiology, Clinical Medicine and Medical Jurisprudence, and the interest aroused in his successes of the previous year was enhanced by his once more occupying the premier position in all subjects.

On May 13th, 1836, James Paget passed the membership examination of the College of Surgeons, and his Certificate is preserved in the Library. Among others, it contains signatures of John Goldwyer Andrews (President), Sir Astley Cooper, Sir Anthony Carlisle, Honoratus Leigh Thomas, Robert Keate, John Painter Vincent, George James Guthrie, Anthony White, Sir Benjamin Collins Brodie and Samuel Cooper, all of whom held the office of President during their careers.

Paget now waited for an appointment at the Hospital. He took a few pupils, wrote for the *Medical Gazette*, of which he was sub-editor from 1837-1842, and learned Dutch and Italian, having previously acquired French and German. He did journalistic work for the *Quarterly Review*, the *Penny Cyclopaedia*, and the *Biographical Dictionary*, published by the Society for the Diffusion of Useful Knowledge. He generally worked until 1 or 2 o'clock every morning, but was very poor. His father had died, after the failure of his business, and the sons set out to repay all creditors. The last payment was made in 1862.

In 1837 Paget was appointed Curator of the Museum, and he made a catalogue, continuing that of Stanley, the completed work being published in three volumes. The original manuscript is preserved in the Hospital Archives. This led to his being invited to compile a *Catalogue of the pathological Specimens of the Royal College of Surgeons of England*, which was originally published in five volumes, 1846-49. In the preparation of a second edition of four volumes, published 1882-85, Paget was assisted by J. F. Goodhart and Alban Doran.

James Paget was ill with typhus during the first three months of 1839, but in the summer was appointed Demonstrator of Morbid Anatomy at Bart.'s. Two years

later he became surgeon to Finsbury Dispensary, and in 1843 was elected one of the original Fellows of the College of Surgeons. The same year Paget took up residence inside the College as Warden, which position he occupied until 1851. He had married in May, 1844, spending a one-day honeymoon at Oxford.

Also in 1843, Paget became Lecturer in Physiology, his lectures providing most of the material for the first edition of William Senhouse Kirkes's *Hand-book of Physiology*, 1848, which, under various editors has survived to the present day. It is now edited by R. J. S. McDowall. The year 1847 saw the appointment of James Paget as Professor of Anatomy and Surgery at the College of Surgeons, and he also became Assistant Surgeon to Bart.'s. It was during the period 1849-50 that James Paget, as Warden of the College, was responsible for the admission of Elizabeth Blackwell, the first woman to study in the Hospital.

Paget published his lectures on general pathology in the *Medical Times and Gazette*, these being later revised and published as *Lectures on surgical Pathology*, 2 vols., 1853, a pioneer work on the subject. A second edition, revised and edited by William Turner was published in 1863, a third in 1870, and a fourth in 1876.

In 1874 and 1877 respectively, James Paget published original descriptions of "Paget's disease of the nipple," (*St. Bart. Hosp. Rep.*, 10, 1874, pp. 87-89) and "Paget's disease," (osteitis deformans). (*Med-Chir. Trans.*, 60 1877, pp. 37-64; 1882, pp. 225-236), both of which are recognised as classic contributions to medical literature.

Among the many honours bestowed upon Paget, the following in particular deserve mention: in 1851 he was elected F.R.S., and served five times on the Council; March, 1858 saw his appointment as Surgeon Extraordinary to Queen Victoria; and he was appointed a member of the Senate of London University in 1860.

On April 3rd, 1861, Paget was appointed Senior Assistant Surgeon, and on July 24th, Surgeon to Bart.'s, and in the following year was elected Surgeon to Christ's Hospital. He became Surgeon-in-Ordinary to the Prince of Wales in 1865, and in the same year became Lecturer on Surgery at Bart.'s, holding that office until 1869.

October, 1867, saw the appointment of James Paget as Serjeant Surgeon Extraordin-

ary to Queen Victoria, and ten years later he became Serjeant Surgeon, the patent for which, with its magnificent seal, is housed with the Hospital Archives. It is accompanied by Paget's certificate of honorary Fellowship of the Royal College of Surgeons in Ireland, dated April 20th, 1886.

James Paget was President of the Clinical Society in 1869, of the Royal Medical and Chirurgical Society and of the Royal College of Surgeons in 1875, and of the Pathological Society in 1887. He received numerous honorary degrees and distinctions, being created a baronet in 1871. In the same year he resigned his office of Surgeon to the Hospital, and was appointed Consulting Surgeon. Sir John Millais painted his portrait in 1872, and it now hangs in the Great Hall.

Sir James Paget published *Clinical Lectures and Essays* in 1875, and two years later delivered the Hunterian Oration before the Prince of Wales, Gladstone, the Duke of Argyll, the Duke of Westminster, Dean Stanley, Lord Acton, and Huxley, among other distinguished persons present.

In 1878 Sir James Paget gave up operating, and on February 10th, 1881, he was elected a Governor of Bart.'s. When seventy-seven years of age, Sir James made a careful survey of his old cases, publishing the results as *Studies of old Case Books*, 1891.

Paget had addressed the Abernethian Society on its fiftieth anniversary, and on May 1st, 1895, he was present when Norman Moore gave an address at the Centenary Celebrations. Sir James, himself, gave the Inaugural Address of the 100th Session, which was probably his last paper to be printed during his lifetime, and appeared just sixty years after his first publication. The address was published in the *British Medical Journal* of October 20th, 1894, pp. 874-877.

On January 7th, 1895, Lady Paget died, and in the following year Sir James finally "retired." He was unable to speak above a whisper, to move or stand without assistance, but bore these infirmities during the last two years of his life with infinite patience and humour. He still loved music, and liked to be driven around London in his carriage. Sir James Paget died on the night of Saturday, December 30th, 1899. Part of the funeral service was held in Westminster Abbey, but he was buried with his wife at Finchley.

Sir James Paget had prepared his "Memoirs," which his son Stephen proceeded to edit, the volume appearing in 1901.

It was reprinted on at least seven occasions.

The Medical College Library houses a certificate presented to Sir James Paget by the Abernethian Society in 1871 upon his resignation as treasurer; copies of reprints of his papers in periodical literature; a bibliography of his writings by Helen C. Putnam (1902); seven volumes of his case-books; some autograph letters, and portraits. Copies of testimonials to him, written out in his own neat handwriting, are preserved in the Hospital Archives.

A brief survey of such a full and distinguished career can only sketch in hazy outline the outstanding features of eighty-five eventful years. Paget built success from absolute poverty by sheer hard work, and achieved his pre-eminent position without making enemies. He was beloved by royalty and by

the poor, while his professional colleagues held him in the highest esteem.

After John Abernethy, Sir James Paget should be regarded as the most outstanding personality in the history of the Medical College. As its first Warden and as a lecturer he impressed students by his upright character and professional knowledge. Yet, although dignified and fully conscious of the enviable position he had achieved, Sir James Paget did not allow success to turn his head. He was deeply religious and as his son tells us, "He would even say grace over his medicine." He is heard of at the present time mainly through the diseases which bear his name, but he should receive due consideration as botanist, anatomist, physiologist, pathologist, surgeon—and as an eminent son of Bart.'s.

## SPORT

### R. U. F. C.

#### March 5th, v. Old Colfeians

RESULT: WON BY 11 POINTS TO 3.

This fixture was arranged at the last minute owing to a late cancellation and provided a frankly disappointing game. Bart.'s were much the better side but failed to take many of their chances and only managed to give a mediocre display.

Starting well, the Hospital were soon ahead—through a good try in which most of the side handled before John went over and Dick added the points with a good kick. After this promising start, play became indeterminate, Bart.'s losing much of their fire and allowing the opposition to come near to scoring on several occasions; however, at half-time the score was 5-0 to Bart.'s.

After the interval, some more ragged play followed for about 10 minutes before Bart.'s got into their stride. John scored his second try of the match by taking the ball out of the hands of the opposing scrum-half; then Third kicked a good penalty goal and Bart.'s were now on top. A bad lapse in defence conceded one unconverted try.

#### March 12th, v. Nottingham

RESULT: DRAWN—3 POINTS EACH.

In a keenly contested, somewhat scrappy game Bart.'s played well to draw with the visitors from Nottingham. The Hospital pack showed plenty of life and although out-weighted managed to get more than their fair share of the ball from the set scrum; in the loose, Notts forwards were allowed to come through rather too often, but generally speaking the lively spoiling play of Bart.'s stopped many dangerous movements. The backs tended to lack speed and cohesion when running with the ball, but in defence the visitors were closely marked outside the scrum and given but few chances.

After a scrappy first half the game developed into a fast, open affair. Nottingham were unlucky not to have scored in the first half from two excellent drop kicks by their fly-half, but the sides crossed over without a score.

Macpherson opened the scoring for Bart.'s with a magnificent penalty goal from 35 yards, just after

the restart. This led to some good open play and a strong Notts attack was stopped only by the excellent tackling of Roberts on the left wing. Bart.'s again swung into attack; the pace became hotter but the Hospital continued to press until, in the last 30 seconds, an excellent movement by Notts gave them a try far out; the kick failed from a difficult angle and so the game ended in a draw.

#### March 19th, v. Cheltenham

RESULT: LOST BY 0 POINTS TO 16.

An urgent last-minute telephone call to South Wales where Strong was on holiday, enabled us to field 15 men against Cheltenham.

We did not acquit ourselves well in attack, but good tackling by the backs kept the score against us to two goals, a try and a dropped goal. Pearce, the Cheltenham and Gloucestershire scrum-half, scored the greater part of his side's points. Despite an unusual pack supporting him and an unusually shaped right ear, our captain hooked with his customary competence, led his very weary followers with inspiring verve, and entertained the crowd to ghastly yells whenever his injured ear was subjected to trauma.

John supplied some bright moments in what was euphemistically described in the local Press as a "modest game."

#### March 26th, v. Moseley

RESULT: LOST—3 POINTS TO 27.

The home team started off in devastating form and had scored 13 points in less than 10 minutes. The spectators were obviously expecting a major rout, but the Bart.'s players pulled themselves together and, thereafter, fought gamely to the end.

The forwards, some of them out of training and in unusual positions, could never quite match the big Moseley pack; this superiority, plus the elusive Edge at stand-off half, were the deciding factors in a fast, open game.

Struthers and Clare were in fine form in the centre, and Murphy dealt suitably with Layton, while Baker maintained his excellent form at full-back.

Corbet scored the Bart.'s try by following up his

own kick ahead and winning the race for the touch-down. He followed this with an excellent piece of work when he deprived Edge of the ball when that worthy was ambling along behind the goal-line, hoping to touch down between the posts. Well done, Cobber!

Hick, who had been playing well, had the misfortune to fracture his tibia in the second half. The ever-versatile Holland deputised, much to the chagrin of Corbet, who always fancied himself as a scrum-half.

Dick thrilled the crowd soon afterwards with a crash tackle near the corner flag, which was executed with such force that he, too, nearly had to be carried off.

The piece de résistance, however, came from a tall, fair-haired second-row forward. Let it be said at once that he played a truly stalwart game: so much so that he was taking a well-earned "breather" when Edge kicked ahead. The ball came to rest beside him and, seeing a clear way ahead, he was galvanised into action. The crowd rose to a man! A dash down the wing and he was over! Yet something held him back. Could anything be wrong? Or was he concocting some devilish cunning manoeuvre? Slowly he moved forward. The crowd roared. This was it! Alas, it was indeed. The skipper, who started three yards in front, just got back in time to receive the inside pass as the exhausted warrior sank slowly to the ground.

*The Annual General Meeting of the R.F.C. will be held on Friday, May 6th, at 5.30 p.m., in the Medical and Surgical Lecture Theatre. This will be followed by the Annual Dinner, tickets for which may be obtained from either P. D. Moyes or J. L. M. Corbet.*

## CRICKET CLUB

The Captain this year is P. D. Moyes, the Secretary, P. G. Haigh. Trial nets have been arranged and it is hoped that all newcomers to the Hospital wishing to play in any of the teams will get in touch with either of the above.

M. D. Mehta has been appointed Captain of the 2nd XI.

The 1st XI tour this year will take place in Sussex in mid-August.

## CROSS COUNTRY CLUB

Four matches were held in the second half of the season, the results of which showed a great improvement on those held before Christmas.

#### February 2nd, v. Wye College at Wye

RESULT: 1ST, BART.'S, 23 POINTS; 2ND, WYE, 32 POINTS.

Wye College rightly claims to possess one of the few true cross-country courses in the South. In the longest six miles which one is ever likely to encounter, no less than four hills present themselves. Each appearing to be far larger than the one before, and twice as steep.

However, this proved to be our first victory, which gave slight consolation to those who—"really shouldn't have eaten so much lunch before the run."

Bart.'s positions: 1st (equal), A. E. Dormer and J. I. Burn, 37 mins. 34 secs.; 3rd, P. D. Matthews; 7th, G. Wallace; 13th, J. Taylor; 14th, J. Nielsen. Distance: 6 miles.

#### February 5th, v. Bristol University, v. Bagnor University at Bath

RESULT: 1ST, BRISTOL, 34 POINTS; 2ND, BART.'S, 42 POINTS; 3RD, BANGOR, 44 POINTS.

Notwithstanding the fact that this was the second race in one week, a creditable performance was put up against a strong Bristol side. Dormer was unlucky not to finish higher than he did, this being due to shoe trouble half-way round. J. Menon ran a well judged race to beat the Bristol University champion in convincing fashion by 10 seconds.

Bart.'s positions: 1st, J. Menon, 40 mins. 20 secs.; 3rd, J. I. Burn; 9th, A. E. Dormer; 18th, G. Wallace; 19th, J. Taylor; 20th, J. Nielsen; 21st, F. Montfort.

Distance: 6½ miles.

#### February 12th, v. Kings College at Chislehurst

RESULT: 1ST, KINGS, 14 POINTS; 2ND, BART.'S, 22 POINTS.

A sorry day for Bart.'s this, and one that it is prudent not to linger over any longer than is necessary. Suffice to say that we could do no better than find four runners only to compete against these old rivals of Bart.'s.

Another splendid run by Dormer, well backed up by G. Wallace.

Bart.'s positions: 1st, A. E. Dormer, 41 mins. 20 secs.; 7th, G. Wallace; 11th, J. Taylor; 12th, J. Nielsen.

Distance: 6½ miles.

#### February 19th, v. Barclays Bank at Norbiton

RESULT: 1ST, BARCLAYS BANK, 18 POINTS; 2ND, BART.'S, 37 POINTS.

This was a new fixture and proved a most enjoyable one. The Bank proved too strong for us, but the distance was in their favour and we were by no means disgraced. What made the day even more pleasant was the fact that Mick Glanvill was able to take time off from his R.A.F. duties to come and run for the Hospital.

Bart.'s positions: 4th, J. I. Burn, 45 mins. 35 secs.; 6th, A. E. Dormer; 9th, M. E. Glanvill; 10th, G. Sparrow; 14th, G. Wallace.

Distance: 7½ miles.

### UNITED HOSPITALS CHAMPIONSHIPS

#### March 12th at Petersham

RESULT: 1ST, BART.'S, 31 POINTS; 2ND, GUYS, 55 POINTS; 3RD, MIDDLESEX, 61 POINTS; 4TH, LONDON, 63 POINTS.

The Championships were held over the United Hospitals' new course at Petersham, which winds its way through Richmond Park to the Kingston Gate, a steep climb up to the Common, and thence home through the bracken and trees.

Bart.'s was well represented in a large field of over 30 runners from five Hospitals. As expected, J. A. Menon took the lead early on in the race, and never lost this position. His time of just over 29 minutes for the five miles was good, and with greater opposition would no doubt have been much nearer the record for the course. This was his second successive victory in the Championships and a fitting conclusion to a successful season.

Other Bart.'s runners were well to the fore, and with five men home in the first 12 the Kent-Hughes Cup was ours for the fourth year in succession.

Bart.'s positions: 1st, J. Menon, 29 mins. 0.7 secs.; 3rd, J. I. Burn; 4th, A. E. Dormer; 8th, H. B. Lee; 11th, P. D. Matthews; 14th, M. E. Glanvill; 15th, G. Wallace; 21st, J. Taylor; 26th, J. Nielsen. Distance: 5 miles.

So ended a season which started somewhat shakily, improved slightly as time went on, and ended on a triumphant note in the one victory which really mattered.

A special word of praise is due to Messrs. Dormer, Nielsen, Taylor and Wallace who gave the Club their fullest support throughout the season.

J. I. B.

SUMMER SEASON, 1949.

At the recent A.G.M. of the Athletic Club, the following officers were elected for the coming year:—

*President:* Mr. H. B. Stallard, F.R.C.S.

*Captain:* J. I. Burn.

*Vice-Captain:* J. A. Menon.

*Hon. Secretary:* P. D. Matthews.

*Assistant Secretary:* A. E. Dormer.

## MEDICINE IN SHAKESPEARE'S TIME

By M. J. CLARKE-WILLIAMS.

"... by which the reader is convinced, I hope, of the insignificance of Hypothefes, and the importance of Observation..."

—Francis Clifton, M.D.

"A Plan for the Improvement of Phfyck." 1732.

The period to be described is not strictly that of Shakespeare's lifetime, for he was born at a time when the changes affecting Medicine, and indeed every branch of learning, were already under way. In order to view the state of Medicine existing during his lifetime one must therefore go back to the dawning of the sixteenth century. Such a study forms a background to the medical references, which are to be found in Shakespeare's plays. Nor is it intended to confine this study to the state of medical knowledge in England but rather to range across the century seeking the important discoveries and the men whose contributions to Medicine were the greatest. Most of the work was, it is true, carried out abroad but certain Englishmen appear among the famous doctors of the period. Despite the tedious methods of travel between one country and another, new discoveries in science were fairly rapidly disseminated throughout the civilized world. And it is fair to assume, I believe, that the state of medical knowledge in England was, in broad outline, similar to that co-existing in other countries where medical thought was advancing more swiftly.

The Renaissance in learning came late to England, but when it came it produced the Golden Age, far surpassing the Italian Renaissance which it followed by so many

SPORTS DAY THIS YEAR WILL BE HELD ON SATURDAY, JULY 2nd.

## WOMEN'S HOCKEY CLUB

The Women's Hockey Club, which was formed last October, has played five matches this season. Two of these were won and three lost, Middlesex Hospital Radiographers, Bromley High School and Dickensons Ladies' Club proving too strong for us.

Professor Wormall has consented to become President of the Club, which was captained this season by Eileen Caldwell.

We should like to thank the men's hockey club for the help they have given us, and Mr. White for his co-operation.

years. Little or no progress had been made in Medicine in the Middle Ages and Early Renaissance: the surgeons and physicians were for the most part insignificant. It has been said that the great Elizabethan glory shed little of its light upon our profession, and yet it was a great phase of consolidation and re-orientation of medical thought. It followed a period of thirteen hundred years during which medical knowledge far from remaining stationary, actually retrogressed. The dogmatic authority of the ancients was now for the first time questioned and scientists began again to look for themselves rather than accept without demur the views laid down by Galen and others.

It was in anatomy that the greatest advances were made during the 16th century. Physiology had not as yet been dissociated from anatomy, the latter being studied by dissection and the former merely inferred from the observed structure. Jean Fernel was the first to apply the word "physiologia" to a special branch of medical knowledge. In the early years of the century the many-headed genius of Leonardo da Vinci commands one's attention. The sheets of his anatomical drawings preserved in the King's collection at Windsor make a fascinating study. Mostly the text is illustrated with small drawings, though there are some full page ones as well. Interspersed throughout

the anatomical and physiological notes are mathematical calculations, architectural doodling and the artist's notes on faces and figures that have attracted his attention! Unfortunately these drawings and his illustrations for Marc Antonio della Torre's anatomical treatise were never published and in fact were unknown until 1898.

One year previous to the death of Leonardo da Vinci in 1515, there was born in Brussels a certain André Wesel, better known as Andreas Vesalius. He was the son of the apothecary to Emperor Charles V and after graduating at Louvain he decided to study medicine. For a time he worked in Paris under Sylvius, but soon he was dissatisfied with the way Sylvius subordinated all his teaching to the theories of Galen. He studied at several Universities before going to Padua where he received his doctorate of medicine in December, 1537. He was immediately offered the Professorship in Anatomy and Surgery, a post which he held for more than six years. By his careful dissection and observation he soon began to expose Galenic errors which had stood unchallenged for one thousand three hundred years. In association with the artist Jan Calcar, who had been a student under Titian, Vesalius produced "De Fabrica Humani Corporis," which was printed in Basel in 1543 by his trusted friend Oporinus, the Professor of Greek there. It is interesting to note that one of the illustrations in this book is reputed to be the source of the inspiration of Shakespeare's "Alas, poor Yorick . . ." scene in "Hamlet." The authority of Galen in anatomy, based chiefly upon dissections of the Barbary ape and the pig, was approaching its end. Vesalius met with fierce opposition not only from the older generation of anatomists but also from some of his own students. So powerful was this opposition that Vesalius, then only 29 years of age, could no longer stand against it; he left Padua and became court physician to Emperor Charles V. He held this appointment for 20 years until his death, returning from the Holy Land, in 1564. Despite the short period of his anatomical work he had caused an upheaval in anatomical thought, and his good work was carried on by many of his pupils, notably Miguel Serveto, Bartholomew Eustachio and Gabriele Fallopius. Throughout his work Vesalius strove to discover the true structure of the human body and later in life when his successor in the Professorship at Padua, Fallopius, corrected

some Vesalian errors, Vesalius rather than refute the new teaching as earlier generations would have done, longed to return to the dissecting table and verify for himself these new observations. Indeed he was returning to resume the chair at Padua when his ship was wrecked off the Island of Zante, where he died.

The 16th century was a womb rich in eponymous anatomical structures, and it is not entirely coincidence that a large number of the names so commemorated are those of Vesalius's pupils. Alongside the names of Eustachius and Fallopius should stand that of Hieronymus Fabricius, who in 1600 published "De formato fetu" and also did much work on the valves in veins, which was later to influence an English student of his, William Harvey. John Caius was reader in anatomy at the Barber Surgeon's Hall in the middle of the century, having studied anatomy at Padua with Vesalius, with whom it is said he was great friends. Anatomical instruction was not started in England until the latter half of the century and John Caius is believed to have been among the first teachers of anatomy in England. By an Act of Parliament of 1540 the bodies of four executed criminals were allowed annually to the Barber Surgeons for dissection. The dissections in those days were performed in public and were a well recognised "entertainment." Upon this groundwork of improved knowledge of anatomical structure were built the great advances in surgery in the 17th century and the breakaway of physiology and its establishment as a separate science.

Among surgeons too there was the general spirit of restlessness and although no very notable advances were made during the century in the practice of surgery, the considerable advances in anatomy had unsettled the authority of the ancients upon which surgeons had relied for so long. There was a re-assessment of current surgical practice, led principally by Ambroise Paré, and many old procedures that had proved effective, but had fallen into disuse, were revived. The chief operations which a surgeon at this time might be called upon to perform were lithotomy by Celsus, Marian, or Franco's methods; repair of hernia; amputation of limbs; and various operations upon the skull. Paré, who was the most notable surgeon of this period, was born in 1509 and at the age of 20 came to Paris to study as a barber's apprentice. A large portion of his

surgical work was done with the army on the battlefield, where his particular interest was in the treatment of gunshot wounds, about which he wrote a classical treatise. He performed operations for hernia that did not involve castration, unlike most of those performed by his contemporaries. Paré introduced podalic version into obstetrics and also the induction of labour for antepartum hæmorrhage. He devised many new instruments, re-introduced the ligature and revived the practice of amputating through healthy tissue instead of at the edge of the diseased part. Both Ambroise Paré and Felix Würtz (1518-1575) wrote books on general surgery that were superior to any previous works.

In the field of plastic surgery Gasparo Tagliacozzi of Bologna introduced an operation for the repair of the nose, that is still performed at the present time. In 1500 a Swiss sowgelder, Jakob Nufer, performed the first successful cesarean section upon his own wife, who survived the ordeal to bear several further children normally. There is, however, some doubt as to its being a true cesarean section for it is believed that it was an extra-uterine pregnancy. Post-mortem examinations were introduced into pathology by Antonio Benivieni, who performed over 20 such examinations on various diseased persons at the close of the 15th century. The general standstill in surgery during the 16th century and the plethora of "strangely-visited people, all swollen and ulcerous, pitiful to the eye, the mere despair of surgery," makes one wonder why the 16th century was so poor and the 18th so rich in great surgeons. The late Professor Clifford Allbutt, in writing of the surgery of this period, posed the question: "If Italy while mistress of the formative arts produced great surgeons, does the poverty of England in these arts illustrate its defects in surgery, until both arrived with Hogarth and Reynolds, Cheselden and Hunter?"

Just as Vesalius dominates anatomy during this period, Ambroise Paré surgery, so in medicine also there is one outstanding figure. It is the enigmatic personality of Philip Aureolus Theophrastus Bombastus von Hohenheim—Paracelsus. It is difficult to assess how much of him was genuine and how much sheer exhibitionist. He refuted the teachings of Galen, and indeed publicly burnt the works of Galen and Avicenna at his first lecture, but he did not substitute any satisfactory alternative. He built up a system

of medicine based on his own imagination respecting only Hippocrates amongst the ancient writers. He did not however believe that diseases were due to changes in the primal bodies and he propounded the theory that they were morbid species that invaded the body. He taught that diseases were due to one of five causes: (1) Ens Astrale; (2) Ens Veneni; (3) Ens Naturale; (4) Ens Spirituale; (5) Ens Dei. Paracelsus even if no great doctor was an highly skilled chemist, he introduced mineral substances into therapeutics. And yet he wrote in his book "De Philosophia": "*Pulsus coninetur in firmamento, Physionomia in astris; Chiromancia in mineralibus; Spiritus in euro et zephyro; Febris in terre motibus.*" Meaningless nonsense! His denunciation of the ancients though excessive did much good, for this was a time when physicians studied Galen rather than disease, and if Galen's remedies were successful so much the better for the patient; if not it was a fault in nature and man was not able to do anything further. Diseases that had been pronounced incurable by the old authority were left to progress without any attempt being made to cure them. Paracelsus did much to break down this old attitude. Alas, he led a debauched private life and died at the age of 48 as the result of a tavern brawl.

Jerome Cardan, a follower of Paracelsus, although an astrologer and mathematician primarily, was of the opinion that great physicians were born once in a thousand years and that he was himself the seventh! Medical practice at this time was a fantastic mixture of herb doctoring, quackery, superstition and magic. No treatment can be rational until the processes involved are understood, but in the 16th century little even had the virtue of being empirical. The age-old "Doctrines of Signatures" still largely governed treatment, yellow celandine being given for jaundice and kidney shaped beans for renal diseases. To a large extent medical treatment was given by unclassed hordes of itinerant cataract-couchers, lithotomists, herniotomists and booth surgeons, described by William Clowes, surgeon to St. Bartholomew's Hospital from 1575-1586, as "no better than runagates or vagabonds . . . shameless in countenance, lewd in disposition, brutish in judgment and understanding."

This was an age of epidemics, plagues and pestilential visitations. In England the first half of the century was marked by four

separate epidemics of the Sudor Anglicus or sweating sickness. The best contemporary description of this malady is by the famous Cambridge physician, John Caius, in: "A Boke or Counsell Against the Disease Commonly Called the Sweate or Sweatynge Sicknesse," by John Caius, doctor in physicke. London 1552. It is interesting to note that the first outbreak of this now unknown disease coincided with Henry, Earl of Richmond's landing at Milford in August, 1485. And that the last major epidemic was recorded in 1551. In 1563 the English harvest failed, famine was widespread and in its wake came the plague. No less than 20,000 people in London alone perished during it. In 1565 smallpox and measles swept through London and between 1596 and 1599 "malignant fevers" prevailed throughout England. Again in 1603, one year after the first performance of "Hamlet," London was ravished by the plague, which killed 36,000 people in the city. The practice of holding services in England for the Royal curing of Scrofula or the King's Evil continued throughout the century, the form of the service only differing from one reign to another. Leprosy was on the wane; but venereal diseases were increasing, gonorrhœa became common about 1520. Hieronymus Fracastorius published a poem in 1530, which he had written nine years earlier, entitled "Syphilis, sive morbus Gallicus." It is from the name of the shepherd boy, Syphilus, that the disease takes its name. Fracastorius believed that "when there is a conjunction of many stars, under larger fixed stars, it may then be predicted that a contagion is about to spread." It was Jean

Fernel (1497-1558), Professor of Medicine at Paris, who brought together in "Universa Medicina" what is probably the most systematic and comprehensive exposition of the state of medical knowledge in the first half of the 16th century. He has been called "the Restorer of the Science of Medicine."

In order to place the various advances in medical knowledge during the 16th century in perspective, it would perhaps be convenient to take the case of a student in the 16th century who is transported to the present day. Were he a student at the commencement of that century his knowledge of medicine and surgery would be of no avail to him in comprehending present medical diagnosis and treatment. Even a student at the close of the century would be little if any more enlightened. However, in the case of anatomy it would be quite different. The 1505 anatomy student would be as ignorant as his fellows studying medicine or surgery, but those who studied Vesalius's work in the latter part of the century would be at home in any modern dissecting room. Their terminology is the same as that used to-day to a large extent, despite the Birmingham revision. Indeed one might say that a close and careful study of "De Fabrica Humanæ Corporis" would provide sufficient anatomical knowledge to pass a Second M.B. Anatomy Paper without difficulty! That Shakespeare knew of the "Fabrica" is more than probable and the clues to most of his medical references must lie amongst other contemporary medical literature which was known and studied by the Poet.

## BOOK REVIEWS

**CARDIOLOGY**, by William Evans, M.D., D.Sc., F.R.C.P. Butterworth & Co. Ltd., pp. xi + 310. Price 35s.

This book, a companion to the same author's "Cardiography," is one which will be of great value both to student and practitioner.

Based on the author's wide experience as a cardiologist, it contains many points of practical wisdom. It does, however, express the personal views of the author, some of which are not universally accepted, and for this reason the student facing his examiners must exercise a certain degree of caution.

Perussion of the heart, for example, though regarded by many cardiologists as obsolete, still remains, before most examining boards, a cardinal manoeuvre in cardiac examination. The general mist which beshrouds the interpretation of the less common heart murmurs and sounds, is here swept away in well set out differentiation of their varying significance.

The book is full of excellent illustrations and X-rays, but it might be argued that physical examination, discussed in three pages, has been neglected at the expense of radiography, five pages, and electro cardiography, four pages.

However, the merits of this book far outweigh its demerits and it should find an important place in all medical bookshelves.

The book itself is attractively produced and well bound.

**INTRODUCTORY BOTANY**, by Alexander Nelson, E. & S. Livingstone Ltd., pp. viii + 479. Price 22s. 6d.

This is an excellent book, and will be welcomed by all students who study Botany in the preliminary stages of their degree courses.

It has three main sections. The first is on the morphology, anatomy, and reproduction of the flowering plants; the second covers the lower plant groups; and the third deals with the physiology of plants, including sections on ecology and genetics.

The author has, naturally, selected certain plant types for detailed study, but he has rightly put these studies in their right perspective by giving the reader glimpses of the wider expanse of the plant kingdom, and by indicating the relations between one plant group and another.

The section on plant physiology is well developed. Relevant physical and chemical phenomena are first described, and then these are used to illustrate the fundamental physiological processes in the plant, such as water utilisation, photosynthesis, respiration, nutrition, etc.

The diagrams are good, and thoroughly uphold the higher standard shown in modern biological text-books.

The book is pleasant and interesting to read, in spite of the fact that the author has had to condense a lot of information into an economic space.

The subject matter of this book is far greater than that required by students of this College for their first year work, and the reviewer hesitates to recommend it for this reason. If a student is interested in reading outside the syllabus of the 1st M.B. examination he will find the book admirable.

**AIDS TO PSYCHOLOGY**, by John H. Ewen. Third Edition. Baillière, Tindall & Cox, pp. vii + 192. Price 5s.

This little book gives a well judged and interesting birds-eye view of a subject still regarded by many as a civilised form of witchcraft. It gives as best it can the many divergent theories existing in this field and serves well as an introduction to more extensive reading.

**AN ELEMENTARY ATLAS OF RADIOGRAPHY**, by H. Wallace Jones, E. Noble Chamberlain and E. L. Rubin. John Wright & Sons Ltd., pp. 108. Price

This very useful little book will fill a gap in knowledge of many a student and practitioner. Its subject matter electro-cardiography and cardiac radiography has been set forth with most admirable conciseness and simplicity without losing any of its value for the reader. It consists chiefly of well chosen electro-cardiograms and cardiac X-rays, with short explanatory notes beneath each one. The need for a book of this nature has long been felt and the authors should be congratulated on such a very helpful precis of the subjects with which they deal.

**HANDBOOK OF SURGERY**, by Eric C. Mekié and Ian Mackenzie. Second edition. E. & S. Livingstone, pp. xvi + 764.

The second edition of this handbook has been considerably revised in order to allow for the rapid changes in treatment and custom which have lately taken place. Separate sections have been included dealing with chemotherapy and other drugs of recent vintage. It has, however, retained the same general character of its predecessor. The scope of a hand-book must be limited, but in the space of its 764 pages the author has managed to include nearly all matters which the unfortunate examinee might be expected to know; it is, essentially, a book for such a person.

**FIRST STEPS IN CHILDHOOD**, by G. M. Kerr, M.B., B.S. Clerke & Cockeran, pp. 120. Price 3s. 6d.

The aim of this book is to answer the general questions occurring to a mother, while indicating the necessity of personal qualified advice for special problems. The sub-title, "A commonsense guide to the physical and mental welfare of children from the time of weaning to the age of seven," fully expresses the scope of the book and the achievement of the author. There are useful chapters on diets and minor injuries, and a list of medicine-cupboard essentials. Advocacy of vaccine treatment for whooping-cough is the only important mistake in a book which should be useful to all mothers and many doctors.

**HINTS ON PRESCRIBING**, by J. B. Primmer, M.B., Ch.B., D.P.H., J.P. Research Books. Pp. vi + 51. Price 3s. 6d.

This is a hand-list of prescriptions designed for economical general practice under the National Health Service Act. It consists of well-worn, and in some cases outmoded remedies, faithfully transcribed from other works, and nearly all in Apothecaries' notation. The author condemns poly-pharmacy; and himself indulges in what might be called polydiagnosis, or the treatment of the manifestation without reference to the disease. The book cannot be recommended to the general practitioner, who could compile a better list himself, nor to the student, who is obliged to be more specific; but it is generously interleaved with blank pages for the reader's own additions, or comment.

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**TEXTBOOK OF MIDWIFERY**, by Margaret Puxon, M.D., M.R.C.O.G. First Edition. Syviro Publications Ltd., pp. 326. Price 25s.

This is the first appearance of a work which, as the preface says, takes a course between the examination synopsis and the annotated work.

The text is short and precise, the subjects are well laid out and thoroughly written. The wording is in a very readable form.

However, it remains to be seen whether students and practitioners are prepared to pay as much for a handbook, printed on rather inferior paper, as they would for a textbook of Obstetrics.

D. A.

**CUNNINGHAM MANUAL OF PRACTICAL ANATOMY**, Revised and edited by Professor J. C. Brash, M.C., M.A., M.D., F.R.C.S., Ed., F.R.S.E. Eleventh Edition. Vol. I—General introduction; upper limb, lower limb, with 44 plates (including 44 radiographs) and 144 illustrations. Oxford University Press. Price 21s., pp. XIX + 387.

The latest edition of this famous dissecting manual is edited by Professor J. C. Brash alone, Dr. E. B. Jamieson having retired.

Although the broad outline of the previous edition remains substantially the same, there has been a complete revision of the text which has led to a considerable reduction in length.

This reduction is welcomed from the point of view that any amount of unnecessary reading is always undesirable, but, at the same time, some of the lighter passages which have been omitted tended to relieve the burden of continuous concentration for the student reader.

Whereas the text-illustrations remain for the most part unaltered, many of the older radiographs have been replaced by a new series which includes some very fine specimens of injected arteries which are a great improvement on their predecessors.

It is to be regretted that other text books which enjoy a comparatively safe life could not all be printed, bound, and produced as beautifully as one which is so soon despoiled by its intimate association with the dissecting table.

**MEDICAL AND NURSERY DICTIONARY AND ENCYCLOPAEDIA** by Evelyn Pearce. Ninth Edition. Faber & Faber Ltd., pp. V + 723. Price 17s. 6d.

Compilers of medical dictionaries are at a constant disadvantage compared to their colleagues in the spheres of language. For the latter the majority of additions between editions tend to be in the nature of slang and may be omitted or included according to their feelings on the subject. With medical subjects the scope is always changing and at such a speed that parts of the book may become out-of-date from the time the proofs are read to its appearance in the libraries.

Miss Pearce has completely reversed and enlarged her popular work which will be welcomed by student nurses as an aid in the preparation for exams., and by those qualified as a source of reference.

The book deals with a very, wide range of diseases and, in those in which nursing plays the major role, in detail. Some of the information is unnecessary and might be omitted; for example, the paragraph on electricity, which is presumably intended for those knowing nothing of the subject, would tend to hinder rather than help the novice. Again, when dealing with the heart, it is alleged that the bundle of His "acts as, and is frequently called," the pace-maker; apart from the fact that the information is incorrect, one feels that such knowledge is of little value to the nurse. In view of its continual use in the diagnosis of heart disease, some mention of the electro-cardiograph would be welcomed.

However, despite such minor criticisms, it is a useful book and, considering its size, moderately priced.

## ANNOUNCEMENTS

### DEATHS

**BREWITT**. On February 14th, 1949, in South Africa, aged 90, James Burney, M.R.C.S., L.S.A.

**HAYWARD**. On March 12th, 1949, aged 83, John Arthur, M.D., F.R.C.S. Late House Physician to Sir William Church and Sir Francis Champneys.

### CHANGE OF ADDRESS

Dr. Noel Chilton to The Shieling, Earl's Colne, Essex.

### CAMBRIDGE GRADUATES CLUB OF ST. BARTHOLOMEW'S HOSPITAL

The Club will be holding a sherry party on Friday, May 20th, in the library. Will any Bart.'s-Cambridge graduate who has not received a notice to this effect, and who wishes to attend the meeting, please inform either Mr. H. Jackson Burrows or Dr. Kenneth Black (Secretaries) enclosing their address and membership subscription of 10/6.

### SCHOLARSHIPS AND PRIZES

BRACKENBURY SCHOLARSHIP IN MEDICINE	Not awarded.
BURROWS PRIZE	Not awarded.
SKYNNER PRIZE	J. G. WIDDICOMBE.
BRACKENBURY SCHOLARSHIP IN SURGERY	P. A. FREEMAN.
WALSHAM PRIZE	G. H. C. MELOTTE.
WILLETT MEDAL	G. H. C. MELOTTE.
ROXBURGH PRIZE	M. KAYE.
KIRKES SCHOLARSHIP AND GOLD MEDAL	A. D. MUNROE-FAURE (Scholarship) Medal not awarded.
MATTHEW DUNCAN MEDAL AND PRIZE	J. B. DOSSETOR (Medal not awarded).
SENIOR SCHOLARSHIP IN ANATOMY / PHYSIOLOGY/BIOCHEMISTRY	Prox. Access. G. IARNOKY. J. Cook, N. S. Painter.
HARVEY PRIZE	J. S. DODGE.
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FOSTER PRIZE	B. D. LASCELLES. H. I. Lockett, H. B. Ross.
TREASURER'S PRIZE	J. F. PEARCE. J. E. Cairns.

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## ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

Vol. LIII

JUNE, 1949

No. 6

"Why," said a towering sergeant of the City of London Police in a tone that brooked no argument, "is it that students all over the world are so irresponsible?" The remark, occasioned by the recent incident of the Lord Mayor *versus* Percy, was offered in a friendly but none the less authoritative manner, and, discretion being at times the better part of valour, it was perforce accepted at its face value. It has, however, remained buried like a thorn in the subconscious; no student, who of all people is the most sensitive to disparaging remarks, appreciates being dubbed irresponsible, and this column, believing that chivalry is not yet dead, feels compelled to enter the lists on behalf of Students *versus* the City of London Police. It is to be regretted that a full-scale tournée attended by a conclave of the City aldermen might not be held on the steps of St. Paul's, for, after all, it was over the body of that fair princess the Lord Mayor that the whole trouble arose. However, we have been told in all good faith that the pen is mightier than the sword, and the forceful logic of that axiom is well brought home when the opposition bids fair to be a 6 ft. 4 in. tall sergeant of the City Police.

To raise the argument to the higher levels of Philosophy, one may say with grandiose obscurantism that *au fond* it is merely a matter of relativity. Conventions of responsibility or irresponsibility are determined, one must assume, by that comforting conglomeration "the masses."

True, a sergeant of police can eminently be regarded as an oracle of conventional correctness, but in matters of philosophy he may be excused his duties; nevertheless, since he embodies in his person the offices of law and order and thereby, one imagines, the wishes of these "masses," the community

must not grumble if his words are taken as an expression of its opinion. Should we one morning wake up to find that the population of Greater London, with the exception of the City of London Police, had metamorphosed overnight, like caterpillars, into a variety of student forms, the same sergeant would discover the sentiments of his remark a little out of tune with those of his employers. His job accordingly would then be "to promote and assist to the best of his ability all forms of student rags and demonstrations with which he might have to do." No doubt such a *volte face* could be well accommodated by his English genius for compromise without upsetting the proverbial legend of unshakable dignity which so becomingly surrounds our British police forces; unfortunately, the likelihood of such a metamorphosis is, one feels, depressingly distant. To promote a decent respect for the student in the expanse of a police sergeant's magisterial breast, attack must proceed along more subtle lines. Different parties might hold different views on the form which would prove the most fruitful. No doubt the hospital rugby team, assisted by the delights of the now extinct vicarage, could inspire our allegorical sergeant to a state of bibulous amiability, in which condition he might swear to make all his superiors eat their helmets should they so much as drop the most veiled aspersion on the responsibility of students in his presence. With all due deference to the rugby club, however, one might justifiably feel that the confidence so inspired in the responsibility of students, and more especially medical students, might suffer a slight reverse next morning while their new convert stood in the dispensary queue for his "migrane" pills.

No, one's scheme of attack should proceed upon lines of quiet suggestion. It would be a



daring and possibly successful move to conduct our sergeant over the hospital one morning commenting lightly upon the busy passage of each student as he makes his way to "Diviani's," the "White Hart," or even the refectory; any mention of their destination would naturally be in the worst taste. "How," one would demand in earnest tones, "is it that the lives of hundreds of patients are entrusted to the gentle care of students if they are to be found wanting in responsibility?" "Look," one would adjure him, "at the tattered library volumes and the cracked museum cases," silent witnesses to Herculian labours. "There," one would point with a triumphant finger, "you have the results of hard-working responsible students." This particular sergeant would know little of hospitals or students.

At this point one must digress to anticipate some objections to the *grand tour* which would surely arise. Can one judge the responsibility of students throughout the country by the character of those found at Bart.'s? An assumption such as this would not pass without provoking a flood of modest protestation from other hospitals and student

bodies. "Pish" would be the gracious reply, "but, of course, your students are as good as ours"; it would be agreed unanimously that on behalf of such a cause a little friendly flattery would not be misplaced.

If such a scheme would fail to convince the sergeant of the injustice of his statement one would be forced to loose the last weapons of one's armoury upon him in the form of poesy, for romanticism often hides beneath the bleakest of exteriors; the following might well tip the scales:—

*"When from his classic dreams the student steals*

*Amid the buzz of crowds, the whirl of wheels,*

*To muse unnoticed, while around him press*

*The meteor forms of equipage and dress.*

*Alone in wonder lost he seems to stand,*

*A very stranger in his native land."*

"—so true" one would add in reminiscent tones "of students all over the world."

Should success still not be forthcoming, then, surely, long ingrained prejudice would be the only explanation for failure.

## PROFESSOR SIR JAMES PATERSON-ROSS, K.C.V.O.



The JOURNAL offers its sincere congratulations to Professor J. Paterson-Ross on his appointment as a Knight Commander of the Royal Victorian Order for services rendered to the King during his recent illness.

We must also congratulate Mr. J. C. Longland on his appointment as a Member of the Royal Victorian Order for services rendered in the same cause.

## CLINICAL VALUE OF ELECTROENCEPHALOGRAPHY

By J. W. ALDREN TURNER, D.M., F.R.C.P.

THE electroencephalogram is a valuable accessory investigation in certain neurological problems when it is considered in relation to the clinical aspects of the case. Without adequate consideration of the history and findings on clinical examination it is largely valueless and may be misleading. Though electrical activity in animal brains had been recorded previously, Berger in 1929 was the first to record the electrical activity of the human brain through the intact skull, using a Siemens galvanometer. The deflections were very small and it was only when adequate means of amplification had been developed, largely by Adrian and Matthews at Cambridge, that study of the human E.E.G. became possible.

### METHOD OF RECORDING:

From the patient's point of view there is no discomfort during the recording of the E.E.G. He lies comfortably on a couch, as far as possible cut off from noise and other distractions. Saline pad electrodes are placed on the unshaved scalp after the hair has been carefully separated at the points of contact, and the small electrical potentials are amplified by condenser-coupled amplifiers, the actual record being made by ink-writing oscillographs. Each line of the record represents the potential difference between an adjacent pair of electrodes. Three or more channels are used at the same time, and by moving the electrodes or by special wires and switches the whole of the head can be examined systematically.

The E.E.G. is usually recorded at least three hours after the patient's last meal, as some abnormalities are more likely to be present with a low blood sugar. Alkalosis

also tends to bring out abnormalities in epileptics, and at the end of the recording of the resting record the patient is asked to breathe in and out deeply for three minutes and the E.E.G. recorded during this period and for two to three minutes afterwards, for comparison with the resting record.

### THE NORMAL ELECTROENCEPHALOGRAM:

The dominant feature of the normal E.E.G. is the alpha or Berger rhythm. This consists of waves with a frequency of 8-13 cycles a second arising in the occipital region, 10 a second being the commonest frequency. In the majority of subjects the rhythm is only present when the eyes are closed and the mind undistracted. When the eyes are opened or when the patient tries to think out a problem the alpha waves are inhibited (Fig 1). There is some variability from person to person in the development and frequency of the alpha rhythm but it is relatively constant in its characteristics in any one person. Though most commonly it is confined to the occipital region, in some people it may be recorded from more anterior parts of the brain. Before the age of 5 the E.E.G. is too unstable to be of any practical value and there is frequently some instability up to the age of 14 or even later.

Minor abnormalities may be found in the E.E.G. of apparently normal people in whom there is no clinical evidence of cerebral disease; Williams found non-specific abnormalities in 5 per cent. of highly selected air-crew personnel in the R.A.F., in 10 per cent. of unselected Army personnel, and in 26 per cent. of 148 patients suffering from psychoneurotic conditions, and he suggested that these abnormalities indicated an inborn

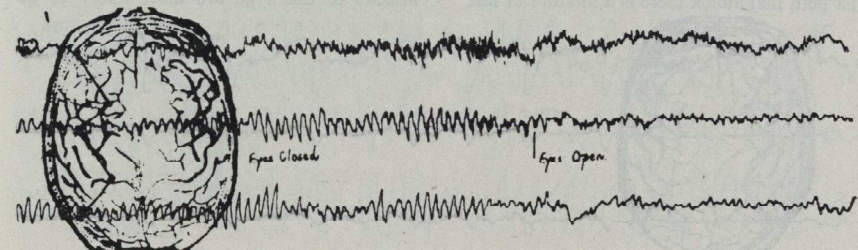


Fig. 1  
A 9 c/sec. alpha rhythm in the posterior two channels. The regular alpha rhythm stops when the eyes are opened.

constitutional abnormality affecting the central nervous system.

There are certain artefacts which may appear in the E.E.G.: muscle action potentials from the scalp muscles may give fast waves, particularly in the frontal leads which are easily recognised (Fig. 2), and blinking may cause slow high-voltage waves which may appear in bursts (Fig. 3). The source of these latter waves can be determined by watching the patient during the recording.

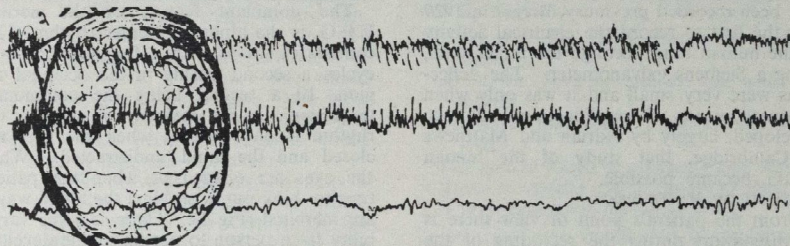


Fig. 2

Artifact caused by muscle action potentials in the frontal and temporal muscles. The muscle activity causes rapid waves most evident in the anterior two leads.

#### THE E.E.G. IN PATHOLOGICAL CONDITIONS:

**Epilepsy.** The diagnosis of epilepsy is made most certainly by seeing an attack or by obtaining an adequate account of an attack from a reliable observer, but definite help in the diagnosis can in some cases be obtained from E.E.G. records.

During an epileptic attack there are always abnormal waves in the E.E.G. In a major attack there are fast waves, up to 25-30 a second of high voltage, and prior to the onset of the clinical attack these waves rapidly increase in size and frequency. In psychomotor attacks or epileptic equivalents the typical wave form is a burst of four to six a second flat-topped waves (Fig. 4) while in a petit mal attack there is a mixture of fast

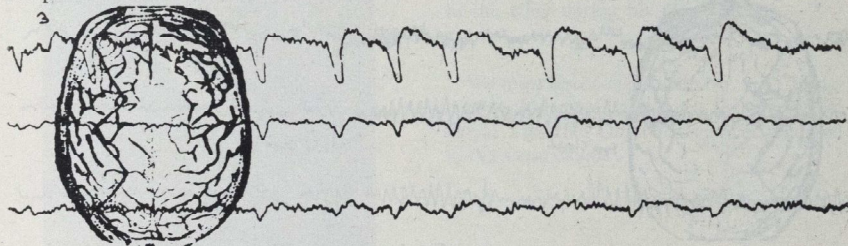


Fig. 3

Artifact caused by rapid blinking. Rhythmic slow waves appear in the frontal leads. The cause of these can be determined by watching the patient during the recording.

and slow activity, the typical record being a paroxysmal outburst of "wave and spike" complexes which consist of a quick, sharp spike followed by a slow round-topped wave (Fig. 5). From the clinical point of view, however, the E.E.G. between attacks is more important than the findings during an attack, as the chances of a patient having a clinical epileptic attack while the record is being made are obviously very small. It must be emphasised that in about 25 per

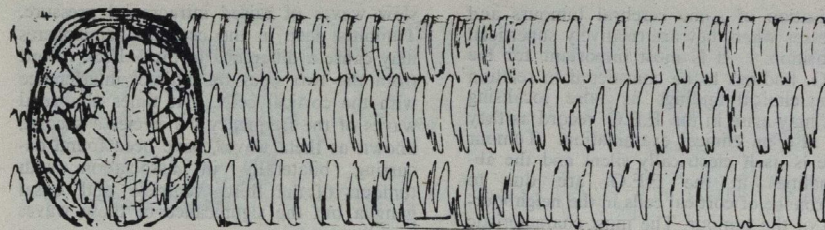


Fig. 4

Bursts of high voltage flat topped waves associated with "psycho-motor epilepsy" or epileptic equivalents.

found in patients who suffer from clinical petit mal than in those who only have occasional major attacks. Though stress has been laid on the different types of waves associated with various types of epileptic attack, this differentiation is by no means absolute and it is not uncommon to find wave and spike complexes in the inter-seizure records of patients who have major attacks and apparently do not have clinical petit mal.

The diagnostic wave-forms of epilepsy may not be present in the resting record but may occur when alkalosis is produced by three minutes over-breathing, and this should always be carried out during the recording of the E.E.G. of suspected epileptics.

On the whole, more diagnostic records are obtained when the patient is not taking any anti-epileptic drug such as Pheno-barbitone, but in my opinion drugs of this type should not be stopped for the purpose of recording the E.E.G., as in any epileptic when therapy is stopped suddenly there is a danger of an outburst of fits and sometimes even status epilepticus.

Interesting results have been found when E.E.G. records were made on the relatives of patients with epilepsy: abnormal records

were found in 60 per cent. of the relatives of a series of 94 epileptics as compared with 10 per cent. of a control group of 100 persons with no family history of epilepsy (Lennox, Gibbs and Gibbs, 1940). When records were taken from the parents of known epileptics, in 35 per cent. the E.E.G. was abnormal in both parents, and in only 5 per cent. did both parents have normal records.

**Space-occupying lesions.** Raised intracranial pressure is usually associated with slow waves, of about three cycles a second arising from all areas of the cortex (Fig. 6). There is no exact correlation between the height of the intracranial pressure and the appearance of these waves. It is thought that they are due to oedema of the brain rather than raised intracranial pressure in itself, as they can frequently be abolished temporarily by intravenous injection of hypertonic solutions but not by lowering the intracranial pressure by removal of cerebro-spinal fluid. Generalised slow waves of a similar type may be associated with other conditions interfering with cortical function such as surgical anaesthesia and coma from various causes.

The E.E.G. is of undoubted value in the

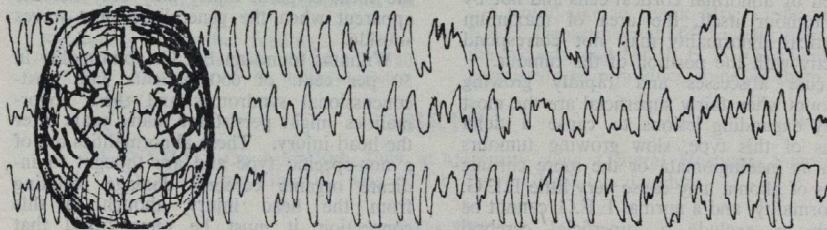


Fig. 5

Typical "spike and wave" formations of *petit mal*. This record was made during a clinical *petit mal*.

localisation of some cerebral tumours and abscesses when they are relatively superficial in position. It is most important for the E.E.G. findings to be considered in relation to the clinical findings as false localising signs may arise in the E.E.G. record as they may also on clinical examination. Tumour tissue is itself electrically silent and the abnormalities in the E.E.G. are due to disturbance of cortical cells in the neighbourhood of the tumour. The most characteristic finding in the presence of a superficially placed cerebral tumour is a focus of 2-3 cycles a second waves of high voltage, usually known as delta waves. The most accurate method of localisation is by finding "phase-reversal" which means that the deflections

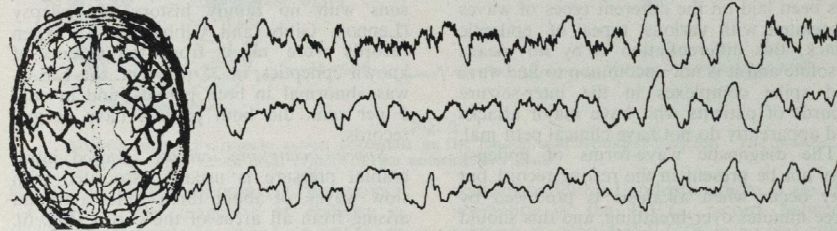


Fig. 6  
From a patient with raised intra-cranial pressure. There are irregular high voltage slow waves varying to some extent in frequency.

in the E.E.G. are in opposite directions about a peak potential (Fig. 7). This is done by finding the area from which delta waves are arising with the standard recordings and then altering the position of the electrodes and placing them in places at right-angles to one another till phase reversal can be demonstrated. In some cases this is not possible and reliance has to be placed on finding the area with the maximum intensity of slow waves. As the abnormal waves are produced by abnormal cortical cells and not by the tumour itself, the area of maximum electrical abnormality may not correspond exactly with the position of the tumour.

Acute abscesses and rapidly growing tumours when fairly superficial are the most likely expanding lesions to cause a delta focus of this type, slow growing tumours such as meningiomata or the more chronic types of glioma may cause very little E.E.G. abnormality, and a normal E.E.G. cannot be taken to exclude a superficial cerebral tumour.

Tumours in the posterior fossa do not cause E.E.G. abnormality except the diffuse

slow waves of raised intracranial pressure. Tumours deep in the cerebral hemispheres may cause a difference in the E.E.G. record from the two sides by indirect interference with the cortical cells. At times abnormal waves of the frequency 4-7 cycles a second, known as theta waves, have been found occurring bilaterally in association with tumours of the third ventricle and basal ganglia but the significance of these waves is still uncertain.

**Head injuries.** A blunt head injury with concussion causes generalised slow waves in the E.E.G.; the length of time these persist varies with the severity of the injury. Generally clinical and E.E.G. improvement

correspond fairly closely but in some patients an E.E.G. abnormality may persist after the patient is free of symptoms and physical signs, and it is thought that there is more likelihood of relapse of symptoms in this group of patients.

Localised injuries may cause a focus of delta waves similar to the focus found with a superficially placed tumour and in patients in whom there has been concussion in addition to the focal injury E.E.G. evidence of the local cerebral injury may only become apparent when the generalised slow waves subside.

Williams found an E.E.G. abnormality in 50 per cent. of 600 patients with post-concussional syndromes and these abnormalities might persist for many years after the head injury. These abnormalities are of a non-specific type and are thought to indicate organic cerebral damage resulting from the head injury, though in this connection it must be remembered that slight E.E.G. abnormalities are found in about 10 per cent. of apparently normal people.

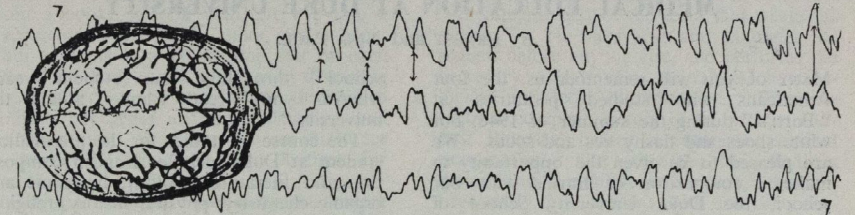


Fig. 7  
Delta wave focus in the left posterior frontal region. "Phase reversal," indicated by the arrows, is seen in the first and second channels. This shows that the focus of origin of the delta waves is approximately under the electrode common to these two channels.

#### CEREBRAL VASCULAR DISEASE:

In general, normal E.E.G. records are found in cerebral vascular disease, though occasional cases show a focus of delta waves.

#### CONCLUSIONS:

It has only been possible to indicate briefly some of the conditions in which E.E.G. examination may be of help when considered in association with the whole clinical picture. There are many other aspects of electroencephalography in which interesting results have been obtained. It is an important instrument for research in neuro-physiology; much of interest has been learned in connection with various psychiatric conditions particularly the high percentage of abnormal records in aggressive psychopaths, and it is of value in assessing the effect of various drugs in the treatment of epilepsy. The main clinical value of E.E.G. examination at the present time is (1) in cases of suspected epilepsy, and (2) in the localisation of superficially placed cerebral tumours and abscesses. In both these groups of cases, however, there are very definite limitations to its usefulness, and normal E.E.G. records must not be taken to disprove the diagnosis of epilepsy or of cerebral tumour.

#### References for further reading:—

Adrian, E. D. and Yamagiwa, K. (1935). *Brain* 58:323. The origin of the Berger rhythm.

- Cobb, W. A. (1944). *J. Neur. Neurosurg. Psychiat.* 7:96. The electroencephalographic localisation of intracranial neoplasms.
- Gibbs, F. A., Gibbs, E. L. and Lennox, W. J. (1938). *Arch. Neur. Psychiat.* 39:298. Cerebral dysrhythmias of epilepsy.
- Jewsbury, F. C. O. (1948). *St. Thomas's Hosp. Gaz.* 46:194. Principles of electroencephalography.
- Lennox, W. J., Gibbs, E. L. and Gibbs, F. A. (1940). *Arch. Neur. Psychiat.* 44:1155. The inheritance of epilepsy as revealed by the electroencephalograph.
- Strauss, H. and Greenstein, L. (1948). *Arch. Neur. Psychiat.* 59:395. The electroencephalogram in cerebrovascular disease.
- Walter, W. G. (1938). *J. Neur. Psychiat.* 1:359. Technique and application of electroencephalography.
- Walter, W. G. and others (1948). *Proc. Roy. Soc. Med. (Sect. Neur.)* 41:237. Discussion on the electroencephalogram in organic cerebral disease.
- Williams, D. (1939). *Brain* 62:321. Abnormal cortical potentials associated with high intracranial pressure.
- Williams, D. (1941). *J. Neur. Psychiat.* 4:257. The significance of an abnormal electroencephalogram.
- Williams, D. (1941). *J. Neur. Psychiat.* 4:107. The electroencephalogram in acute head injuries.
- Williams, D. (1941). *J. Neur. Psychiat.* 4:131. The electroencephalogram in chronic post-traumatic states.

I would like to thank Mrs. Leslie of the E.E.G. Department at Hill End for help with the records, and Mr. J. E. A. O'Connell for permission to reproduce some of them.

#### BIRTH

**GLANVILL.** On April 10th, 1949, at Maternity wing General Hospital, Sunderland, to Dr. Catherine Glanvill, wife of Dr. Terry Glanvill, a daughter.

#### DEATH

**MORSE.** On 21st April, at his home at Boscombe, Bournemouth, Charles George Hugh ("Toby") Morse, O.St.J., M.A., M.B., B.Ch., M.R.C.S., L.R.C.P., aged 65.

## MEDICAL EDUCATION AT DUKE UNIVERSITY

By ERNEST and NINA PAGE.

MANY of you will remember us, the four Americans who studied pediatrics at "Bart's" during the summer of 1948; our white shoes and flashy ties and socks. We are pleased to be given the opportunity to make a comparison of Bart's with our school, the Duke University School of Medicine, and we believe that you will better understand our comments if we tell you about our educational system.

After three years in the "primary grades" and five in the "grammar grades" the average American student who contemplates the study of medicine enters "high school" where he remains for four years. During his high school career he completes four years of English; four years of a foreign language or two years each of two foreign languages, such as Latin, German, Spanish or French; four years of natural science, a general introductory course, biology, chemistry, and physics; two or three years of history and government; and three or four years of algebra, geometry, and trigonometry. In addition there may be elective courses in typewriting, music (choral or instrumental) and public speaking. Except for short-distance transportation, lunches, books and supplies the cost of his education, thus far, has been borne by the government. If he attends a consolidated rural or small-city school and lives two miles or farther from the school, he is transported to and from school at government expense.

After graduating from high school the student enters a college or university where he pays approximately £250 a year for tuition, room, and meals. There, during his first year, he tries to do everything possible: joins the glee club, the chapel choir, and a national fraternity which usually has a reputation for "being good," meets some women students, or "co-eds," and then thinks about his course of study. Because teaching usually consists of lecturing to from twenty to one hundred students at a time there is, in some colleges, little or no intimate conversation or discussion with the professors. In some small colleges, however, there usually are small groups in closer contact with the professors. Such colleges are more nearly like those in the Universities of Oxford and Cambridge. You will observe here a difference in manner of expression. We "go to

school" throughout our student years, whereas you "read" and "attend the university."

The course of studies for the pre-medical student at Duke includes English composition and literature, zoology, inorganic and organic chemistry, physics, history, religion, mathematics, three years of French or German, and a large variety of other subjects varying with his individual interests. A student usually graduates from college aged twenty-one or twenty-two years and then enters upon what is reputed to be the longest, hardest, and most tiring struggle of them all, medicine.

During his welcoming talk on the first day of medicine school our professor of anatomy said to the group: "From this day forward medicine will be your mistress, and all other matters, wife and family, will be secondary." That attitude prevailed throughout the writers' training and the training of many others in different schools in this country. Many professors think that the number of facts to be learned by the student has increased greatly during the past two or three decades; that the technical procedures are more numerous; and that more reading must necessarily be done. So unrelenting is the pressure on a medical student that he feels always a sensation of fleeting time and work that must be completed. In this connection a recent move has been contemplated to increase the duration of medical training from four to five years.

At the Duke University of Medicine the first and second years are pre-clinical years and are divided into gross and microscopic anatomy, neuro-anatomy, bio-chemistry, physiology, bacteriology, pharmacology, pathology and physical diagnosis. The anatomy course of dissection is now being supplemented by excellent moving pictures in colour of a detailed dissection of an entire cadaver, and each anatomical region is shown four different times. There are numerous projection slides in colour for teaching and reviewing relationships of adjacent parts and for teaching histology. The primary aim, however, is to perform the dissection, to study at the dissecting table, and to learn histological material by looking at the actual tissue. At any hour of the day or night a student may

dissect, hold a muscle in hand while he reads from a book, or look with one eye into a microscope and with the other into a book. Four students as a group, one pair on each side of the body, work together in dissecting one cadaver for the four months devoted to nothing but gross anatomy, histology and neuroanatomy. A professor or an instructor is available throughout the daytime for questions and problems.

During the course of pathology, the student attends numerous autopsies, participating in four to six. Participation includes writing a summary of the clinical history, a description of the gross and microscopic appearance of all organs, and a diagnosis. In this course also, the museum is open for use throughout the night. The museum is very different from yours at Bart's; at Duke all the organs from each case are retained in covered pots of preservative from which they may be transferred, for the purpose of studying them, into pans where they may be seen and handled. As yet, Duke has nothing so famous as Pott's original specimen. Consequently, damage to historical specimens is not so much to be feared. At Duke, studying the anatomical change in each individual organ is a matter of secondary importance; of primary importance is seeing the reaction of the patient as a whole to the disease, and the spread of the disease throughout the patient's body by following the patient from a summary of the clinical course to an examination of the gross organs and the microscopic sections. All of the foregoing aids and a description of each case by a staff member are readily available to each medical student.

In other pre-clinical subjects, stress is placed upon learning by seeing and performing simple laboratory experiments on animals and the students. Each student is a subject for almost all routine clinical tests, such as a gastric analysis, blood chemistry determinations, urinalyses, and liver function tests. These tests, a small part of the biochemistry course, teach normal values, variations, theory, and a respect for the discomfort felt by the patient.

The two clinical years are devoted to junior and senior medicine and surgery for a total of six months each. Every student spends one half of each such six months period in the out-patient clinic. Three months are devoted to obstetrics and gynecology and three to pediatrics.

The function of the student is to constitute "an integral part of the team that treats the patient." He interviews and examines the patient before anyone else, and performs the necessary and routine urinalysis, hematological and fecal examinations. Then he writes a complete history of the present-and-past illnesses, makes a complete physical examination, and records the findings thereof and, if possible, arrives at a diagnosis. Frequently these records, with necessary corrections by the intern, constitute the only official record. All of this work must be ready by the morning following the arrival of the patient even when the latter arrives in the evening or early night. The history includes all the negative findings so that it can be used as a picture of the patient's past with which further developments may be compared at the time of the first admission and also during later visits. The student and intern insert "progress notes" from day to day in order to make the record more helpful to the next doctor who may attend the patient. In addition the teacher gives his diagnosis and the consultant his impression and the results of his examinations such as a urological instrumentation or neurosurgical procedures. About one half of the time is devoted to practical work as, for example, the care and treatment of patients, laboratory examinations, the administration of intravenous fluids and blood transfusions, and spinal punctures. The student is frequently told that the patient "belongs to him"; that he should take care of the patient and his needs; and that he should foresee and execute simple diagnostic tests and suggest other more complicated but necessary tests and X-rays to the house staff. The student is frequently asked what drug or treatment he would use, but he never has the authority to prescribe medicines on a ward nor in an out-patient clinic.

Since the clinical clerk works so much with the patient, it is considered conducive to good training if he performs his duties with the bearing of a doctor. For this reason he is always called "Doctor" by professors, nurses, and housemen. By attending with poise and thoughtfulness he tries to encourage the patient to address him and to think and speak of him as "my doctor." Occasionally this is strikingly illustrated when a patient refuses to take medicine or to carry out an order from a member of the house staff or a professor "because my doctor didn't tell me to do that."

In medicine, lectures on various subjects are usually given each day between 8.30 a.m. and 10.30 a.m. Ward rounds are held from 10.30 a.m. till 12.30 p.m. These rounds, made with house staff and professor, are concerned with the presentation of patients who entered the night before and the student's diagnosis and treatment of each case. The discussion usually includes the physiology and pathology of the disease and the rationale of the treatment. This discussion introduces everyone to the patient so that interest will be aroused and the clinical course will be easier to follow on subsequent rounds and in general discussion. In the afternoon laboratory work and a discussion of a disease or therapeutics by the assistant resident doctor takes up the earlier hours, and seeing the new patients the later hours. Evening hours are free for reading after the new patients are completed and all laboratory work is finished. Much of the teaching is accomplished by means of informal discussion of the patient and his problems of diagnosis and treatment between the student and resident staff throughout the day and evening. In medicine each student has a maximum load of three new admissions per week with an overall total of four to nine old and new patients.

In junior surgery the patient-load is five and nine. The student "work-up" is about the same as in medicine. Here, lectures deal with surgical subjects, and the rounds differ from medical rounds in that a patient is chosen to illustrate a disease. These rounds last only one hour, three days a week. On junior surgery the student "scrubs" and holds retractors on his patient whether the operation is a hemorrhoidectomy or pneumonectomy. Half of the three months' period is devoted to special surgical problems, such as orthopedics, urology, neurosurgery, ear, eye, nose and throat. In the senior year one week is devoted to anesthesiology, each student giving about ten anesthetics and observing others. A course in experimental surgery on dogs is given in which a group of four rotate as nurse, operator, anesthetist and assistant operator. Each student serves as operator or assistant operator on a laparotomy, thyroidectomy, caecotomy, cholecystectomy, intestinal anastomosis and gastrojejunostomy. The chief purpose of this training is to learn aseptic technique.

In obstetrics and gynecology everyone works in the out-patient and pre-natal clinics and rotates for deliveries and other in-

patients. In-patients consist of post-natal patients, abortion cases, and a variety of gynecological problems. The student must sit with his antepartum patient from the time labour begins until after delivery. Since this section of the country is called the "eclamptic belt," partly because patients do not follow antepartum instructions, many toxemics are admitted and must be attended constantly by a student. The teaching is done by means of four lectures on obstetrics, two pre-operative conferences for gynecological patients, and two lectures on endocrinology per week. Here, too, the student must scrub on gynecological operations and on the ten to fifteen deliveries assigned to him, of which he performs five to ten himself. In contrast to Bart.'s there are no nurse midwives and no deliveries outside of the hospital. The student spends two weeks of this three months period on the psychiatric ward observing therapy, talking to patients, and attending conferences.

The out-patient clinics are similar for all services. After taking a complete history, examining the patient, and doing the laboratory work, the student presents the patient to the consultant, states his diagnosis, and proposes a treatment or necessary examinations to establish a diagnosis. The consultant may or may not follow the student's suggestions. The clinics are open each afternoon, except Saturday, from 1.00 p.m. to 5.00 p.m.

In pediatrics there is a similar schedule of teaching, a general clinic, and special return clinics for newborn children, problem children, and epileptics. The wards are open to students earlier and later in the day than at Bart.'s. The clerks take the histories directly from the parents, do a complete physical examination, and perform the laboratory work. For two weeks the student works in the psychiatric clinic taking histories, and for two more weeks works in the eye, ear, nose and throat clinic.

After medical school the student is required by Duke to serve as an intern (houseman) for at least two years before the official diploma and degree are given. In order to practice medicine he must then take an examination in the state in which he will practice, or take a National Board examination which is recognized in most states. These correspond to your "qualifying" examinations.

There follows now a discussion of a few of the more obvious differences between the

Duke University School of Medicine and Saint Bartholomew's Hospital.

At Duke there is a men's dormitory for medical students on the university grounds only three or four minutes walk from the medical school and hospital. This convenience is another reason for work at night and the late hours that students spend at the hospital. Even though the student be married or a young woman, who cannot live on the campus, the distances are not great and travel is quicker than in London, for Durham is populated by only 70,000 people. The accessibility of facilities and friendly association of the seventy-two members of each class lead to many social functions, such as picnics and parties for small groups and dances every three months for the whole school. But with all the foregoing conveniences Duke has neither a Journal nor an athletic team which represent the medical school.

At Duke the medical school and hospital are in the same long building surrounding numerous courts with the medical school at one end and the hospital at the other. The entire structure was erected twenty years ago by means of a grant of money from the endowment of the university by a tobacco millionaire. The buildings of the men's college, the chapel, the medical school, and the hospital are Gothic in style and are set in a forest of pine trees. Close by the hospital is a beautiful garden. Within the hospital are a post office and individual metal lockers for coats, instruments and books. The lunchroom facilities for the students are somewhat better at Bart.'s because of their proximity to the hospital, the relative inexpensiveness of the food, and shorter queues. At Duke the professors and interns eat in the same room in the hospital, whereas, the students must walk to the university dining halls and stand in lines of twenty to sixty persons. At Duke Medical School there is no "common room" where students may join in conversation. Consequently the dining halls, the "soda shop" and sometimes the laboratories hum with conversation when students meet there. On one side of the large reading room of the library are easy chairs for comfortable and leisurely reading. On the other side of the room are tables and cushioned chairs. The medical library at Duke contains more journals (approximately 450) than does Bart.'s, and is open from 8.30 a.m. until 10.30 p.m., seven days the

week. Everyone has ready access to all journals and books, which are kept on open shelves, and may remove them from the library for one or two weeks. It is true that some books disappear, but it is believed that their accessibility for reading outweighs the loss.

Many people maintain that Americans depend too much on laboratory procedures for diagnostic purposes and not enough on clinical acumen. In part this is true. However, many physicians want some laboratory data to support their observations or history, and others think that, especially in a teaching hospital, any clinical observation which can be borne out by biological values is useful in teaching the underlying pathological processes and biochemical changes. Moreover, many doctors knowing that the requested studies will be abnormal still want them for the purpose of following the course of the disease and for prognostic purposes. Another reason for our laboratory investigations is the large amount of research carried on by teachers in both the preclinical and clinical departments which frequently calls for numerous tests. It is our impression that routine hemoglobin determinations, white cell counts, urinalyses, and Wasserman reactions are frowned upon in England, but it should be pointed out that diseases such as early diabetes, syphilis, anemia and occasionally leukemia are found by this method when their presence is not otherwise detectable. One other objective in which our laboratory work is an aid is the earlier diagnosis of disease and the consequent shortening of the course of the disease and the hospital stay.

The financial responsibility of the patient is quite different also. Since Duke has been in operation only two decades, there have been few benefactors leaving money to the institution. As a result the patient must pay for his treatment because the hospital is self-sustaining. The public in-patients must pay £2 per day for bed, food, medicines, X-rays and operating room fees. If the patient cannot afford the money, the county welfare or some other eleemosynary agency helps. So as to dispel any beliefs that you may hold that the hospital overcharges public ward in-patients, you may be assured that a large part of fees from private patients of the professors and a percentage of their room fees go towards maintaining the public wards. It is easy to understand, therefore, why there must be so much haste in diagnosing and

treating patients. Private patients occupy about one-half of the beds in this 600-bed hospital. Their accommodations are more pleasant and they may choose their physician, but the services rendered are about the same as services received by public ward patients. Recently students on medicine have been working on private wards, and the trial has met with apparent success. The physicians who staff the private wards and private out-patient clinic as well as the physicians in research take turns rounding with the medical students on the public wards.

In general the objectives at Duke are to learn a rapid routine examination which covers many diagnostic possibilities thus leaving as much time as possible for reading, thinking, and observing; to learn by seeing and doing everything to each patient so that the correlation of the disease with the history, the physical findings and the laboratory findings will be remembered longer; to learn the application of basic knowledge in the

selection of proper lines of investigation and in the care and treatment of the patient.

It is true that you have centuries of experience and tradition behind your methods of teaching, while we have a fresh approach of only twenty years. However, the quality of a doctor and his worth to society depend not so much upon his teachers or their methods of teaching, whether by working on after fatigue creeps in or by stopping for a pot of tea and conversation, as upon the man behind the title, his integrity, industry and initiative.

We would like to thank all of you for answering our questions and acquainting us with the routine at Bart.'s and English life in general. We would like your criticism of our system of education and will not be hurt because we know your reputation for making comments and asking questions be it in Parliament or Hyde Park. We would like also to thank our two deans who made our trip possible and gave us the opportunity better to understand England and to appreciate our common heritage.

## CORRESPONDENCE

### CAMPAIGNING IN CONDITIONS OF GREAT HEAT

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

It is, of course, admitted that England's climate is a national disgrace and the right of the inhabitants to grumble about it is usually allowed to pass unchallenged. Dr. Cruden's account of Heat Stroke in the Garden of Eden, though particularly interesting, is perhaps unfortunate in that it definitely establishes that there are worse places than the Home Counties, and, for myself, having served in Egypt in two wars I agree with him. A tent temperature of 135° I regard as truly appalling, remembering as I do a daily temperature of 120° during the period of afternoon rest (2.0 p.m.—4 p.m.) at a time when we were part of the garrison of the Suez Canal in the summer of 1915. Later we found that there were even worse conditions in the Aden hinterland, and it seemed impossible that either we or the horses of "B" Battery H.A.C., in which I was then serving, could ever get used to such heat. But we did, and it is in the matter of acclimatisation that I would venture to endeavour to supplement Dr. Cruden's careful study of the prevention and treatment of Heat Stroke.

Before giving one or two examples of this it is perhaps interesting to note that whereas in 1915 and onwards everyone wore sun helmets in the Near East, and later there were added protective strips sewn into tunics to cover the spine, yet in 1940 when we reached Egypt people smiled at our

sun helmets, and after a fortnight I never again wore one either in Egypt, or Somaliland, Kenya or Tanganyika, nor did I see any troops wearing them. I did, however, notice that some of the European civilians of Kenya were very careful never to omit wearing their sun helmets during the middle day heat. Perhaps they had been previously victims of sun stroke. I don't know how to explain these changed habits of British troops in respect of exposure to the sun but it is a fact that in the territories referred to no harm resulted though it must be admitted that the climate was less severe than that of Mesopotamia.

That the control of body heat is obviously a matter of great military importance may be instanced by what happened when our troops occupied Diego Suarez, the harbour at the top of Madagascar. The task force was brought by sea from this country and following the practice of those times sun bathing was forbidden during the voyage. Soon after the successful landing some of the troops had to dig themselves in for a short period. To do so they, of course, took off their shirts, for the heat was extreme, and as a result many got seriously blistered. The commander who can put his troops into action prepared to meet unusual local conditions obviously gains an important asset. Cautious and progressive exposure to the sun is one way of training troops to fight in the tropics; to teach them to do without water is another, for troops who must fight in tropical deserts cannot be supplied with enough water to follow the routine so well organized for mechanics in base workshops at, say, Basra, or even for those whose task is to toil in New York

hospitals during a heat wave. But the ability to march and fight in great heat with an extremely limited fluid intake is one which can be acquired and this is well illustrated by the experiences of "B" Battery, H.A.C., during the assaults in 1917 from the deserts of southern Palestine upon the Turks at Gaza. I was not serving with them at that time but several instances are given in the History of the Honourable Company in the Great War, which speaks, for example, of "reconnaissance lasting thirty-six hours" for which the men started with full water bottles and got one refill from the regimental water-carts. The palm of honour, however, must be shared by the officers and men with the horses of the battery which had for this work been trained to water not thrice but only once in twenty-four hours. As a result of this the following unequalled record was achieved:—"Since leaving Beersheba, nine days previously, we had marched about one hundred miles and fought two general actions and the horses had only watered three times. In this period we lost only eight horses from exhaustion." The intervals between waterings were 68, 72 and 76 hours. Though this episode did not occur during the height of summer but in September, the temperature by day was above 100°, the night being cool. Such things are only possible in a unit trained to perfection and conscious of the value of a firm discipline which forbade that any water should be drunk from the water bottles (and there was no other source) until the O.C. gave permission for this. Just how such endurance is physiologically possible it is hard to understand but it seems that as a result of a specially organised acclimatisation the normal method of keeping cool by sweating is partly held in abeyance and the animal, man or beast, thereby manages to conserve the precious water for other vital processes.

Dr. Cruden's admirable descriptions of Heat Exhaustion and Acute Heat Stroke show how extremely serious are these conditions and I feel sure that he will agree that their incidence can be lessened if officers are taught how to care for their men.

Yours faithfully,

R. OGIER WARD.

149 Harley Street,  
London, W.1.  
21st April, 1949.

### THE NATIONAL HEALTH SERVICE

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

Your correspondent, Mr. J. D. B. Andrews, in criticising your February Editorial picked some unhappy examples of the achievements of the National Health Service for he was, of course, merely reiterating certain statistics which Government speakers cited in a recent debate in the House of Commons.

The true value of a health service is not to be measured by the number of dentures and spectacles supplied but by the overall quality of service available at a reasonable and economic rate of expenditure. Furthermore, where contributions to such a service are compulsory it is hardly justifiable to

estimate its popularity by the number of people seeking its "benefits." It is, I suppose, inevitable but somewhat pathetic, that the politicians and your correspondent are enamoured with certain quantitative aspects of the service. The majority of your readers and educated members of the general public will consider the numbers of dentures, spectacles and hearing-aids supplied as poor vindication of the colossal upheaval and expense engendered by the new scheme.

It is surely ludicrous to suggest that the true value of the service is demonstrated by the fact that 95% of the population have "signed on." I too, with my family, have signed on, not because of any love for the scheme but because I see no reason why my general practitioner (who, like many of his kind, is suffering great financial hardship) should miss four extra capitation fees. After being compelled to subscribe to a scheme of this kind the public would surely be foolish if they did not register for its benefits.

Your correspondent is quite wrong in suggesting that those not taking advantage of the medical service would only be out of pocket tenpence per week. Does he not realise that this contribution covers less than a fifth of the present costs of the scheme and that the rest is provided by the exchequer out of direct and indirect taxation. Those not using the scheme stand to lose far more than tenpence per week and it should be remembered that they have to pay the cost of all drugs and appliances as well as their doctors' fees. The "popularity" of the scheme is, therefore, seen to be comparable to the alleged popularity of certain leaders and political parties in the rigged elections of a dictatorship.

I enjoin Mr. Andrews to reflect upon the underlying philosophy of the National Health Service Act. From the point of view of the public its greatest faults are, firstly, that they have absolutely no conception of the wholly exorbitant cost of the service and, secondly, that it encourages the irresponsible element (present in all too many of us) to seek their rights while failing to bring home to them their responsibilities. From the point of view of the profession it interferes to a wholly unwarrantable degree with our independence and makes us largely subservient to political control and theory of one sort or another.

If the public, the profession and the minister were all angels the plan might work quite well; and, if we really were all angels there would be no need for the plan. It is unfortunately true that plans of this kind all too often produce results which are the very reverse of those intended.

In its grandiose, materialistic and political conception of what constitutes a Health Service, as also in the manner by which it has been implemented, the National Health Service Act (notwithstanding those millions of intra-oral and ocular accessories mentioned by your correspondent!) does, as you say Sir, constitute one of the greater follies of History.

There would be no justification in my claiming more of your space to describe the many evil effects of the Act. Your correspondent has only to read the medical journals and newspapers, to talk to the average practitioner or to study the present difficulties of entry into general practice

to understand some of these things. I will venture to prophesy that when Mr. Andrews graduates from his armchair in the Abernethian room to the realities of medical practice there is a very strong chance that he will be in agreement with you.

I remain Sir,

Yours faithfully  
REGINALD S. MURLEY,  
M.S., F.R.C.S.

43, Newlands Avenue,  
Radlett, Herts.

April 24th, 1949.

(This correspondence must now cease.—EDITOR.)

### THE S.C.U.

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

With the steady growth of the medical curriculum and the never-ceasing demands of the more immediately practical aspects of his craft, the medical student—perhaps to a greater extent than any other type of student—finds it difficult to retain

a grasp of life in its wholeness. Large tracts of human experience pass him by, imperfectly assimilated. He tends to become remote from the questions raised by religion and philosophy, and has little time to ponder over their significance to the personal and social problems of our age.

But if we cannot undertake an exhaustive study of these problems, short, regular attempts to talk them out and discuss them will do much to halt the onset of that condition so fatal to a doctor—the exclusively technical mentality.

The Student Christian Movement seeks, *inter alia*, to provide opportunities for such study and discussion. The recently-formed Branch at Bart's wishes to give notice of its existence to all students, Christian or otherwise, who are interested in such problems and are willing to do some hard thinking to gain an understanding of them.

Yours faithfully,

H. M. COLLYMORE.

President.

The Abernethian Room,  
St. Bartholomew's Hospital.

May 2nd, 1949.

## SPORT

### RUGGER CLUB

April 16th, v. Bedford

RESULT: LOST BY 20 POINTS TO 0.

It is a sad day when so many Bart's rugger players are "otherwise engaged" that three people from outside the hospital had to be called in to complete the team: such was the case against Bedford. However, the loyal dozen, and the extra three, battled well against one of the best sides in the country.

Played in tropical heat and on very hard ground, the game was surprisingly fast and entertaining. One of the lightest packs ever to take the field for Bart's did very well indeed, but their superior weight forward and the not inconsiderable skill of Haynes at stand-off half just told in Bedford's favour.

J. B. Holland played a brilliant game at scrum half, and we are very grateful to him for turning out for us. Mathews and Baker tackled like demons and Struther was, as always, a tower of strength.

April 23rd, Middlesex Sevens

In the second round, the Bart's Seven, playing very shakily, scraped home against Queen Mary College, but the third round match against Middlesex Hospital was of sterner stuff. It was acclaimed as the best match of the day on the St. Mary's Hospital ground at Teddington and the highlight was the John-Dick "scissors" which all but produced a try and certainly brought the crowd to their feet.

So Bart's ended the season with colours flying, going down to their friendly rivals who managed to reach the seventh round.

### CRICKET CLUB

April 7th, v. St. Thomas's Hospital

RESULT: BART'S 151—7 (dec.).

ST. THOMAS'S HOSPITAL 89.

A victory by 62 runs in the first match provided

Weight—3rd, John; 4th, Wint.

Winning performance—Distance, 38 ft. 6½ ins.  
Discus—3rd, John; 4th, Lascelles.

Winning performance—Distance 105ft. 10½ ins.  
Javelin—1st, John.

Winning performance—Distance, 144ft. 5 ins.  
Relay (4 x 220 yds.)—1st, Bart's.

Congratulations to Arthur Wint who has been elected Captain of London University Athletic Club.

Two future dates to remember are:—  
Saturday, June 11—United Hospitals' Championships at Chelsea.

Saturday, July 2—66th Annual Sports Day at Chislehurst.

### A SHORT ESSAY ON RUGBY SUPPORTERS

By PHYLLIS TYNE

No reference is intended to persons dead or dying. Anyone believing himself to be portrayed should be unutterably ashamed.

THE passing of yet another Rugby season brings melancholy to the hearts of the devotees, but much remains, for as discretion is the better part of valour, so discussion is the better part of football.

The deeds of the mighty have been chronicled by a mighty pen, but what of those whose names do not appear in letters of fire—the supporters who add so much to hospital football. The part they play is a humble one, so I shall write their epitaph, for in humility my pen owns no equal. But though the part they play is humble, immortality shall fit them well, for on Elysian plains where perfect rugby is played by perfect teams (but not, we hope, with perfect spheres) their support will still be needed.

In this short study of the genus "Supporter," let us adopt the methods of the Oxford School, and start with a short historical resumé. Here, unfortunately, we have no lantern slides to afford us a little innocent amusement, so that whilst retaining the method, we must forego the technique. However—to our essay.

In the autumn of 1946 a body of public spirited gentlemen opened a subscription list, so that a number of instruments could be purchased. The money poured into the coffers until at the end of the first week two shillings and sixpence had been received. At this stage, flattery and cajolery were abandoned and brute force accounted for the total soon reaching the one pound mark.

The word instruments and the underlying policy of this move may now be profitably defined. Firstly, the policy was to provide

a somewhat bedraggled Rugby team with musical accompaniment, so that the resultant noise would either encourage deeds of heroic splendour, or cause the opposing team to give a tasteful imitation of the Walls of Jericho. Neither of these results has been achieved as yet, but the health giving results accruing to the gentlemen actually operating the devices have proved so beneficial that a cup match is not now complete without one hunting horn, one fog horn, one drinking horn and a horn handled penknife, to say nothing of one ship's siren—the late property of H.M.S. "Gamage."

But, alas, the Cup has gone elsewhere and our machines are hibernating for yet another summer, for we fear too much the ghost of Dr. Grace to parade our wares at cricket matches, and it is too, too exhausting keeping up with the boats in a rowing regatta—blowing a four foot coach horn withal.

We take courage for next season, however, for should Mr. Seymour Cocks' Bill become law, we are expecting a different class of horn blowers to join our ranks, a class whose pink coats should add still another touch of colour to our already colourful cup matches.

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## DISEASES OF THE STUDIOUS

*Some time ago, a kindly relative lent me some books which he considered would be useful to me in my studies. Amongst them was a copy of "BUCHAN'S DOMESTIC MEDICINE." Not unnaturally, it was to this volume that my attention was first directed, and, on discovering that it was published in 1803, I must confess that more than a few hours were spent amongst its faded pages. The writer covers a wide range of diseases—few of which he found incurable—and treats each one in a matter-of-fact, straightforward way that compares most favourably with some of the times of this more "enlightened" age. His views on: "Cold Bathing, with Remarks on the Cafes, in which the Warm Bath is more advisable," are remarkable: his ideas with regard to*

Intense thinking is so destructive to health, that few instances can be produced of studious persons who are strong and healthy. Hard study always implies a sedentary life; and when intense thinking is joined to the want of exercise, the consequences must be bad. We have frequently known even a few months of close application to study ruin an excellent constitution, by inducing a train of nervous complaints which could never be removed. Man is evidently not formed for continual thought more than for perpetual action, and would be as soon worn out by the one as by the other.

So great is the power of the mind over the body, that, by its influence, the whole vital motions may be accelerated or retarded, to almost any degree. Thus cheerfulness and mirth quicken the circulation, and promote all the secretions; whereas sadness and profound thought never fail to retard them. Hence it would appear, that even a degree of thoughtlessness is necessary to health. Indeed the perpetual thinker seldom enjoys either health or spirits; while the person who can hardly be said to think at all, generally enjoys both.

Perpetual thinkers, as they are called, seldom think long. In a few years they generally become quite stupid, and exhibit a melancholy proof how readily the greatest blessings may be abused. Thinking, like everything else, when carried to extreme, becomes a vice; nor can anything afford a greater proof of wisdom, than for a man frequently and

Intemperance and Corfets, illuminating; but the chapter that interested me most, and the one that I considered so applicable to our section of the community, was that dealing with the Studious. I have no idea what effect it may have on the majority of the readers, but I was so thoroughly alarmed by some of the melancholy prognostications that, in lieu of the twelve-mile horse ride suggested, I went straight out and trundled my ancient push-bike around ten miles of Suffolk countryside: it did me the world of good.

*N.B.—I have modernised the text slightly by changing f's to s's as they are inclined to hamper one's reading and may lead to undesirable confusion here and there.*

*D.C.*

seasonably to unbend his mind. This may generally be done by mixing in cheerful company, active diversions, or the like.

Instead of attempting to investigate the nature of that connection which subsists between the mind and the body, or to inquire into the manner in which they mutually affect each other, we shall only mention those diseases to which the learned are more peculiarly liable, and endeavour to point out the means of avoiding them.

Studious persons are very subject to the gout. This painful disease in a great measure proceeds from indigestion, and an obstructed perspiration. It is impossible that the man who sits from morning till night should either digest his food, or have any of the secretions in due quantity. But when that matter which should be thrown off by the skin, is retained in the body, and the humours are not duly prepared, diseases must ensue.

The studious are likewise very liable to the stone and gravel. Exercise greatly promotes both the secretion and discharge of urine; consequently a sedentary life must have the contrary effect. Any one may be satisfied of this by observing, that he passes much more urine by day than in the night, and also when he walks or rides, than when he sits. The discharge of urine not only prevents the gravel and stone, but many other diseases.

The circulation in the liver being slow, obstructions in that organ can hardly fail to be the consequence of inactivity. Hence

sedentary people are frequently afflicted with schirrous livers. But the proper secretion and discharge of the bile is so necessary a part of the animal economy, that where these are not duly performed, the health must soon be impaired. Jaundice, indigestion, loss of appetite, and a wasting of the whole body, seldom fail to be the consequences of a vitiated state of the liver or obstructions of the bile.

Few diseases prove more fatal to the studious than consumptions of the lungs. It has already been observed, that this organ cannot be duly expanded in those who do not take proper exercise; and where that is the case, obstructions and adhesions will ensue. Not only want of exercise, but the posture in which studious persons generally sit, is very hurtful to the lungs. Those who read or write much are ready to contract a habit of bending forwards, and often press with their breast upon a table or bench. This posture cannot fail to hurt the lungs.

The functions of the heart may likewise by this means be injured. I remember to have seen a man opened, whose pericardium adhered to the breast-bone in such a manner as to obstruct the motion of the heart, and occasion his death. The only probable cause that could be assigned for this singular symptom was, that the man, whose business was writing, used constantly to sit in a bending posture, with his breast pressing upon the edge of a plain table.

No person can enjoy health who does not properly digest his food. But intense thinking and inactivity never fail to weaken the powers of digestion. Hence the humours become crude and vitiated, the solids weak and relaxed, and the whole constitution goes to ruin.

Long and intense thinking often occasions grievous headaches, which bring on vertigoes, apoplexies, palsies, and other fatal disorders. The best way to prevent these is, never to study too long at one time, and to keep the body regular, either by proper food, or taking frequently a little of some opening medicine.

Those who read or write much are often afflicted with sore eyes. Studying by candle-light is peculiarly hurtful to the sight. This ought to be practised as seldom as possible. When it is unavoidable, the eyes should be shaded, and the head should not be held too low. When the eyes are weak or painful, they should be bathed every night and morning in cold water, to which a little brandy may be added.

It has already been observed, that the excretions are very defective in the studious. The dropsy is often occasioned by the retention of those humours which ought to be carried off in this way. Any person may observe, that sitting makes his legs swell, and that this goes off by exercise; which clearly points out the method of prevention.

Fevers, especially of the nervous kind, are often the effect of study. Nothing affects the nerves so much as intense thought. It in a manner unhinges the whole human frame, and not only hurts the vital motions, but disorders the mind itself. Hence a delirium, melancholy, and even madness, are often the effect of close application to study. In fine, there is no disease which can proceed either from a bad state of the humours, a defect of the usual secretions, or a debility of the nervous system, which may not be induced by intense thinking.

But the most afflicting of all the diseases which attack the studious is the hypochondriac. This disease seldom fails to be the companion of deep thought. It may rather be called a complication of maladies than a single one. To what a wretched condition are the best of men often reduced by it! Their strength and appetite fail; a perpetual gloom hangs over their minds; they live in the constant dread of death, and are continually in search of relief from medicine, where, alas! it is not to be found. Those who labour under this disorder, though they are often made the subject of ridicule, justly claim our sympathy and compassion.

Hardly anything can be more preposterous than for a person to make study his sole business. A mere student is seldom a useful member of society. He often neglects the most important duties of life, in order to pursue studies of a very trifling nature. Indeed, it rarely happens that any useful invention is the effect of mere study. The farther men dive into profound researches, they generally deviate the more from common sense, and too often lose sight of it altogether. Profound speculations, instead of making men wiser or better, generally render them absolute sceptics and overwhelm them with doubts and uncertainty. All that is necessary for man to know, in order to be happy, is easily obtained; and the rest, like the forbidden fruit, serves only to increase his misery.

Studious persons, in order to relieve their minds, must not only discontinue to read and write, but engage in some employment or



diversion that will so far occupy the thought as to make them forget the business of the closet. A solitary ride or walk are so far from relaxing the mind that they rather encourage thought. Nothing can divert the mind when it gets into a train of serious thinking, but attention to subjects of a more trivial nature. These prove a kind of play to the mind and consequently relieve it.

Learned men often contract a contempt for what they call trifling company. They are ashamed to be seen with any but philosophers. This, however, is no proof of their being philosophers themselves. No man deserves that name who is ashamed to unbend his mind by associating with the cheerful and gay. Even the society of children will relieve the mind and expel the gloom which application to study is too apt to occasion.

As studious persons are necessarily much within doors, they should make choice of a large and well-aired place for study. This would not only prevent the bad effects which attend confined air, but would cheer the spirits and have a most happy influence on both the body and mind. It is said of Euripides, the tragedian, that he used to retire to a dark cave to compose his tragedies; and of Demosthenes, the Grecian orator, that he chose a place for study where nothing could be either heard or seen. With all deference to such venerable names, we cannot help condemning their taste. A man may surely think to as good purpose in an elegant apartment as in a cave; and may have as happy conceptions where the all-cheering rays of the sun render the air wholesome, as in places where they never enter.

Those who read or write much should be very attentive to their posture. They ought to sit and stand by turns, always keeping as nearly in an erect posture as possible. Those who dictate may do it walking. It has an excellent effect frequently to read or speak aloud. This not only exercises the lungs, but almost the whole body. Hence studious people are greatly benefited by delivering discourses in public. Public speakers, indeed, sometimes hurt themselves by over-acting their part; but this is their own fault. The martyr to mere vociferation merits not our sympathy.

The morning has, by all medical writers, been reckoned the best time for study. It is so. But it is also the most proper season for exercise, while the stomach is empty and the spirits refreshed with sleep. Studious people

should, therefore, sometimes spend the morning in walking, riding, or some manly diversions without doors. This would make them return to study with greater alacrity, and would be of more service than twice the time after their spirits are worn out with fatigue. It is not sufficient to take diversion only when we can think no longer. Every studious person should make it a part of his business and should let nothing interrupt his hours of recreation more than those of study.

Music has a very happy effect in relieving the mind when fatigued with study. It would be well if every studious person were so far acquainted with that science as to amuse himself after severe thought by playing such airs as have a tendency to raise the spirits and inspire cheerfulness and good humour.

It is a reproach to learning that any of her votaries, to relieve the mind after study, should betake themselves to the use of strong liquors. This, indeed, is a remedy; but it is a desperate one and always proves destructive. Would such persons, when their spirits are low, get on horseback and ride ten or a dozen miles they would find it a more effectual remedy than any cordial medicine in the apothecary's shop, or all the strong liquors in the world.

The following is my plan, and I cannot recommend a better to others. When my mind is fatigued with studies or other serious business, I mount my horse and ride ten or twelve miles into the country, where I spend a day, and sometimes two, with a cheerful friend; after which I never fail to return to town with new vigour and to pursue my studies or business with fresh alacrity.

It is much to be regretted that learned men pay so little regard to these things! There is not anything more common than to see a miserable object overrun with nervous diseases bathing, walking, riding, and, in a word, doing everything for health after it is gone; yet, if anyone had recommended these things to him by way of prevention the advice would, in all probability, have been treated with contempt, or, at least, with neglect. Such is the weakness and folly of mankind, and such the want of foresight, even in those who ought to be wiser than others!

With regard to the diet of the studious, we see no reason why they should abstain from any kind of food that is wholesome, provided they use it in moderation. They ought, however, to be sparing in the use of everything that is windy, rancid, or hard of diges-

tion. Their suppers should always be light or taken soon in the evening. Their drink may be water, fine malt liquor, not too strong, good cider, wine and water, or, if troubled with acidities, water mixed with a little brandy, rum, or other genuine spirit.

We shall only observe, with regard to those kinds of exercise which are most proper for the studious, that they should not be too violent, nor ever carried to the degree of excessive fatigue. They ought likewise to be frequently varied so as to give action to all the different parts of the body, and should, as often as possible, be taken in the open air. In general, riding on horseback, walking, working in a garden, or playing at some active diversions are the best.

We would likewise recommend the use of the cold bath to the studious. It will, in some measure, supply the place of exercise, and should not be neglected by persons of a

relaxed habit, especially in the warm season.

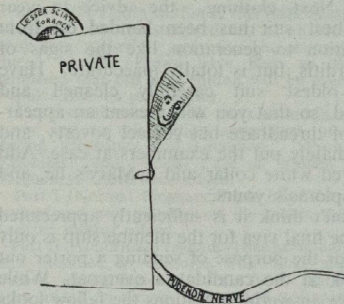
No person ought either to take violent exercise or to study immediately after a full meal.

In the above remarks on the usual diseases of the studious my chief object was to warn them of the evil consequences of *painful and intense thinking*. But I should be sorry to damp the ardour of their literary pursuits, which are injurious to health only when continued with incessant toil at late hours and without due intervals of rest, refreshment, relaxation and exercise. It is not thought, says the medical poet, 'tis painful thinking that corrodes our clay. I deemed it necessary to be more explicit on this head, in consequence of having found that my former cautions to men of genius and science had been understood in too rigorous a sense as discouraging the manly exertion of real talents.

## AIDS TO ANATOMY

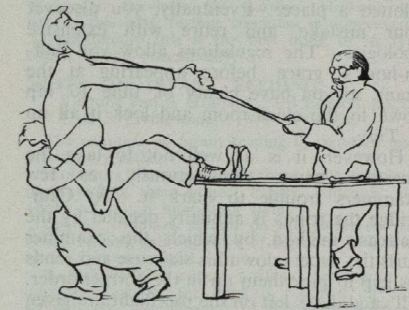
or *Legends of the Cave men*

### PUDENDAL NERVE



Alas of this we cannot write.  
In truth we are ashamed  
To tell you how Pudendal Nerve  
Came thus to be so named.

### DIGITAL FOSSA



T'was in a viva-voce—  
"What goes in here you lout?"  
The poor wretch stuck his finger in  
But couldn't get it out.

J.S.B.

## THE JOURNAL

Contributions must reach the Editor before the first Tuesday of the month for inclusion in the following number.

## HOW TO PASS EXAMINATIONS

By ALAN TOIS

I DON'T suppose a man can read medicine longer than eighteen months before losing the naive idea that passing examinations has anything to do with skill, knowledge, or ability. Exams can only be overcome by a mixture of showmanship, quick-wittedness, and downright low cunning: thus they remain perfectly fair tests of the qualities demanded of the successful doctor.

Let us consider the road to success in detail:

### *The Written Paper*

An infallible method of passing the written part of the contest is known to old hands as *The Two-room System*. Now, examinations these days are usually conducted in two or more rooms, labelled 1-250, 251-500, or some such figure. Suppose your number is 301. You wander with the crowd into the 1-250 room and parade anxiously up and down the aisles. The questions will be set out on the candidates' desks and no effort is required to familiarize yourself with the whole paper. When everyone is settling down and beginning to write, you present yourself with considerable agitation, to the invigilator, telling him you haven't been allotted a place. Eventually, you discover your mistake, and retire with extensive apologies. The regulations allow you half-an-hour's grace before appearing at the exam, so you have plenty of time to nip down to the cloak-room and look it all up in *Tidy*.

However, it is as well not to take the question paper too seriously, as few examiners trouble to mark it. At Cambridge the tripos is annually decided by the staircase method, by which the examiner hurls the papers down his staircase and sends his gyp to pick them up in the correct order. All candidates left on the top flight are given firsts, the landing collects a number of seconds, thirds are distributed to the mass on the lower flight and anyone on the ground floor fails. Then there is the habit by which examiners pass the tedious hours, betting the candidate five marks or so he won't make such and such a mistake on the following page—it's a fair do, the pundit often loses.

### *The Path Viva*

Incomprehensible slides are easily dealt with—simply rack down the microscope

until you crack the cover-slip. They will then have to bring you a new slide and a new microscope. If you are still foxed, repeat the manoeuvre. Eventually they will run out of slides, microscopes, or patience, or all three simultaneously.

As for the bottles, in the Cambridge M.B., at any rate, they leave you alone with three specimens withdrawn from a central pool before coming back to question you on them. A friend of mine, finding himself floored by one of the three jars, took a gastric ulcer from the main collection and slipped the mystery into the convenient sleeve of his M.A. gown. Later, remembering advice from other candidates, he hurled the evidence in the dead of night over Garret Hostel Bridge. The tinkle of glass upon glass reached his ears—everyone had the same idea, and the pathological museum at Cambridge is slowly silting up the River Cam.

### *The Viva and Clinical*

This is the most difficult part of the whole exam. Firstly, the mode of arrival is highly important. It is as fatal to arrive for the Conjoint in a taxi as it is essential to present yourself at the College of Physicians with one. Next, clothing—the advice to wear your best suit has been handed on from generation to generation, like the signs of pericarditis, but is totally inaccurate. Have your oldest suit carefully cleaned and pressed, so that you will present an appearance of threadbare but genteel poverty, and immediately put the examiners at ease. Add a frayed white collar and a Mary's tie, and the diploma's yours.

I don't think it is sufficiently appreciated that the final viva for the membership is only held for the purpose of sending a porter out to look at the candidate's overcoat. While you are answering questions the fellow looks through the door and makes a secret sign to decide your fate. Dark form-fitting overcoats are passed, and a black homberg with a rolled umbrella puts you on the list of prospective Fellows.

In the clinical, the golden rule is *The Customer is Always Right*. Ask the patient—he knows. A friend of mine applied this advice recently, but was highly annoyed to find the patient—a respectable-looking elderly gent—had no idea why he was being

detained in hospital. Physical examination proved entirely negative. The bell was about to ring, and little beads of sweat stood out on my friend's brow. "I like doctors," said the patient, chattily, "particularly young doctors like you." "Thank you very much," replied my friend, without much enthusiasm. "Yes," went on the old boy. "I've taken a fancy to you. I'd like you to come and stay with me for the week-end." "Charmed, I'm sure," grunted the candidate between his teeth, desperately fiddling about with an ophthalmoscope. "I haven't much of a place," continued the patient, "just a few thousand acres out Maidenhead way. Bit of rough shooting if you want it, and I've fishing rights on the Thames. Tell you what

I'll do. I'll send one of my chauffeurs down with a Rolls—the gold-plated one. Of course," he added confidentially, "I'm one of the governors of the Bank of England." By that time my friend had flown at his pupils with a torch. Even so, in the subsequent entirely satisfactory interview, while he was desperately making up physical signs, he was haunted by the disquieting notion that the fellow really was one of the governors of the Bank of England.

Well, there you are—the above directions have carried me successfully from School Certificate to qualification. The only occasion, I regret to say, on which they miscarried was the Membership. But, as everyone knows, that exam is blasted unfair.

## B.W.I. RE-UNION DINNER

A reunion dinner of old Bart's men was held in the Hotel Normandie, Trinidad, B.W.I., on December 3rd, 1948, in honour of Mr. Rodney Maingot who was visiting the Island. Others present were:—Stanley E. Littlepage, R. C. Dolly, M. V. Boucand, K. Bhagan, E. De Verteuil, V. M. Metivier, Miss Winifred Grace Holding (now Matron-in-chief, Northern Rhodesia), T. E. A. Boucand, L. A. H. McShine, T. R. McDougall, D. McShine, C. Knowles and T. Henry Pierre. It is hoped that in future the dinner will be held annually.

## BOOK REVIEWS

**EDEN & HOLLAND'S MANUAL OF OBSTETRICS**, by Alan Brews. 9th Edition. Pp. 796 + xii. J. & A. Churchill, Ltd. 1948. Price 42s.

Before the eighth edition of this book became out of date, it was the standard text of all those who took their midwifery seriously. The changes introduced by Dr. Brews have been so skilfully tempered that this new edition will be even more popular than its predecessor.

The presentation is in IX parts bound in a single cover and to this edition appendices on "Diet during Pregnancy and Lactation," "Post Natal Exercises" and "Social Care of Women during Pregnancy," have been added.

Part I (Normal Pregnancy) has been thoroughly revised and new material on the ovum, the fetus and the mother added.

Part II (Abnormal Pregnancy) has been rearranged and modified to conform with what might be termed chronological order. New matter has been added on Graves disease and embryonic and fetal abnormalities.

Parts III and IV (Normal and Abnormal Labour) remain little altered since the basic principles of obstetrics do not change, but a review of analgesia has been included and relatively minor alterations made.

Part V (The Puerperium) has been almost entirely re-written and now conforms with the current practice in chemotherapy and physiotherapy.

Part VI (The Fetus) includes a review of Barcroft's work and its application.

Part VII (The Newly Born Child) now includes new work on haemolytic diseases and chemotherapy applied neonatally.

Part VIII (Obstetrical Operations). Apart from the prominence now given to lower segment Caesarian section this remains essentially the same.

Part IX (Maternal Mortality and Morbidity, The Maternity Service). Sir Eardley Holland has revised this part, further comment is unnecessary. Undoubtedly this is the best book of its type extant at the present day.

**NOTES ON INFANT FEEDING**, by G. B. Fleming and S. Graham. 3rd Edition, pp. 66. E. & S. Livingstone. 1948. Price 3s.

The chapters on infant feeding in standard texts are usually rather dull.

Professors Fleming and Graham have succeeded in presenting their subject briefly, concisely and above all in an interesting style.

Correct emphasis is laid on the preference for breast feeding and one third of the book is devoted to its various aspects.

A further third covers artificial feeding in an adequate fashion; the book is rounded off with sections on "The Feeding of Premature Infants," "Failure to Thrive" and "Diarrhoea and Vomiting."

Appendices of useful data are included. In all an excellent book which deserves better than the flimsy cover which houses it.

**PROBLEMS OF FERTILITY IN GENERAL PRACTICE**, by M. H. Jackson, J. Malleon, J. Stallworthy and K. Walker. Hamish Hamilton, 1948, pp. 255. Price 17s. 6d.

This book really deals with two problems; the first part covers the investigation and treatment of the infertile marriage and the second part is a

Careful survey of the various methods of clinical contraception. Neither of these subjects is particularly well provided for in the average gynaecological textbook, and the subject is of great importance, both to the general practitioner and the specialist. There is no doubt that much maladjustment exists in many marriages and that this is responsible for many functional and some organic disorders in both partners.

The style of this book is crisp and forthright, and the subject matter accurate and reliable. Treatment is up-to-date. The chapters by John Stallworthy are particularly good. He has had the courage to jettison some of the time-honoured rubbish which has been copied from textbook to textbook. His conservative and sensible treatment of the retroverted and gravid uterus is refreshing. Every practising doctor sooner or later will have to give advice about contraception. Even if he does not actually provide the means in his own consulting room, he must know the principles of the various methods and their short-comings and possible complications.

This book is easy to read, and when read, comfortable to digest; it represents at the moment the best British viewpoint on infertility and contraception, and will be acceptable to all grades of clinician from the medical students to the consultant.

**SYNOPSIS OF REGIONAL ANATOMY**, by T. B. Johnston, C.B.E., M.D. J. & A. Churchill, Ltd. 6th Edition, pp. viii + 436. Price 18s.

This manual requires no introduction to students. The general arrangement is as in previous editions, and new material has been added on the Extra-pyramidal System and variously throughout the text. It is, as the author points out, a book from which to revise anatomy, region by region, and is not intended for those dissecting the cadaver for the first time.

Used in conjunction with drawings to be found in the larger text-books, it can be strongly commended to revision students.

**TEXTBOOK OF GYNAECOLOGY**, by Wilfred Shaw, J. and A. Churchill, Ltd. 5th Edition, 1948, pp. 660. Price 25s.

Neither Mr. Shaw nor his Textbook of Gynaecology require any introduction to Bart's men; both are familiar features of the landscape.

This new edition is some twenty pages larger than the last, and, although the arrangement is the same, much of it has been re-written to conform with current views. Ovarian tumours, for instance, are now classified on the basis of Schiller's and Meigs's work.

The book is clearly written and covers the subject very adequately. Its production is in keeping with the high standard associated with Messrs. Churchill.

**QUEEN CHARLOTTE'S TEXTBOOK OF OBSTETRICS**, by the Clinical Staff of the Hospital. J. & A. Churchill, Ltd., London. 7th edition, 1948, pp. 572. Price 28s.

This edition, appearing five years after the last, includes much new material and brings the work up to date. Despite the fact that there are many contributors, the editor has done his job well and the cohesion is good. This book can be recommended to all who are starting their midwifery.

**AIDS TO TRAY AND TROLLEY SETTING**, by Marjorie Houghton. Ballière, Tindall & Cox. 4th Edition, pp. xiii + 208. Price 5s.

**AIDS TO SURGICAL NURSING**, by Katherine Armstrong. Ballière, Tindall & Cox. 4th Edition, pp. xii + 432. Price 6s.

Both these books are well known in the "Aids" series. Miss Houghton has a compact subject to cover, and does it competently. "Aids to Surgical Nursing" is a courageous effort to cover a wide field, and suffers from the usual defects of a small book on a large subject. The pathology is confusing; gastroenterostomy is surely not the operation of choice for peptic ulcer; the section on methods of blood transfusion might well be cut.

**MODERN PRACTICE IN PSYCHOLOGICAL MEDICINE, 1949**. Edited by J. R. Rees. Published by Butterworth and Co. Ltd., London, 1949.

This book is beautifully printed on fine art paper and bound in the American style; it will, therefore, be a valuable article of export. It is, however, a little difficult to know what the publishers (or the editor, incidentally) expected this book to be. Is it to be regarded as a textbook? If so, it is hard to imagine a textbook by twenty-eight authors, all presenting different points of view. A good textbook should be the work of one author, or at the most of two who think alike and share a common literary style. In this connection, one is reminded of the Duke in Chesterton's play, "Magic," who was so "broad-minded" that whenever he sent a cheque on request to the Vegetarian League, say, would by the same post send a cheque for an equal amount to the Butchers' Benevolent Association. For instance, Dr. R. G. Gordon in chapter 2 gives us an account of the human psyche (twenty pages) largely in terms of McDougall and Jung. Chapter 3, which is supposed to interpret the human psyche with an "abnormal" slant, is by a member of the staff of the Tavistock Clinic and is undiluted and highly concentrated Freud and Melanie Klein. A textbook by one, or at the most two authors would present a point of view which could be judged on its own merits. Each of the contributors to this book could have written (and many of them have written) a book or books on their particular subjects; but, when they are expected to compress and condense to the dimensions of an article, what remains for the most part is doctrine without argumentation, which in the case of psychiatry is far from convincing. Nor is this book a well digested and synthesised précis of modern progress in psychiatry of the kind with which Messrs. Churchill's excellent "Recent Advances" series has made us so familiar. For example, to refer once more to Dr. Gordon's chapter, the references bear the following dates: 1928, 1923, 1917, 1923, 1948, 1923, 1923—only one reference later than 1928! In fact, hardly any of the "chapters" can be said to be fully up-to-date and continental work receives scant recognition.

Nevertheless, "Modern Practice in Psychological Medicine" will find a place in most medical libraries in virtue of its title and the distinction in the field of psychiatry of many of its contributors.

Nevertheless, "Modern Practice in Psychological Medicine" will find a place in most medical libraries in virtue of its title and the distinction in the field of psychiatry of many of its contributors.

## CLINICAL CASEBOOK

### MYXOEDEMA

By M. B. McILROY, M.R.C.P.

Miss J. L., aged 26, came to hospital on March 8th, 1949, complaining of swelling of the legs.

One year previously she had developed a blister on her left foot which became infected and took three months to heal. The left leg had been swollen since then and for six months there had been swelling of right leg. For three months she had been gaining weight and had noticed dyspnoea on exertion, constipation and dryness of the skin. She had been unable to concentrate and had found difficulty in learning her parts for amateur dramatic performances. She had also noticed that she slept a lot, was lethargic and disliked the cold. There were no headaches and the menses were normal. Six years previously the patient had had an attack of hyperthyroidism lasting three months with a goitre, prominent eyes, irritability, loss of weight and nervousness. She had been treated with Phenobarbitone and the symptoms had disappeared. The patient's father has diabetes mellitus and has had a goitre for twenty years. He is now taking thyroid.

On examination the patient's general appearance suggested myxoedema. The face was puffy and the skin dry. She was intelligent, but rather slow both mentally and physically. The hair and eyebrows were normal. The eyes were slightly prominent but there was no lidlag. The fundi and visual fields were normal. The mucous membranes were slightly pale. There was no goitre. The heart was normal, the pulse rate 66 and the blood pressure 105/70. The only other abnormality was swelling of the ankles, which pitted slightly on pressure. The urine was normal.

The patient was admitted to hospital for investigation and the following results were obtained.

Haemoglobin 66% (Haldane), R.B.C. 3.7 millions per cu. mm., W.B.C. 6,900 per cu. mm., B.M.R. -36%, Blood Cholesterol 172 mg. and 202 mg./100cc. E.C.G. showed low voltage complexes with flat T waves. Chest X-ray showed normal heart and lungs. X-ray of skull was normal with a slightly small pituitary fossa. Glucose Tolerance curve was normal and 17 ketosteroid excretion was 1.6 mg. in 24 hours.

A diagnosis of myxoedema was made and the patient treated with Thyroid Extract gr.  $\frac{1}{2}$  daily. The dose was increased after a week to gr. 1 daily and the patient was discharged. She has since attended the outpatient department and the dose of thyroid has been increased.

There is no doubt that this patient has diminished Thyroid function, the B.M.R. and E.C.G. confirm the clinical diagnosis. The underlying cause is more difficult to determine. Hypothyroidism or myxoedema occurs either as a primary disease or secondary to changes in the thyroid or pituitary. Primary myxoedema is usually found in women after the menopause. The Thyroid gland is small and atrophic. There is some evidence of pituitary disturbance even in this condition as the 17 ketosteroids are low. The 17

ketosteroids reflect adrenal cortical activity and the low figures in myxoedema suggest that the disease is not due to simple thyroxine deficiency. It is possible that the pituitary may be responsible for the depression of both thyroid and adrenal activity. Secondary myxoedema may follow simple goitre, or fibrosis of the gland as in Hashimoto's disease. It may also follow partial thyroidectomy for thyrotoxicosis. Myxoedema following simple goitre is often due to iodine lack and is found in areas where goitre is endemic. Hypothyroidism secondary to pituitary destruction occurs in Simmond's disease and with pituitary tumours such as chromophobe adenomata, eosinophil adenomata and suprasellar cysts.

There is no evidence that this patient has secondary myxoedema. Although there is a past history of goitre, the thyroid is now normal in size. There has been no surgical intervention, and there is no evidence of pituitary destruction. Pituitary tumours can be excluded by the absence of pressure symptoms such as headaches, hemianopia or other visual disturbances and by the absence of radiological changes in the pituitary fossa. Simmond's disease produces a different clinical picture with amenorrhoea, wasting, a low blood sugar, a flat glucose tolerance curve and progeria in addition to hypothyroidism. It is likely then that this patient has developed primary myxoedema at an early age.

The occurrence of first hyperthyroidism and then myxoedema is of interest in relation to the surgical treatment of toxic goitre. If this patient had been operated upon when she had hyperthyroidism, the myxoedema would have been attributed to the operation.

The anaemia in this case was probably due to lack of thyroid as the colour index was normal. Anaemia in association with Myxoedema may be of three varieties. The commonest is iron deficiency anaemia due to blood loss from menorrhagia. The colour index in this variety is low. Pernicious anaemia with a high colour index is sometimes found in older patients. Occasionally the anaemia is due to thyroxine deficiency in which case it should respond to Thyroid Extract.

The normal values for the blood cholesterol are of some interest, as it is frequently said that a raised blood cholesterol is always found in myxoedema. A normal blood cholesterol and a normal E.C.G. do not exclude myxoedema.

There is some difference of opinion about amount of thyroid which should be given in the early stages of treatment. Cardiovascular changes have been seen in patients started on large doses of thyroid, so it is advisable to start with small doses. The dose can be increased later until the disease is controlled. The maintenance dose of thyroid varies and is usually of the order of 5 grains daily.

*Summary.* This patient had developed primary myxoedema at the early age of 26.

## EXAMINATION RESULTS

## UNIVERSITY OF OXFORD

## 2nd M.B. EXAMINATION

## Forensic Medicine &amp; Public Health

Dossetor, I. B. Widdicombe, J. G. Godden, J. L.  
Wheelwright, J. \*Glossop, M. W.

## Special &amp; Clinical Pathology

Dossetor, J. B. Tallack, F. V. Widdicombe, J. G.

\* Completed exam. for the degree M.B., B.Chir. (Cantab.).

Hilary Term, 1949  
Tallack, F. V.

Hilary Term, 1949

## UNIVERSITY OF LONDON

## Special Second Examination for Medical Degrees

Albright, S. W.	Cox, W. H. A. C.	Hicks, J. P. N.	Pickard, A. M.
Blau, J. N.	Davies, G.	Hill, F. A.	Poole, G. H. G.
Bloom, M.	Davies, H. T.	Holbrook, B. W.	Romaues, J. L.
Boyse, E. A.	Davies, P. E.	Horsfall, B. E. C.	Singer, G. E.
Brown, H. E.	Dean, L. C.	Jenkins, D. G. W.	Stevenson, K. M.
Brown, J. R.	Derrington, M. M.	Jones, K.	Tarnoky, G. E. M.
Bruce, J. D.	Dodge, J. S.	Lascelles, B. D.	Thomas, B. D.
Brydson, M. D.	Dreaper, R. E.	Lewis, B.	Thomas, G. E.
Cave, J. D. H.	Finch, C. P.	Lockett, H. I.	Todd, J. N.
Charles, H. P.	Fitt, W. P.	Manuel, J.	Train, P.
Chia, A. K.	Frears, R. E.	Newill, R. G. D.	Vickers, R.
Chuck, V. R.	Gaskell, F.	Ogden, P. M.	Watts, M. B.
Clappen, J. A.	Girling, J. A.	Painter, N. S.	Williamson, P. J.
Clulow, G. E.	Gobert Jones, J. A.	Palmer, C. A. L.	Wilson, M. S.
Cook, J.	Haggett, R.	Parker, R. B.	Winsor, M. A.
Coole, C. W.	Haigh, P. G.	Pearson, R. V.	Winston, F.

March, 1949

## Second Examination for Medical Degrees (For External Students)

McDonald, I. K.

March, 1949

## Examination for the Academic Postgraduate Diploma in Medical Radiology (Therapy)

## Part I

Emery, E. W.

March, 1949

## Examination for the Academic Postgraduate Certificate in Public Health

Glanvill, A. I. H. Mayers, J. R.

April, 1949

## SOCIETY OF APOTHECARIES

## FINAL EXAMINATION

March, 1949

## Surgery

Horrocks, K. C. Thompson, B. E. L.

## Pathology

Horrocks, K. C.

## Midwifery

Giri, G. A. R.

The following Candidate, having completed the Final Examination, is granted the Diploma of the Society.

Thompson, B. E. L.

## RECENT PAPERS BY BART'S MEN

ABRAHAM, SIR ADOLPHE. The role and value of the anamnesis. *Lancet*, April 2, 1949, pp. 553-5.

\*BANKS, T. E., and others. The use of radioactive isotopes in immunological investigations. 2. The fate of injected <sup>32</sup>P-containing proteins. *Biochem. J.*, 43, iv., 1948, pp. 518-23.

BETT, W. R. James Carson (1772-1843). *NAPT Bull.*, Feb., 1949, pp. 19-20.

— Max Nitze (1848-1906). *Med. Press*, March 9, 1949, p. 254.

— Oscar Lassar (1849-1907). *Brit. J. Derm. Syph.*, 61, March, 1949, p. 108.

BOURSNELL, J. C. See Banks, T. E., and others.

\*CAPPS, F. C. W. Malignant disease of the paranasal sinuses. *Ann. Roy. Coll. Surg.*, 4, Jan., 1949, pp. 38-48.

COLTART, W. D. Hammer-toe. *Practitioner*, 162, April, 1949, pp. 338-9.

\*CUNNINGHAM, GEORGE J. Trilocular heart with bilateral aneurysmal dilatation of the pulmonary arteries. *J. Path. and Bact.*, 60, July, 1948, pp. 379-86.

DEWEY, HILARY M. See Banks, T. E., and others.  
FRANCIS, G. E. See Banks, T. E., and others.

\*FRANKLIN, K. J. X-ray studies of the kidney circulation. *Sci. News*, 10, 1949, pp. 101-123.

GRIFFITHS, SIR HUGH ERNEST. The surgeon in industry. *Brit. Med. J.*, Feb. 12, 1949, pp. 255-60.

HARPER, R. KEMP. Cholecystography. *Practitioner*, 162, March, 1949, pp. 217-23.

\*HOWELL, TREVOR H. Senile deterioration of the central nervous system: a clinical study. *Brit. Med. J.*, Jan. 8, 1949, p. 56.

\*JORDAN, I. W. and SPENCE, H. A case of congenital tuberculosis. *Brit. Med. J.*, Feb. 5, 1949, pp. 217-9.

KEELE, KENNETH D. (Hewer, A. J. H., and others). A clinical method of assessing analgesics. *Lancet*, March 12, 1949, pp. 431-5.

\*— (Matheson, N. M., and —). A radiological appearance of the papilla Vateri in pancreatic disease. *Brit. J. Surg.*, 36, Jan., 1949, pp. 329-31.

KINMONTH, J. B. and ROBERTSON, D. J. Injection treatment of varicose veins: radiological and histological investigations of methods. *Brit. J. Surg.*, 36, Jan., 1949, pp. 294-300.

\*MEDVEI, V. C. Endocrine disorders and the mind. *Practitioner*, 162, Feb., 1949, pp. 139-47.

\*MURLEY, R. S. Surgical aspects of thrombosis. *Med. Press*, Feb. 2, 1949, pp. 134-40.

\*NICOL, W. D. (Covell, G. and others). "Paludrine" (Proguanil) in prophylaxis and treatment of malarial infections caused by a West African strain of *P. falciparum*. *Brit. Med. J.*, Jan. 15, 1949, p. 88.

\*OSWALD, N., and PARKINSON, T. Honeycomb lungs. *Quart. J. Med.*, N.S. 18, Jan., 1949, pp. 1-20.

RAVEN, R. W. Radial surgery in advanced squamous carcinoma. *Lancet*, Feb. 12, 1949, pp. 261-3.

ROBERTSON, D. I. See Kinmonth, J. B., and —

\*ROUALLE, H. L. M. Rupture of intestine due to non-penetrating injury. *Brit. Med. J.*, Feb. 26, 1949, pp. 350-1.

\*— The solitary thyroid nodule and thyrotoxicosis. *Brit. J. Surg.*, 36, Jan., 1949, pp. 312-4.

\*SHAW, WILFRED. Vaginal operations for cystocele, prolapse of the uterus, and stress incontinence. *Surg. Gynec. Obstet.*, 88, Jan., 1949, pp. 11-22.

TELLING, MAXWELL. Differential diagnosis of bronchial carcinoma. *Med. Press*, Feb. 23, 1949, pp. 205-11.

TUPPER, R. See Banks, T. E., and others.

\*TURNER, E. GREY. A visit to East African branches. *Brit. Med. J.*, Feb. 12, 1949, pp. 70-1.

VARTAN, C. K. The rhesus factor—a simplification. *Med. World*, 69, Feb. 4, 1949, pp. 743-5.

\*WARD, R. OGIER. Extravesical radium therapy in cancer of the bladder. *Brit. J. Urol.*, 20, Dec., 1948, pp. 191-202.

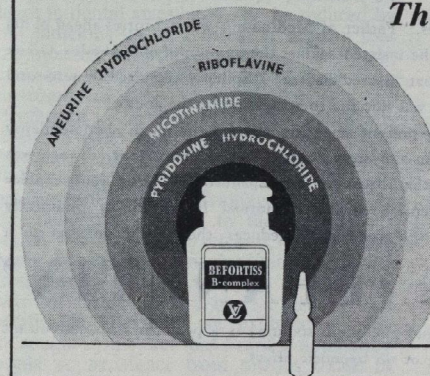
\*WEBER, F. PARKES. Combined osseous and dermal dysplasias—developmental osteodermopathies. *Med. Press*, Jan. 19, 1949, pp. 55-6.

\*WORMALL, A. See Banks, T. E., and others.

\* Reprint received and herewith acknowledged.

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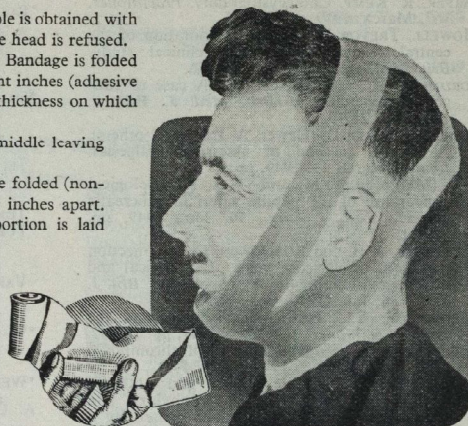
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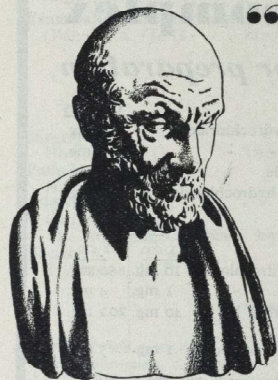
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### MEDICINE IN MUSIC

"Music can soften pain to ease"—so said Pope and so in a rather more prosaic manner say two dental correspondents in a recent number of *Anæsthesiology*. The horror of attending the dentist can it seems be relieved by the discreet application of a few bars of well-chosen music. Gone is the proverbial picture of the dentist as a medium through which all the most refined tortures of Hell are administered to the defenceless patient. Now we see him as a genial musician chatting airily upon the therapeutic qualities of Mr. Beethoven or Mr. Crosby. The contention put forward by these two correspondents in short is this—the amount of nitrous oxide and its attendant oxygen deprivation, prevalently practised we learn in dental anaesthesia, can be reduced by the judicious use of music. It appears that the most effective pieces have "... a smooth, even tone and contain no harsh or startling instrumentation." Debussy's *Clair de Lune*, Beethoven's *Moonlight Sonata*, Humperdinck's *Dream Pantomime*, Wagner's *Forest Murmurs* and *Evening Star* and Fibach's *Poème* are all recommended for their analgesic qualities. The advantages claimed for this delightful addition to the anaesthetist's art are that it abolishes retching and vomiting whilst at the same time facilitating recovery from the anaesthetic. One may well wonder why Mr. Frank Sinatra has no place in this impressive selection; an explanation may be sought in the fact that Frankie apparently needs no assistance from nitrous oxide to reduce his admirers to a comatose condition—and after all even anaesthetists must live.

But not only is the patient entertained with quiet music, he has at hand a remote volume control to while away his anxious moments.

Such consideration is worthy of all the great traditions of medicine. Who amongst us is not delighted with a knob or two upon which to exercise the vagaries of a twiddling nature? Indeed under such circumstances it becomes a matter of urgent necessity, for not to do so would land one back in the painful realities of the dentist's hands. "Let me die to the sound of delirious music," said the poet; if we could but resurrect him we could now lead him to the dentist's chair with the assurance that he might die a hundred such deaths whenever he so chose.

If we trace the history of music and medicine through the ages a truly remarkable revelation of its powers becomes apparent; symptoms of the most diverse nature are all vulnerable to its healing qualities. Aesculapius cured his patients with soothing songs says Pindar. What he cured or sang is unfortunately not recorded; one can but hope he had a medicinal voice of tolerable quality, for even the most abject of patients will jib at the more painful treatments. Theophrastus was of the opinion that music was a capital cure for gout and was specific against the bite of vipers. He had not, one imagines, suffered from either, and his guess after all was as good as the next man's. Cato maintained that music was good for limbs out of joint and there is no doubt that such treatment would be well appreciated nowadays by the hospital staff if not by the patients. Under such circumstances the question of holding the orthopaedic clinic at 11 a.m. in the refectory would merit serious consideration. In their delicate manners both Shakespeare and Boyle agree that music exercises a beneficial effect *super vesicam*.