# SAINT BARTHOLOMEW'S HOSPITAL JOURNAL


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## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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### CONTENTS

# ST. BARTHOLOMEW'S

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## REHABILITATION

The last few months have seen several changes at Bart.'s. In October the children's ward moved from Dalziel of Wooler down to Kenton in the East Wing. At the end of the same month Mr. Naunton Morgan's and Dr. Spence's firms were welcomed back to London. Both are now in the George V Building.

The old year has been tolled out and the new year rung in to the tune of the builders' hammers. The war scars of the Hospital are gradually being made good and we can already see the first-fruits of the Hospital Planning Committee. We have observed with interest the progress of the temporary building beside the lecture theatre and it will not be long now before the almoners can take up residence in it. Some time in the early part of this year more temporary buildings will be erected on the Little Britain site to house the cleaners and the other occupants of the West Wing. The latter will then be available to the workmen who will make the necessary alterations and repairs in order that wards may once more be opened there. Also in the near future the old Casualty Block situated behind the East Wing is to be renovated. It is to be the new Pædiatric Unit and will hold forty beds. The women students may be glad to hear that they are to have a new cloakroom in the basement of this building. The Physiotherapists will leave the ground floor of the East Wing together with the children, still to remain their neighbours. The Orthopædic Department will be returning from Hill End to fill the vacant space. For the time being there will be no more operating theatres and the present accommodation will have to suffice. The Surgery Ward, with approximately twelve beds reserved for short-term in-patients is to be opened again. It will be in its old place next door to Medical Out-Patients in the Out-Patients Block. It is hoped that all these projects will be fulfilled this year. Greater plans for the development and building of the Hospital are also afoot but are as yet too embryonic to be disclosed.

Perhaps the most gratifying sight from the students' point of view is the presence of the decorators in the museum. The roof is being re-glazed and, let us hope, made waterproof. Those who choose to browse among the specimens on a rainy day will no longer need to wear their mackintoshes and there will be no more buckets dispersed about the floor to collect the drips. The walls are being painted, not in the original sickly green, but in pale cream and black, the nearest convenient approach to the Bart.'s colours. The whole of the main floor is to be devoted to the teaching collection and the specimens are being re-catalogued. It is planned that the bottles will eventually be arranged in bays around the walls with tables and stools provided to facilitate study. If this, when achieved, proves as popular as the present systematic demonstrations which are organised week by week by Professor Blacklock, the museum should be a hub of activity. We may look forward to having a museum of as high a standard as those at some of the other London teaching hospitals.

The wheels of the machine of rehabilitation are moving fast at Bart.'s. The long-promised developments and improvements are no longer in the realms of wishful thinking. At the beginning of 1951 we can look ahead towards many of the good things that have been bespoken, with the assurance of their fulfilment in the course of time.

# THE CIRCULATION

## AN EXTENDED CONNOTATION

*By* PROF. K. J. FRANKLIN

The object of this brief survey is to show that the connotation of the word "circulation" needs to be revised and extended in the light of recent evidence, obtained mostly by biochemists, about what Rudolph Schoenheimer (1942) so felicitously styled the dynamic state of the body constituents. For without such extension the relative importance of the various fluid movements within the body is liable to be wrongly assessed and judgment, in consequence, to be fallacious. Further, there can be no proper appreciation of these different movements functioning as component parts of a single, ever-restless whole. Understanding of the present position is aided by reference to the evolution of ideas and knowledge, the chief points in the story including the following:—

1. *From the time of Galen* (130-*c.* 200 *A.D.*) *to that of Harvey there was acceptance of the idea of a slow onward movement of fluid through the body.* Though Galen thought in terms of an ebb and flow of blood on the venous side (liver, systemic veins, right heart, and pulmonary arteries) of the cardiovascular system and of a similar oscillation on the arterial side (left heart, systemic arteries, and pulmonary veins), he obviously envisaged some slow forward movement of fluid in addition to these to-and-fro ones of the blood, and this forward movement was not confined to blood-vascular channels, though it occurred in part through them. For he had to account for the facts that the body took in food and drink by the mouth and eliminated, by various routes, the fluid waste products resulting from such intake. The chyle, according to his schema, passed from the gut to the liver, where it became venous blood and was endowed with the spirit of growth. Then, some of the venous blood kept passing from the right side of the heart to the left one to be endowed in this latter with the spirit of life; the passage was effected, Galen held, through minute pores in the inter-ventricular septum. Finally, a small portion of the arterial blood kept passing up to the brain and was therein endowed with the spirit of mind or soul so that an activating fluid could flow down the hollow nerves to the organs they supplied. There was thus, for Galen, and in consequence for his successors for many centuries, the idea of a slow onward movement of fluid through the body, with the cardio-vascular system providing part of the total pathway for this movement.

2. *William Harvey* (1578-1657) *emended Galen's schema by correcting his wrong ideas about the blood movement.* In 1616 and 1628 Harvey showed that the obvious blood movement is from heart to arteries and from veins to heart, and he postulated the arterio-venous completion of the circuit; he demonstrated, also, the *rapidity* and *amount* of the movement and its wide normal range in both respects. He considered that the heart distributed the products of digestion, and in 1652 he wrote that the mesenteric veins, as well as the lacteals, were concerned with absorption. In his publications, therefore, Galen's idea of movement of fluid from the alimentary canal into the cardiovascular system, and thereafter of an excretion of waste products, was perpetuated, though it was now associated with a correct appreciation of the course of the blood flow, and reasonable ideas about its rapidity and amount.

Richard Lower (1631-1691), Harvey's major scientific successor in circulation studies in the seventeenth century, who showed that the blood becomes arterialized in the lungs and who was one of the pioneers in transfusion experiments, summarized (1669) his personal outlook on fluid movement in the following passage:—"The ~~course~~ cause of our life consists in this alone, that the blood in its continuous passage through the whole of the body carries round heat and nutriment to all the organs, and that ever-fresh chyle passes into the blood in due amount, restoring with equivalent supplies the daily loss of blood-fluid and refreshing it with its continuous inflow."*

* In this connection it is only right to mention that Lower was speaking with some authority in respect of the chyle movement, for he had done some interesting and ingenious experiments on its passage through the thoracic duct and thence into the cardiovascular system.



3. *The blood circulation became more and more the dominant part of the total fluid movement picture.* Until well on into the present century, the only parts of the total fluid movement picture, apart from the blood circulation, which were at all seriously taken into account were the passage of chyle from the intestine to the venous system and the secretory activities of various glands. Separation off of the fluid from the blood was implicit in the very word "secretion," but the idea was made more precise in 1842 when Bowman published his account of the renal circulation and his concept of kidney function. Thenceforward, though it was not stressed, there was tacit acceptance of the fact that the blood from the left ventricle is modified in its course by the loss of water and dissolved substances to the renal and other secretions. However, such increase in knowledge of outside fluid movements was completely outstripped, for technical reasons, by the simultaneous increase in knowledge of the blood circulation, and in consequence there was progressively greater lack of balance between the main subdivisions of the total fluid movement picture. If, to illustrate this point, we go back a mere three decades from to-day, we find that there was then very inadequate information about lymph flow, that tissue fluid was not at all precisely defined let alone its changes appreciated, that modern work upon the cerebrospinal fluid was only just past its initial stages, and that determinations of the filtration rate of the kidneys were still to come. Inevitably, therefore, these other fluid movements were treated as being of minor importance by comparison with the blood circulation, and one part of the full story wrongly dominated the whole.

4. *The introduction of modern biochemical methods restored the balance.* The more balanced picture which we now have has come largely through the use of isotopes to determine the extent and rate of the extra-vascular fluid circulation, but also in part through such procedures as the use of special chemical substances to determine the rate of renal filtration. An important date was 1923, when Hevesy initiated the use of isotopes in biological studies. Thanks to methods such as those mentioned, research on extra-vascular fluid movements has at last been placed on a proper footing, and we are beginning to appreciate the vastness of the turn-round of water and solutes which is involved. We have learned, too, that the component parts of the tissue cells themselves are continuously being replaced at an astoundingly rapid rate. We can well say πάντα ῥεῖ οὐδὲν μένει everything is in a constant state of flux, nothing remains stationary.

Later on, another article, not by myself, will give quantitative details about these fluid movements. My own immediate object has been achieved if I have shown that the blood circulation is only part of the whole picture, and that our concepts need to be extended if we are to benefit to the full from the brilliant biochemical researches of the past thirty years. Only so shall we have an up-to-date understanding of the normal and be able to assess the earliest departures from that normal in the best interests of the patient. And only so shall we rightly carry on, in modern times, the tradition bequeathed to us by the tirelessly inquisitive genius of our greatest Bart.'s man, William Harvey.

## THE THIRTEENTH DECENNIAL CLUB

The Fourth Annual Meeting of the Club was held at Charterhouse Square, and was attended by ninety members under the capable presidency of Dr. M. B. McIlroy. General satisfaction was felt that all members of the club had succeeded in remaining on the Medical Register, and more personal pleasure obtained from the renewal of old friendships.

The Club is open to all qualified Bart.'s men who entered the Hospital or Medical School between the years 1935 and 1945. There will not be a general invitation to all potential members for at least another year, and anyone interested in joining should write to the Club's Secretary at the Hospital.

# THE MOTT CLINIC

## Horton Hospital, Epsom

*By* W. D. NICOL

General Paralysis of the Insane (G.P.I.) is now becoming a rare disease. Until the advent of malaria therapy, which was first employed by Professor Wagner von Jauregg in Vienna in 1917, no treatment which offered any prospect of cure was known. Before the days of malaria therapy cases suffering from G.P.I. were admitted under certificate of mental hospitals. In evidence supplied to the Royal Commission on Venereal Diseases, it was stated that on January 1, 1913, of 103,842 persons suffering from mental disorder in ninety-five public mental hospitals, 6,380 (5,352 men and 1,028 women) were general paralytics. In the London County Council mental hospitals at that time, rather more than 8 per cent of new admissions suffered from this form of insanity. From statistical evidence 75 to 80 per cent of cases died within two years of admission to a mental hospital.

Malaria therapy and more recently penicillin have been responsible for not only prolonging the life of sufferers from this disease, but in about one-third of the cases good remissions have been effected and with the passage of time many of these can be labelled as cures.

The first patient in England to be inoculated with malaria was treated in 1922 at Whittingham Mental Hospital, Lancashire, five years after Wagner von Jauregg's discovery.

It was in 1925 that arrangements were made between the Board of Control, the Ministry of Health and the London County Council to establish a special treatment centre at Horton Hospital. The initiation of this project was largely due to the late Colonel S. P. James, M.D., F.R.S., who at that time was adviser in tropical medicine to the Ministry of Health. James was not interested in G.P.I. but he foresaw the possibility of research in clinical malaria and it is a matter of pride for the author of this paper, who has been associated with the centre since its inception, to be able to record that not only has the knowledge of malaria been greatly increased, but also many problems relating to G.P.I. and other disorders associated with neurosyphilis have been solved. Another worker who has been associated with the special centre from the beginning is Mr. P. G. Shute. The centre was at first limited to a small number of patients—about 10 female beds—and the laboratory arrangements were quite primitive, a disused pantry providing benches for microscopical work and the shelves accommodating cages for mosquitoes. Since those early days the bed accommodation has been increased to 30, when an extension for male patients was added in 1931; the laboratories have expanded and are well equipped and two insectaria for breeding mosquitoes have been built. Apart from treating cases at Horton, the centre is responsible for supplying infective material to any part of the country.

For many years as many as 160 cases were treated at Horton each year, but recently the numbers have fallen considerably and now not more than 100 cases are dealt with annually. This fall in incidence, while gratifying from an epidemiological point of view, causes often considerable anxiety to the staff, who anxiously await the next case in order that a new batch of mosquitoes might be infected with malaria or that malaria blood might be available for transmission to other hospitals.

It is proposed to describe briefly some of the advances gained in our knowledge of these two diseases.

### Malaria

The employment of malaria as a therapeutic agent afforded an excellent opportunity of studying the disease in its primary stage and observing the clinical course of the attack. As far as the malariologist is concerned, the great advantage of studying the disease in the human is the fact that none of the human plasmodia can be transmitted to any animal other than man. Four species of malaria have been employed at Horton—Benign tertian (P. Vivax), Quartan (P. Malariæ), Malignant tertian (P. Falciparum) and P. Ovale.

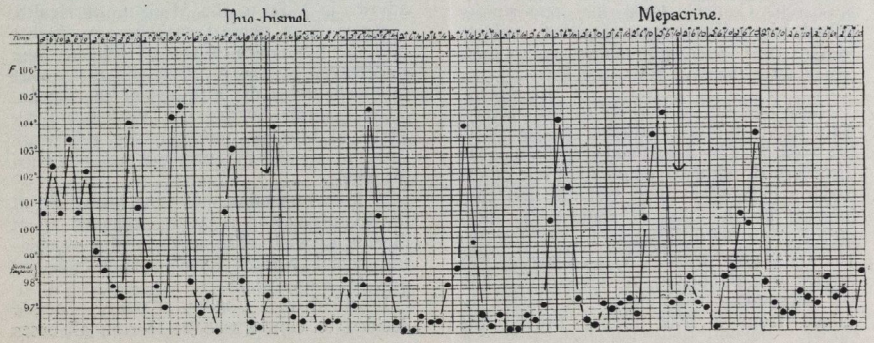
The species most commonly used for therapeutic purposes is Benign tertian, though it is useful to have Quartan available for those patients who have been resident in the tropics at some time or other and find themselves immune to an infection by P. Vivax (Benign tertian). Malignant tertian has been confined to Horton, but has provided excellent research material. P. Ovale as a definite species of malaria was confirmed at Horton in 1931. J. W. W. Stephens in 1922 described the morphological characters of the asexual forms of a malaria parasite in a patient from East Africa and remarked that they were different from those of the usually accepted species. He proposed to establish the parasite as a new species with the name Plasmodium Ovale. In 1927 Stephens and Owen extended this description from a case in Nigeria and in 1930 Warrington Yorke and Owen studied another case from Nigeria. They used this patient's blood for malaria therapy and found those peculiar morphological features constant when the blood was passed from patient to patient by direct blood inoculation. It was in 1931 that Warrington Yorke supplied Horton with some blood from a patient infected from another patient from the Belgian Congo: the passage of the parasite from man to mosquito and from mosquito to man was successfully demonstrated.

The strain of Benign tertian malaria (P. Vivax) employed is known as the Madagascar strain and has been in continuous use since 1925, the passages of the parasite being carried on from man to mosquito and mosquito to man. One of the first clinical observations was the fact that in primary B.T. malaria the fever is daily quotidian and not true tertian. Moreover in most cases the primary attack is neither tertian in character, nor is it benign: the exhibition of some antimalarial drug is invariably required for these primary cases. Only in the relapses, which occur in over 50 per cent of the mosquito inoculated cases, is the fever tertian and benign, the attack clearing up spontaneously after 4 to 5 peaks of fever. It was always the practice to advise that a course of malaria therapy should be given in two stages in order to give the patient a rest; this was effected by giving the patient a small dose of quinine. The discovery by the Americans of the use of thiobismol solved this problem much more satisfactorily. This drug has an amazing selective action on the half-grown parasite only and it is possible therefore to eliminate one generation and retain the other, thus producing true tertian fever and so giving the patient a rest every other day. The accompanying chart illustrates the value of thiobismol, which is administered intramuscularly, the dose being 0.2 gm.

Benign tertian malaria, malignant tertian and P. Ovale have been transmitted through mosquitoes but this has not been achieved until quite recently in the case of quartan, which hitherto was transmitted by blood inoculation. The utilisation of different geographical strains of the same species has provided good material for research and ample proof was forthcoming that European malignant tertian is much more severe



BENIGN TERTIAN MALARIA



clinically than tropical strains. In the past year evidence was adduced in the laboratory that the anopheline indigenous in Northern Europe will become infected by European strains of malignant tertian, but not by the tropical strains which we have used; finally, evidence was obtained that by the employment of a tropical anopheles, such transmission of a tropical strain could be readily achieved. It is interesting to note that the tropical anopheles is also a carrier of European strains. Similarly, Shute has recently been successful in transmitting quartan (P. Malariæ) from mosquito to man and back again by using a tropical anopheles mosquito, but repeated attempts to infect English anopheles failed.

Experimental research in malaria prophylaxis has been carried out with various antimalarial drugs during the past twenty years —Plasmoquine was tried in the first place with partial success, but the toxicity of the drug made it clear that its application in field work would be impracticable. The discovery of the synthetic antimalarial drug Atebrin and Kikuth of the Elberfeld Laboratories in (now known as Mepacrin) by Schulemann Germany opened up a new era of therapeutic and prophylactic possibilities against malaria. It was at Horton that Atebrin was first tried out on man and the promises of this excellent drug have been more than fulfilled by its application in the suppression of malaria, especially in campaigns of the last war which were successfully carried out in hyperendemic malarious areas. It has been long established that the efficacy of a new antimalaria compound can only be tested out thoroughly against a primary attack of malaria. During the last war the Medical Research Council took the opportunity afforded by primary cases of malaria at Horton to test new antimalaria compounds which were then on the secret list.

Shute and his co-workers in the Malaria Laboratory afforded valuable assistance in the work done by Shortt and Garnham in the discovery of the exoerythrocytic cycle of the malaria parasite in man and the first case infected by the bites of some 2,000 mosquitoes, plus the intravenous injection of 200 salivary glands, with P. Vivax malaria, was carried out at Horton on a volunteer, and the subsequent examination of tissue obtained from a liver biopsy proved the presence of the preerythrocytic parasites in the liver.

Apart from the many researches carried out in malaria, much work has also been done in the field of entomology.

The presence of cases suffering from primary attacks of clinical malaria has also provided clinical material for post-graduate instruction, more especially for those taking the D.T.M. and H. course. The visits of malariologists from all parts of the world to Horton has indeed proved stimulating in the exchange of ideas and the application of results of researches in the laboratory has been of great service to workers in the field.

**Neurosyphilis.**

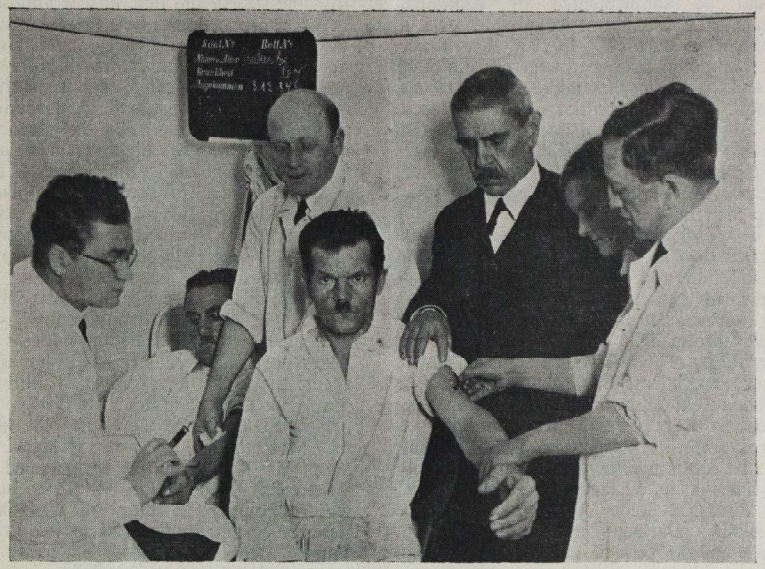
There is no doubt that the hopes of a cure in general paralysis by induced malaria revived enormous interest in this disease. It was largely due to the profound interest taken by the late Mr. R. H. Curtis, Chief Officer of the London County Council Mental Hospitals Department, in the development of the centre that the Council made provision for a research medical officer additional to the medical establishment, and in 1936 Dr. E. L. Hutton was appointed, who, in 1940, was succeeded by Dr. M. Whelen. With the co-operation of Professor Golla, who succeeded the late Sir Frederick Mott, as Director of the Central Pathological Laboratory of the L.C.C. Mental Hospitals at the Maudsley, it became possible to organise a team of workers not only in the field of malaria as organised by Col. James, but in the field of neurosyphilis too. The writer of this article would like to record the continued interest and help, which has always been at our disposal, from Colonel L. W. Harrison, late adviser in V.D. to the Ministry of Health.

Apart from clinical problems, researches into the bionomics of the spirochaete were undertaken by Dr. A. Beck and these were followed under the auspices of the Rockefeller Institute by the late Professor Felix Plaut of Munich—unfortunately this work came to an end in 1940 and has not been resumed.

A follow-up clinic has long been held at the Maudsley and cases are followed up at Horton as well. The services of a psychiatric social worker have been established now for many years.

In 1936 the London County Council decided to concentrate at Horton all cases





*Photograph illustrating the first inoculation of a patient for malaria therapy by Professor Wagner von Jauregg and his assistants.*

suffering from general paralysis or neurosyphilis, who were admitted to the L.C.C. mental hospitals. This wealth of clinical material has been invaluable in elucidating many problems of neurosyphilis and at the end of 25 years, some 2,500 cases have passed through this special Clinic. Many erroneous impressions on the prognosis of different clinical types were corrected and it was found that the most important factor in achieving a cure or really good remission was to treat the case as early as possible, before irreparable damage to the cerebral cortex was effected. Not only is the prognosis favourable for cases of early acquired G.P.I. but this equally applies to early cases of the congenital disease. The investigation of families of established cases of general paralysis revealed the relatively high incidence of asymptomatic neurosyphilis in the partner and sometimes the children. This discovery led to the employment of malaria as a prophylactic therapeutic agent against the subsequent development of symptomatic neurosyphilis with most gratifying results.

The detection of asymptomatic neurosyphilis is only possible as a result of a complete examination of the cerebrospinal fluid and the need for follow-up lumbar punctures of cases who have been treated cannot be overstressed. We have been fortunate in having the experience of large laboratories, firstly at the Maudsley with the late Dr. S. A. Mann, and now at the Group Laboratory at West Park under the direction of Dr. W. W. Kay, who have carried out all the serological investigations. In a series of over 500 cases followed up serologically by Whelen, it was found that most cerebrospinal fluids following malaria therapy became negative within three years from the end of treatment. In over 90 per cent of patients showing two consecutive "negatives" at an interval of six months or more, the spinal fluid remained persistently negative—an observation of immense practical importance.

For the first seven years malaria alone was used as a therapeutic agent, but it was generally accepted that malaria therapy

should be supplemented by additional therapy. the usual practice was to give a course of an arsenical. In 1946 Nicol made a careful comparison between the results of malaria plus tryparsamide and malaria alone, with a substantial series of cases. The follow-up extended over ten years and results were assessed clinically and serologically. Definitely better results were obtained in cases treated by malaria plus tryparsamide than by malaria alone.

The sociological aspects of the follow-up of cases discharged from hospital is under investigation and the long period of time over which patients continue to make clinical improvement is of great interest, and might throw light on the extraordinary adaptability of the nervous system as shown in the experiments of Graham Brown.

The recent discovery of penicillin has raised fresh hopes for the treatment of neurosyphilis. A spate of literature has been let loose and there are many conflicting views on its efficacy in the treatment of this disease. Some American workers—especially Dattner—have come down heavily on the side of penicillin and claim that penicillin is all that is needed as a therapeutic agent. How far this is true, time alone will decide: it is barely 5 years since penicillin was first used in this country and both clinical and serological results are in many cases undoubtedly satisfactory. Other workers, both in America and this country, are more cautious and there is a growing census of opinion that in the more active pathological process, which occurs in general paralysis, penicillin is probably in need of supplementary treatment, just as was malaria. May not the answer be that the best therapy for advanced neurosyphilis will be a course of penicillin plus malaria? These problems can only be satisfactorily settled by subjecting to careful scrutiny a large series of cases and it is hoped to take advantage of the rich clinical material available at Horton and to attempt to arrive at some definite conclusion. Other problems which require solution are the optimum dosage, the best preparation, the length of time for a given course of penicillin and its relation to malaria—whether before, after or during the malaria attack.

**Conclusion.**

In 1925 a special centre was initiated: facilities were meagre and somewhat primitive, the size of the unit was of almost embryonic proportions. A brief account of the development and history of this unit has been presented, with its ramifications and possibilities. The value of team work has been amply demonstrated, and credit for much of the success must be given to a nursing staff who are highly trained and are familiar with the clinical intricacies of therapeutic malaria. The therapeutic application of one disease (malaria) to cure another (neurosyphilis) has increased our knowledge of both. Since 1925 some 150 papers have been published by members of this team. With the advent of penicillin it was felt that the name "malaria therapy centre" was a misnomer, especially as some patients nowadays never have malaria as a therapeutic agent; they may have only penicillin. The Management Committee at Horton were persuaded to change the name—the title of the Mott Clinic, Horton Hospital, was adopted. The Clinic has been named after Sir Frederick Mott (1853-1926), who in 1895 was appointed Director of the Central Laboratory and Pathologist to the London County Mental Hospitals. For many years he worked at Claybury, until the removal of the laboratory to the Maudsley in 1920. Mott's extensive researches in general paralysis paved the way for further developments in our knowledge, which Mott lived to see. It is a tribute to his untiring energy and industry that this Clinic at Horton has been so named.

The Malaria Laboratory, until this year, has been financed out of the scientific grant of the Ministry of Health and has been under their direction. Now in recognition of its valuable contributions to the advancement of our knowledge of malaria, it has been transferred to the Medical Research Council and is known as the Malaria Reference Laboratory, of the Public Health Laboratories, with Sir Gordon Covell as Director and Mr. P. G. Shute as Assistant Director.

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## THE BEADLE'S DILEMMA

It was Christmas Day in the Mortuary,
The air was still and clear,
Then rose a corpse and shouted, "It's very cold down here."
In came the Duty Beadle, with a belly full of beer,
"Lie down you silly so-and-so
"You can't do that there 'ere."

The Beadle fetched the Steward
As he was duty bound,
The corpse had risen from its tray and had a good look round.
"Now look my corpse," the Steward said,
"What *is* this all about?"
"It's Christmas time" he shouted back,
"And you must let me out."

The Steward, in a quandary,
Was shaken to the core.
Duty Beadle got the "rap" for leaving the big "frig" door.
"I'll get the man who signs you in"
Said the Steward most irate,
"He's likely on the Christmas Show,
"You may be much too late."

The Houseman came in a kind of huff,
Prepared to wriggle with the usual bluff,
"It's plain to me" he quietly said,
"The corpse you have is not quite dead."

The Steward, the Beadle and corpse stood aghast,
The truth of the matter was shown up at last.

THE BEADLES.

*Continued from p. 8.*

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## THE ROYAL SOCIETY OF MEDICINE SECTION OF GENERAL PRACTICE

It may interest readers to know that a Section of General Practice of this Society has recently been formed and its Inaugural Meeting was held on November 22.

The Objects of this Section are :

1. To narrow the widening gap between Specialists and General Practitioners.
2. To provide for the General Practitioner an active link with currently accepted ideas.
3. To keep alive the academic or scientific attitude to Medicine and its allied branches, which is so readily lost in General Practice.

It is proposed to hold meetings of the Section of General Practice on the third Wednesday of each month at 8.15 p.m. during the Society's session and details will be announced in the usual manner in the Society's Diary Card. The meetings are private to Fellows of the Society and Members of the Section.

# A STUDENTS' GUIDE TO LODGINGS

*by* DAVID CARRICK

When the average bright young fellow bursts upon his manhood by becoming a student of that wonderful organization known as London University, he may have several objects in view. Perhaps he is of the calibre that possesses curiously lofty ideas about becoming a credit to his hospital, or even to his parents, in the academic sphere. Possibly he may feel that his forte lies more in the field of healthy, rugged sport. Or, maybe, he is bent merely upon enjoying himself in the story-book fashion, visualizing himself as the hero of some gigantic rag.

Into whichever category he falls; however he may differ from his colleagues; in one important respect he will almost certainly share a common experience: he will have to go into lodgings. Now, although this is the only common factor, and despite the fact that it is vitally important, it is more than frequently overlooked until shortly before the opening of term, by which time it is too late for a serious and meticulous investigation of the problem to be made.

And it is an important consideration, make no mistake about that. The majority of the student's time will be spent in his digs. Here he must eat most of his meals; here he must sleep most of his nights: this must be his second home. Good lodgings may help to improve his various abilities: bad ones may tend to blunt any to which he likes to lay claim.

A careful choice is therefore essential, and under the headings of Price, Position, Cleanliness, Landladies and Fellow-lodgers, the cardinal features will be considered.

### Price

This is obviously a difficult problem. If the student has very limited means he simply cannot pay very much. If, on the other hand, he comes of a wealthy family or is the fortunate recipient of a grant from a magnanimous Government, he is in the position to make a reasonable choice. Whatever his state may be, however, it is a wise man who lays out the maximum possible in this respect, for meagre money can only purchase cold comfort.

### Position

There are two aspects to this, namely, the geographical and the social. Both of them hinge on the previous question because, as a rule, prices fall in direct proportion to the distance from central London, and also to the status of the neighbourhood.

As regards the distance, it is not a particularly good idea to be a long way away however attractive the price may be. It is essential that there should be adequate transport, particularly at night. Any fool can get to his hospital in time for the first lecture, if he really wants to, even if it means rising at some ghastly hour shortly after dawn. Getting back late at night is quite another problem. A very pleasant evening can be badly marred if it is terminated by a taxi-ride followed by a stern walk, a trip on an all-night tram and another stern walk. Such a state of affairs is so disheartening that a feeling may develop, particularly in the small hours, that in future one will not go out and enjoy oneself but rather stay in and work; a dolorous habit when pushed to extremes. Besides, what little is saved in actual weekly rent is probably more than lost in fares, and certainly lost in the tediousness of the business. Admittedly, some tell me that they can do invaluable work during their lengthy sojourns on the Southern: more natural people find that even the "Daily Mirror" is an intellectual problem under rush-hour conditions.

A relatively decent neighbourhood is advisable. A bad area can be depressing and even the keenest student finds that a family quarrel on one side, Dick Barton on the other and a street-brawl round the corner is apt to discourage anything approaching concentrated study.

### Cleanliness

When inspecting your prospective digs never fail to ask if there is a bath, and if so whether it is used for its proper purpose. Do not imagine that because you like to immerse yourself in hot water occasionally, everybody does. A surprisingly high proportion of the population regard hot water



with suspicion, except in tea, and consider bathing a wearisome and even weakening experience only to be reserved for special occasions. If possible make some excuse for going to wash your hands: if the water is still stone-cold after five minutes, it is probable that the boiler is lit only on those special occasions or that the pipes are choked, both of which eventualities should be regarded with suspicion. This visit may also give you the opportunity of inspecting other sanitary arrangements which can be quite startling, particularly if you have given no warning of your impending visit.

Never be deluded into thinking (when making last-minute contracts by post) that, because the price is high, the standard of general cleanliness is also high. This attitude can lead to grievous mistakes.

I remember once being asked by a friend of a relation of mine if I would be so good as to visit her young son who had recently taken up his studies in London. He had gone into digs with a companion, she explained, a lad of about the same age who had made all the arrangements: perhaps I wouldn't mind dropping in one day to see if he was quite happy. I was given to understand that he was a sensitive boy but inclined to be reticent in his letters.

The following Saturday, about lunch-time, having nothing better to do, I called at the address.

The outside of the building was reasonable. One of those gaunt Victorian houses that had once known very much better days; and I had few misgivings on knocking at the door.

After a very considerable delay, a voice which appeared to emanate from the bowels of the earth shouted: "Yus?"

I looked down and saw a woman's head sticking out of a door. It had not been handsome by Nature's design: after the addition of a red dye, with green and purple tints, paper curlers, vermilion paint, and what appeared to be a liberal quantity of flour, the spectacle was quite bizarre. So taken was I with this apparition that I gazed fascinated for a while until wakened from my unearthly reverie by a repetition of the question: "Yus?", with "woddyer want?" tacked on.

I explained that I wished to see young Mr. X, and would be obliged if she would acquaint him with my arrival.

The head disappeared to the accompaniment of fading mutters, and five minutes later there was a grating of locks, pulling of bolts, cracking of paint, and the door opened bringing me into close proximity with the by now familiar head, the vast beetle-like body upon which it was mounted, and a rush of onion-laden air faintly masked by an odour suggestive of a disused brewery.

Standing with her podgy hand on the door she gazed me up and down like a zoo visitor regarding an unusual animal. There was obviously a battle going on in her brain as to whether I should be admitted or not, the pros being weighed against the cons. The pros won, largely, I believe, on account of a rather neat umbrella I had borrowed, and I was shown into a place humorously referred to as the sitting-room and given the choice of five chairs.

It was not the sort of selection about which one of our better known hotels would care to boast, and yet, to an eccentric collector of curios it might have provoked some interest. Three of them looked as though they had been bought as an odd lot from an Insurance Company's sale advertising the penalties of a failure to guard against fire and water. The fourth might have excited an Indian Fakir bent upon displaying his powers of fortitude. Whilst the fifth would have been quite cosy had not somebody sat a cake or trifle deep into its faded seat some years before and failed to remove it. I decided to stand.

I was interrupted in a study of this remarkable room by the appearance of the young man. I apprised him of the reason for my visit and insisted, despite protestations, on being shown his bedroom.

We stopped for a rest on the fourth floor and I examined the one extant bathroom which still functioned in an anaemic sort of way and even boasted of the remnants of a bath. Commenting on an evil-looking black thing that leaned in a drunken fashion over the top, I was told it was a geyser, but my friend explained that he never used it as it was safer to go to the public baths which were very convenient being only ten minutes walk away.

Having recovered my breath we mounted to the bedroom. This was quite a large

room, for a Victorian servant, and remarkably well aired thanks to a broken window. It was, however, extraordinarily austere, for apart from two curious low objects covered in a jumble of grubby blankets, which I was told were beds, the only other article of furniture in the place was a lion's-skin rug. In case this piece of information should conjure up visions of Oriental luxury, I must hasten to add that very little more than the moth-populated head of this once-proud article remained; and far from adding dignity to the room or warmth for the feet, it served merely as a somewhat macabre hazard for nocturnal manoeuvres.

When I had recovered from these and other shocks I asked my friend, a trifle humorously, what he was paid for living under such conditions. Being of a somewhat sensitive disposition he was a little offended by this, and pointed out that he was paying a surprisingly handsome sum. He admitted that things were not quite what he was used to, but thought that his landlady was doing her best: he did not like to complain, anyway, as her constant ill-health made her fractious.

"Doing," of course, was the operative word in that sentence. There were no fewer than nine lodgers haunting that mausoleum, and the woman, by virtue of a knowledge of the inexperience of youth, combined with a certain histrionic ability, must have been making an enormous amount of money each week. Nobody ever remained there for more than one term (I saw to it that my lad was out the next day), but there were always others as green to replace them, and it is only to be hoped that, in the four years that have elapsed since I saw the place, the old scoundrel has retired on her ill-gotten gains.

### Landladies and Fellow-Lodgers

Having dealt once before at some length with landladies as a class alone, I will not plague you with further reminiscences on the same subject except from the point of view of living with the family.

It is possible that, on occasions, this system works smoothly. Personally I have never found it at all satisfactory. Perhaps I have been unlucky.

The first of these I shared with two others and in many respects it was ideal. It was clean, the food was excellent and the beds comfortable. Unfortunately, the landlady, in some respects an estimable woman, had a vice: she was an ardent believer in "what the stars foretell." Pamphlets, magazines and books on the subject littered the house. Each fresh post brought a new batch. All her spare time was consumed in poring over horoscopes and weird and wonderful stellar prognostications. And those forecasts were always right: she saw to that. If she was supposed to have a quarrel on a Wednesday, say, she had one, generally at breakfast time. Nothing in the world would prevent her having it **some** time during the day, and we found it wiser to let her have her head early rather than allowing her to save it up until we returned tired in the evening.

It was all right, mind you, as long as the horoscopes agreed on the particular line. Perhaps she was supposed to be amiable and love everybody: this was merely embarrassing. Perhaps she was supposed to be ill-tempered and horrid: we still knew where we stood. But if two different horoscopes were diametrically opposed, then we were in trouble. It was really most disconcerting. One minute she would be bright and cheerful, the next sour and disagreeable, the atmosphere resembled concentrated April weather, one never knew whether to take a coat off or put an umbrella up from one minute to the next.

From there I went to a place run by a woman and her son. The good lady was most admirable in many ways, and one of the kindest people I have ever met, but her politics were not mine. The son was several shades deeper and more militant in an effete sort of way. He belonged to the class of individuals sometimes referred to as "intellectual," that is, he dressed objectionably and inadequately, had an allergy to barbers and soap, and bore allegiance to any country but his own. He was not a nice man.

During my time there I practically ate, drank, and breathed politics. Early on a serious attempt was made to save me from my views which resulted in the most soul-destroying table-battles which gave my antagonists heartaches of despair and myself indigestion. When it became obvious that I would never see the light—being as blind as some of the more fortunate captains of merchantmen off the Cornish coast in the very bad old days they gave up.



Instead they would tell me long anecdotes concerning people I had never met and felt sure that if I did I would dislike intensely. Or, perhaps, the son would try to get me to enthuse wildly over some prints of modern art. I shall never forget my sense of deep shame on being told that I was admiring a Piccasso upside down. It was no good, though, I could not even agree, hard as I tried, even in this sphere. I realise, of course, that I was at fault, not he. So simple and childlike am I that I have to confess that when I go to an art exhibition I really only enjoy the straight "chocolate-boxy stuff"; my brain just isn't astute enough to ponder the minds of men who put eyes and things in feet of infant dwarves in trances: if it is an intellectual problem I desire, to something mundane like the "Times" crossword I turn.

Such odd visitors they had, too. I attended a party there once, but I didn't really enjoy it. There were one or two recognisably human people there, it is true, but the majority were either young men trying to look as though they needed a shave, or individuals of that singular symbiotic genus for whom one is not sure about vacating a seat in the tube in case, on the one hand, they may be insulted, or on the other an incurable conquest may be made. However that may be, I was regarded as a queer, anyway, at this particular party, as I was wearing a suit.

To return to normal, middle-class life, let us examine the last question: the fellow-lodgers.

It is rarely possible to choose your companion; he is generally given to you to make the most of, but the average landlady will, with the least persuasion, tell you the occupation (if any) in which her present young man indulges: this can be a valuable pointer.

Avoid a person who is not morally obliged to work in the evenings. He may be very pleasant indeed, but the presence of an individual who is free when you yourself are chained to books is very disturbing. If he stays indoors the chances are you will spend the whole time talking. If he wants to go out there is a tendency to accompany him: one just does not like to think of a young man running the risks of London vice, especially if he has money; it is almost a moral obligation to help him. Such a state of affairs, even if elevating to the character, leads to a failure to satisfy examiners.

Assuming that your companion is a student, make sure that he is not doing the same work as yourself: you might just as well lodge in the anatomy department. Constant shop-talk day and night is fatiguing and scarcely educative.

Your man should be of a similar age, or perhaps a little younger. He must be generous yet not expect to borrow. He should be able to argue but not be so stubborn as to fail to ultimately relinquish his opinions and bow to your superior experience and commonsense. Under no circumstances must he be a "differentist," that is, a person who can never under any condition possibly begin to agree with anybody's ideas save his own.

[I was in a billet once with a member of this class. When the rest of us were gloomy he would be cheery, knock-about and jovial; when we were happy he was like a wet blanket. If the weather was appalling he was sure that somebody was benefiting by it: on beautiful days he made dark forecasts about drought. We threw him in the static tank one December night: even then he said it was warm.]

He must not expect you to have the intelligence to assist him with any snags that may arise in his studies: at the same time he must be willing to offer his person for important diagnostic experiments such as heart-sounds, etc. He should be interested in medicine yet know very little about it. Above all, he must have a sense of humour.

To sum up, then, we have the conditions for an ideal life. We have comfortable, clean and pleasant digs situated within reasonable distance of the hospital. Our landlady is a good woman whose one ambition in life is to see that you are contented; and your fellow-lodger is practically a being from another world.

Could there be one thing more to complete our bliss? Undoubtedly. But the complex question of marriage is beyond the scope of this article.

# HERBERT MORLEY FLETCHER

M.A., M.D.Camb., LL.D.Belf., F.R.C.P., F.R.A.C.P.

Born in Lancashire 1864; Died Petworth September 9, 1950

A fine English gentleman. A man of great integrity and talent. A wise counsellor, who had many friends. As his brother-in-law, Dr. Chavasse, Bishop of Rochester, said when delivering his funeral address "All who knew Dr. Fletcher (and to know him was to love him) drew strength and confidence from his serene yet dynamic vitality. He so enjoyed life—every moment of it—and God blessed him with a long life, crammed with service and lived with zest."

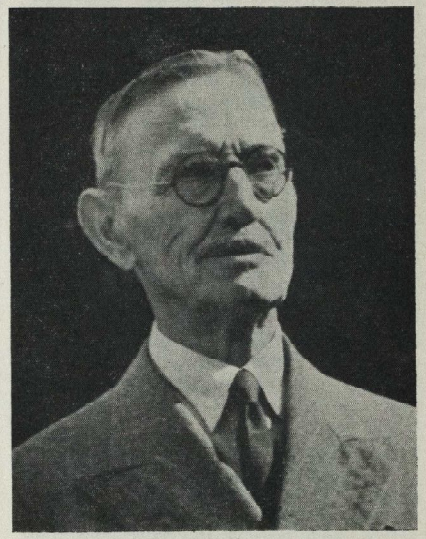
Herbert—or Morley as usually addressed—never grew up or became old. When over 80 his motor insurance company questioned the renewal of his licence. After listening for some time to his reasons for his application, the young man who came to him said, "It is not you I came to interview: I hoped to see your father."

He was married twice: first to Ethel Crossley by whom he had four daughters and two sons; secondly, to Christina, sister of H. U. Willink, and there are two daughters.

On leaving Mill Hill School he entered Trinity College and obtained First Class Honours in both parts of the Science Tripos. After leaving Cambridge he went for a time to Freiberg and Vienna and decided to devote his life to Medicine. Joining St. Bartholomew's he soon became a prominent and successful member of its school. His medical achievements have already been enumerated in many journals and here only a few of them need be described.

For years he held the normal appointments in the Medical School, including that of Curator of the Museum. It was not until 1904 that he became a physician to "Bart.'s," a post which he held for 25 years. During this period he was on the staff of many other hospitals. These were the Metropolitan, East London for Children, Shadwell, Queen Charlotte's, the Alexandra for Diseases of the Hip, the Florence Nightingale, the Bushey Heath, Hertford and the Royal Buckinghamshire Hospitals. He was also Consultant to Osborne, on the Medical Boards of the Navy, of Cruelty to Animals; on innumerable committees, notably King Edward VIIth's Hospital Fund. He was vice-president of the Medical College of "Bart.'s." At the R.S.M. he was president of the Section of Medicine and of Children. At the College of Physicians he always took a prominent position and eventually became the Senior Censor. He was an examiner at Cambridge, Durham, Belfast, Manchester, Sheffield, Glasgow and to the Conjoint Board and Apothecaries.

Fletcher was a very well-known clinician, had wide knowledge and wrote articles on many medical subjects.



In the 1914-18 war he was a Major R.A.M.C. (T.) and served throughout at the 1st London General and other Hospitals. But he was never given promotion and complained that he was the only serving officer never to be allowed to wear a medal of any kind.

There can rarely have been one man who gave such devoted services to so many.

While at Cambridge he was also a well-known athlete—running against Oxford in the hundred yards and quarter mile. In 1888, when a B.A., he was elected President of the C.U.A.C. Throughout his life Fletcher was always present at the University Sports. He was indeed a fine sportsman, had a superb athletic figure and was popular with everyone. He was interested in many other sports including shooting and fishing. He was a good shot and for most of his life a member of syndicates at Downham Market, and later at Lord Albemarle's at Quidenham. With two friends he leased 20 miles of the Feerow, one of the best rivers in Iceland—north of Reikjavik. Here they lived in a hut, cooked their meals, rode on rough Shetland ponies to their beats and caught large numbers of salmon of 10 to 20 pounds each, which they sold to the local farmers for 1d. a pound, to be sun dried and fed to their cattle during the winter.



About 1900 he bought his first motor—a 4½ single-cylinder de Dion car. At that time there were only seven members of the Staff who came to the Hospital in cars. Fletcher was an enthusiastic driver and drove long distances to visit his friends and made numerous visits to Cambridge and Oxford and many other places. For years there was a small group of Bart.'s men who went every year on a Sunday to lunch in one of the colleges. These were the early days of motoring, when there were only bicycle shops or blacksmiths to do any repairs: incidentally these shops were always shut on Sundays. Breakdowns were frequent, and often a good many of the party had to return to London by train. Herbert always disliked waiting. Throughout life, as his envious rivals said, he was always in a hurry. Once when he had started late he got into a queue behind a funeral. There was a lot of traffic but after a moment he decided to risk passing it and nearly succeeded, but the driver of the hearse refused to give way and for this impertinence had both his off-side mud guards removed. Most drivers would have been content with one—but not Herbert. On another occasion when he tried to pass a large tram he was not so successful, his car receiving all the damage.

Skating was another hobby. He was a member of a small select club, which skated at the Botanical, now Queen Mary's Garden. He also went occasionally to Switzerland and was a first-class English style skater.

He took part in many games, even whist, at which he rarely thought what he was playing. He and the writer once held a hand containing all the spades and diamonds. He played golf and occasionally made surprising shots. With his friends he loved his Sunday game at Cassiobury Park and above all his week-ends at Brancaster, where the subscription was one and a half guineas and a first-class caddy two shillings a round. Here he first played with a Haskell ball and hit it what looked like a mile.

One must also mention his houses—98, Harley Street and Hengrove with its garden near Aylesbury. Both of these had beautiful furniture, pictures and books. All his life he had a remarkable knowledge of many different subjects besides medicine. At one time he became interested in pigs and read all about them. History relates that he never owned more than one called "Henry" which he personally tended and fed. He was an authority on gardening and enjoyed showing his fruit trees and shrubs and rare flowers to his friends.

Herbert was a perfect host and it was a great pleasure to be invited to his house to partake of his food, wine and cigars—all of which were exceptionally good. A dinner at Fletcher's was great fun. He was always cheerful and loved telling stories. Once when saying goodbye on the doorstep on a cold winter's night, Herbert said "Robert, did I tell you this one?" Hutchison replied "The night is dark and I am far from home," with which he walked away.

The annual Christmas entertainment at 98, Harley Street after the Cambridge Graduate Dinner was a great occasion, when he threw his house open after dinner to all members of the Club. Occasionally a distinguished guest not from Cambridge was also invited—a great honour. Here we all sat on the floor with drinks and smokes and listened to stories. Year after year Dr. Norman Moore recited the famous tale of "Hairy Rouchy" and recently this story has been reproduced by Reginald Vick. Henry Burroughes also recited his tale about the charwoman, with the famous Mrs. Twiddles in the principal part and told with frequent interruptions such as "Excuse me, stale fish for supper."

Herbert enjoyed everything in life. All was grist that came to his mill. He was an inspiration to many friends, who heard of his death with much grief. He had, indeed, a superb personality and will always be remembered with the greatest affection.

## ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE STUDENTS' UNION

*Income and Expenditure Account—year ended July 31, 1950*

**INCOME**

| | £ | s. | d. |
|---|---|---|---|
| Members' subscriptions (annual instalment from subs. res.) | 2531 | 16 | 7 |
| Interest on investments £172 17s. 2d.; Sundry receipts, i.e., Hill End Fund, Catering Co., S.U. Ball—£37 11s. 9d. | 210 | 8 | 11 |
| Contribution of Med. Col. to expenses at Athletic Ground | 635 | 13 | 6 |
| Total Income | **3377** | **19** | **0** |

**EXPENDITURE**

| | £ | s. | d. |
|---|---|---|---|
| **(1) Expenses at Athletic Ground :—** | | | |
| Wages | 858 | 10 | 9 |
| Rates £223 4s. 1d.; Telephone £17 8 11; Coal £78 10s. 8d. | 319 | 3 | 8 |
| Water, Gas & Elect. £79 6s. 3d.; Sundry Expenses £42 2s. 0d. | 121 | 8 | 3 |
| Ground repairs, etc. £148 18s. 9d.; Rep. to tractors, etc. and petrol £167 10s. 2d. | 316 | 8 | 11 |
| **(2) Expenses at Hospital :—** | | | |
| Newspapers and Periodicals | 99 | 18 | 11 |
| Accountancy charges £52 12s. 6d.; Wages £26 10s. 0d.; Sundry Ex. £34 12s. 8d. | 113 | 15 | 2 |
| Administrative salary £100 0s. 0d.; Telephone and Stationery £2 14s. 10d. | 102 | 14 | 10 |

**(3) Expenses of Clubs and Societies :—**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abernethian Society | 34 | 15 | 6 | Musical Society | 7 | 10 | 0 |
| Athletic Club | 98 | 19 | 4 | Men's Lawn Tennis C. | 56 | 9 | 11 |
| Association Football C. | 79 | 15 | 8 | Ladies' Lawn Tennis C. | 7 | 15 | 1 |
| Boat Club | 112 | 17 | 5 | Physiological Soc. | 5 | 0 | 0 |
| Chess Club | 5 | 0 | 0 | Rifle Club | 36 | 7 | 6 |
| Cricket Club | 113 | 2 | 4 | Rugby Football C. | 357 | 14 | 3 |
| Dramatic Society | 5 | 10 | 0 | Sailing Club | 30 | 0 | 0 |
| Fencing Club | 19 | 13 | 6 | Squash Club | 5 | 0 | 0 |
| Golf Club | 22 | 2 | 9 | Swimming Club | 28 | 11 | 3 |
| Men's Hockey Club | 96 | 3 | 10 | Table Tennis C. | 9 | 12 | 6 |
| Ladies' Hockey Club | 28 | 14 | 0 | U.L.A.U. Aff. Fees | 47 | 15 | 6 |
| | | | | | 1208 | 10 | 4 |

| | | | |
|---|---|---|---|
| **(4) Depreciation** £45 0s. 0d.; Reserve Fund for Equipment £150 0s. 0d. | 195 | 0 | 0 |
| Total Expenditure | **3335** | **10** | **10** |
| **Surplus of Income over Expenditure** | **42** | **8** | **2** |

As is shown by these abbreviated accounts the Students Union had a small surplus last year. Income may rise this year by about £100, but this will not add to next year's surplus for rising costs are likely to absorb it. The "Journal" will probably now require regular assistance from the Union and considering all rising costs, expenditure on Clubs clearly must be kept as stationary as possible.

## EXAMINATION RESULTS

### SOCIETY OF APOTHECARIES

**Final Examination**

**October, 1950**

**Medicine**

Denny, I. B.

### UNIVERSITY OF LONDON

**Ph.D. Examination for Internal Students**
**Faculty of Science**

**October, 1950**

Hale, L. J.

**Third M.B., B.S. Examination for Medical Degrees**

**October, 1950**

**Pass**

| | | | |
|---|---|---|---|
| Andrews, J. D. B. | Griffiths, E. J. | McNeill, K. A. | Sacks, R. H. B. |
| Bhandari, N. P. | Hacking, S. | Marsh, G. W. | Scott, W. C. |
| Brooks, W. V. | Horwitz, H. | Molloy, C. C. | Smith, I. G. |
| Canti, G. | Hovenden, B. J. | Moyes, P. D. | Smyly, D. P. |
| Cocks, R. A. | Jenkins, G. C. | Moynahan, A. R. | Timmins, W. L. |
| Davies, W. H. G. | Liu, S. | Pedersen, D. L. | Vickers, R. |
| Du Heaume, B. H. | McCloy, J. W. | Reading, J. H. | Wise, M. |



**Supplementary Pass List**

| | | | |
|---|---|---|---|
| **Part I** | | | |
| Albright, S. W. | Dadswell, J. V. | Horton, I. A. | Sims, A. I. |
| Apthorp, G. H. | Dick, D. G. | Husainee, M. M. | Singer, G. E. |
| Bapty, A. A. | Dodson, J. W. | Jarvis, H. C. M. | Smith, D. P. Q. |
| Barnes, J. | Dormer, A. E. | Jones, R. F. | Taylor, J. |
| Beattie, A. O. C. | Drysdale-Anderson, R. J. | Manning, G. E. | Taylor, W. N. A. |
| Birch, G. | Dunn, F. M. | Matthews, P. D. | Thomas, G. E. M. |
| Brown, B. St. J. | Farley, J. D. | Montagnon, J. L. | Trevan, A. C. |
| Carroll, D. S. | Fuller, A. P. | Mortiboys, W. H. | Venables, P. |
| Coldrey, P. A. | Gill, R. B. | Nielsen, J. S. | White, W. T. |
| Collymore, H. W. M. | Harman, C. O. D. | O'Brien, M. J. C. | Wilkinson, B. R. |
| Connell, P. H. | Hindley-Smith, R. F. | O'Sullivan, D. R. M. P. B. | Williams, D. K. |
| Corbet, J. L. M. | Hodgson, D. C. | Parrish, J. A. | Williamson, P. J. |
| Courtenay, P. H. E. | Holbrook, B. W. | Rushton, J. H. | Wyatt, H. J. |
| Cox, W. H. A. C. | | | |
| **Part II** | | | |
| Coldrey, J. B. | Cooray, M. P. M. | Gould, G. T. | Ibbotson, R. N. |
| Coldrey, P. A. | Corbet, J. L. M. | Haigh, P. G. | Pittman, J. C. |
| **Part III** | | | |
| Burrows, C. J. | Hindley-Smith, R. F. | Pittman, J. C. | Steinberg, V. L. |
| Clulow, G. E. | Norman, M. H. | | |

## RUGGER CLUB BALL

One is often told that "It's better to travel hopefully than to arrive," and indeed when one considers the publicity which heralded the Rugger Ball, one could almost have been excused for expecting the Ball to fall, like politicians' promises before an election, far of reality and one's expectations.

This publicity was something of which M-G-M or Gaumont-British might well have been proud, for at every conceivable moment and in every conceivable place one was reminded that November 27 was a date to keep. In the refectory a huge home-made poster caught and held one's eye, partly because of its unsightliness and partly because of its promise of free tickets. One was presented with a list of reasons for buying one's ticket early. However, as a result of all this publicity, more than the official number of tickets was sold long before the night itself.

"'And now,' said Mr. Wetherby, 'to the dance'." And what a dance it was! The doors were opened at 7.30 and the bar started to fill immediately. By 8.00 everything was in full swing. The entry of two police officers caused some temporary embarrassment to several members of the hospital, but after these worthies had examined the licence for the bar, they left. Soon, when the band had had time to warm up, the pace, both literally and metaphorically, was hotter than ever.

It was a great pleasure to see several of the vice-presidents of our club there. It was no less a pleasure to welcome Mr. and Mrs. Laurie White. Usually they are far too busy making things enjoyable for us at Chislehurst, to join us in our parties, but we sincerely hope they enjoyed coming to the Ball.

The Ball continued to go with vigour. Several novelty dances, which obviously had been prepared with fiendish delight long beforehand, so succeeded in muddling up several people, that had the bar not shut down so promptly at 11.15, they would probably never have found their own partners again. After this the Ball went rapidly downhill and after an eight-some reel performed perhaps with more gusto than skill, followed the last Waltz, Auld Lang Syne, the King and three cheers for the M.C. And so a very successful Rugger Ball fell to the ground, having been, one might say, converted into a very definite goal.

But one cannot finish without saying, and I'm sure everyone must agree, that the Ball could never have been such a success without the enormous amount of work done by Brian Hick, who filled the posts of publicity manager, box-office, representative to the management and M.C., in his own incomparable way. Let the obvious enjoyment of all be sufficient thanks when I say that without him, there would have been no Ball.

And so, early on November 28, one reached one's bed, very tired but well pleased with the evening's proceedings, feeling perhaps, that one had partaken of a little too much alcohol—though what was it Drysdale had once said about "the proper dose of any drug being enough?" And who's to say how much is enough?

# CORRESPONDENCE

## REGISTER OF BART'S. MEN

*The Editor,*
*St. Bartholomew's Hospital Journal.*

Sir,

In endorsing Mr. Cronk's plea for a Bart.'s Register, members of an older generation will remember that twenty to twenty-five years ago, during Mr. Sargeant's long tenure at the Journal office, such a Register of Bart.'s men was issued regularly. It showed the names and addresses of all Bart.'s men and also I think district lists from which one could find one's nearest Bart.'s colleague in any part of the country. Could not someone find a copy of this publication and bring it up to date?

As for the Old Bart.'s Society, the Decennial Clubs were very appropriate. Have they fallen into desuetude?

Yours, etc.,
RANYARD WEST

7, Darnaway Street,
Edinburgh, 2
December 4, 1950.

*The Editor,*
*St. Bartholomew's Hospital Journal.*

Dear Sir,

I entirely agree with Mr. Cronk's suggestion and would greatly welcome such a Register and the formation of an "Old Bart.'s" Society.

Yours, etc.
C. MARTIN-DOYLE.

Kepax House,
Worcester

# SO TO SPEAK

**The New Materia Medica**

"They are useful—these drugs—they aren't just the sort of things you give."
*From a lecture on medicine.*

**Seen in a Well-known Text Book of Gynaecology**

"Abortion usually occurs before the fourteenth week, and it is abortion during the period of pregnancy that will be described here."

*—It would be interesting to know at what other times the author has found abortion occurring.*

**Table-Talk**

*Surgeon to Anaesthetic Clerk*: "If your patient slept half as well as you do, we should do much better."

# SPORT

## BOAT CLUB

The 58th Annual Regatta of the United Hospitals Rowing Club was held at Putney on Wednesday, November 15, and resulted in a most successful day for St. Bartholomew's. Since mid-September our 1st Eight had been training at Kingston and Chiswick, and later, when the pre-clinicals had returned, we were able to form two additional eights, a senior four, and two junior fours. In the regatta, therefore, Bart.'s was represented by 43 oarsmen; considerably more than any other hospital; an influx of experienced oarsmen and a trial-cap coxwain from Cambridge enabled us to form a senior eight which proved too strong both for the London Hospital, and St. Thomas's whom we met in the final and beat by 1¾ lengths. We were again admirably stroked by John Currie, and our coxwain John Blow proved a valuable asset to the club, not only through his skill in coxing, but also in obtaining the services of a good coach and in negotiating with Cambridge University Boat Club for the purchase of last year's boat race boat. This cup was won in spite of a last-minute change in the crew, G. S. Banwell replacing Rainer Goldsmith who was unfortunately admitted to hospital two days before the regatta. Particularly creditable was the victory of the senior four, who had to race in the final immediately after rowing the final of the senior eights. Their opponents, Middlesex Hospital, were the same four which had won this event last year and were quite fresh; nevertheless we won by two lengths after being behind at the start. Our second eight also proved too strong for the opposition in the junior eights, and had no difficulty in beating University College Hospital and St. Bart.'s III, and in the final, St. Thomas's II and Middlesex.



Although one of our junior fours had only been rowing for six weeks they distinguished themselves by reaching the final after beating Guy's and the Royal Free Hospital. This was probably the first occasion on which the Royal Free had entered a men's "team" for an inter-hospital sporting event. In the final of the junior sculls, G. H. D'Arcy Power beat H. F. Crawford of St. Thomas's past the post, but owing to the absence of the finishing judge a re-row was decreed. However, by mutual agreement the two contestants agreed to call it a dead heat. Bad luck robbed us of another victory in the rugger fours; we were leading Westminster Hospital by two lengths in the final when our rudder line broke, and, by the time that we had disentangled ourselves from the bank, Westminster had gone ahead to win by ½ length.

We should like to express our appreciation of the support we received from members of other clubs and from the ubiquitous "Percy" who arrived newly-decorated and was gallantly defended by these supporters from the assaults of lesser breeds.

Representative crews were:—

| | 1st Eight | 2nd Eight | 3rd Eight |
|---|---|---|---|
| Bow | R. G. D. Newill | C. J. W. Hunter | D. R. Farmer |
| 2. | R. J. Knight | P. Sleight | R. A. Roxburgh |
| 3. | F. R. Spink | P. J. G. Smart | A. H. Luscombe |
| 4. | G. F. B. Birdwood | W. P. Fitt | M. T. Stather-Dunn |
| 5. | G. S. Banwell | J. Randall | R. W. R. Beasley |
| 6. | D. H. Black | P. G. Burton | C. G. Taylor |
| 7. | J. W. B. Palmer | J. D. Salmon | J. F. Newcombe |
| Str. | J. C. M. Currie | P. E. Mann | R. H. Gibbon |
| Cox | R. J. Blow | P. A. Clark | H. E. Rowley |
| | **Senior Four** | **Junior Four "A"** | **Junior Four "B"** |
| Bow | G. S. Banwell | W. G. Harris | M. V. Perkins |
| 2. | G. F. B. Birdwood | G. D. Langham | B. A. L. Hurn |
| 3. | J. W. B. Palmer | J. F. D. Damment | D. H. Bergel |
| Str. | J. C. M. Currie | A. K. Thould | T. A. Evans |
| Cox | —— | H. E. Rowley | E. L. Rees |

**Rugger Four**
J. F. Pearce, A. D. M. Thomas
R. D. Clements, I. H. Cochrane,
D. M. Stainton-Ellis (Cox)

**Junior Sculls**
G. H. D'Arcy Power and J. M. Gray

## RUGBY CLUB

**THE CORNISH TOUR,** November 4th—9th

The tour this year comprised three matches in five days—against Penzance, Redruth and Hayle. We lost to Penzance 0—14, to Redruth 0—3 and to Hayle 0—3. Three matches played and three lost might suggest to some mediocrity, to others despondency and to a few despair, but such is not the case.

The Penzance game was in points our biggest loss of the season and yet in a way it was our greatest game. With three county caps amongst their backs two of which have since received English trials, they presented a formidable array. And as it turned out they were the better side and deserved to win.

The afternoon was crisp, sunny and dry, and indeed, presented ideal conditions for open football. The first half was all Bart.'s; we were in the Penzance 25 for over three quarters of the first half, but we lacked penetration and failed to score. In the second half Penzance got more of the ball and their policy of feeding their speedy wings succeeded in tiring out the Bart.'s pack. Then in the latter stages of the game Williams, the Cambridge blue and Penzance centre, made several very pretty openings and the score rose to 14 points.

The Bart.'s forwards had the better of the Penzance pack and it was to the credit of the Hospital XV that they played open football throughout when it would have been to their advantage to close the game up. The crowd, too, were not slow to appreciate this. It was a first-class and most exhausting game in which to play and also a delight to watch.

At Redruth even the local papers admitted that Bart.'s were unlucky to lose. Redruth were awarded a penalty early in the first half; this they converted and so established a three-point lead which they just managed to maintain. The Bart.'s backs were in great form and really looked aggressive and dangerous. Time and again they all but scored. The Bart.'s forwards gave them plenty of the ball, too, and on the whole outplayed the vigorous Redruth pack. Redruth tended to close the game up despite ideal weather conditions and so nearly all the open movements came from the hospital side.

At Hayle we played under the disadvantage of having no trained hooker, Moyse having had to return to play for United Hospitals and Knipe, the reserve hooker, having been taken ill with pneumonia. This was unfortunate as Hayle had the county hooker, and so despite gallant attempts from our substitute, Hayle got most of the ball from the set scrums. Our backs played well and their defence was sound, but once again penetration was lacking. Hayle scored a try towards the end of the first half and maintained their three-point lead.

It is difficult to select individual names of players who distinguished themselves on the tour, as everybody played hard and well. Clare and Mackay were, however, outstanding amongst the backs and Dick was always a tower of strength in the forwards.

An so came to an end yet another Cornish Tour. We all certainly enjoyed it, and our opponents appeared to enjoy it, too. The value of such a tour cannot be estimated in points for or against; it is something much deeper than this, and I think all would agree that the tour was of great value both to ourselves and above all to the hospital.

C. W. H. H.

**v. STROUD**, Nov. 18 at Stroud. Lost 0—6.

A week of rain, and, to put it mildly, inadequate drainage of the playing field, resulted in this match being played in, if not under, water. Owing to the conditions it was largely a forward battle, and the Bart.'s pack acquitted themselves well. Stroud had the undoubted advantage of being used to their own ground, and their handling, despite a slippery ball, was good. Their wing forwards took full advantage of the unusual conditions and saw that the ball rarely got further than our outside half; more often than not it didn't get as far, despite the good hooking of Moyse, as our scrum half was overwhelmed as soon as he got the ball.

Stroud scored twice in the first half. In the second half the game was even and neither side succeeded in scoring. A. H. John, who played a great game, went over for Bart.'s from a blind-side movement but the try was disallowed as he had had one foot in touch.

**Team :**—G. Small, J. K. Murphy; K. A. Clare, C. W. H. Havard (Capt.), C. Porteous, M. J. A. Davies; A. Mackay, M. V. J. Fitzgerald; P. D. Moyse; R. D. Anderson, D. G. Dick; D. Roche, D. M. Cuthbert; J. F. A. Masckel, A. H. John.

**v. PONTYPRIDD**, Nov. 25, at Home.

It was a great disappointment both to Pontypridd and ourselves that this match was unable to be played owing to the fog. It would have been the Hospital XV's first home match for six weeks, and the Pontypridd team had travelled over 200 miles for the game.

**v. OLD ALLEYNIANS**, December 2, Home.

Result: Draw 6—6.

Bart.'s drew with Old Alleynians by two penalty goals to a try and a penalty goal. This was an excellent game to watch, both sides giving the ball plenty of air. Within five minutes Old Alleynians were three points up with a penalty goal, but a few minutes later, Bart.'s returned with a grand penalty goal by Dick from the ten yard line. The score remained at 3—3 until half time. Ten minutes of the second half had passed when the Old Alleynians' right wing picked up a loose pass from a Bart.'s three-quarter movement, streaked down the right wing and scored in the corner. The kick failed (3—6). Five minutes later Third kicked the second penalty for Bart.'s, making the score 6—6. Despite various attempts at penalties by our opponents and some dangerous-looking passing movements by our backs, there was no further score. The result was a fair one, and the side did extremely well to hold to a draw the victors of such teams as Richmond and London Welsh.

In all departments of the game, the forwards played particularly well, especially Cuthbert, Tallack, Dick and Fitzgerald. What the backs lacked in attack, they certainly made up for in defence.

Lastly it was a joy to see A. M. Baker performing again at full back, after a year's absence, and his tackle of the left wing which removed the latter from the field, was an example to all.

**Team :**—A. M. Baker, J. K. Murphy, C. W. H. Havard, V. G. Caiger, R. F. M. Jones, K. A. Clare, A. Mackay, M. V. J. Fitzgerald, P. D. Mayers, R. J. D. Anderson, A. J. Third, D. W. Roche, J. Tallack, D. G. Dick, D. M. Cuthbert.

## SWIMMING CLUB

The Swimming Club has now resumed its activities, after a lapse of two years, with re-entry into the University of London Inter-Collegiate League. The team has five matches to play in the League as well as friendly matches with other clubs.



**Match v. Goldsmith's College** (League).

Won 10 1.

Bart.'s in their first match this season set a standard of play difficult to maintain, but a definite step towards their intention to get into First Division water polo. Their victory was assisted by the encouragement received from the side. Teamwork was not very apparent to begin with, but Graham in the Bart.'s goal was not seriously troubled and later brought off some good saves. Cohen was outstanding in his characteristic style of open play which resulted in many shots at the goal, several, however, being wide.

All the attack shared the goal scoring—a good example of team play. Goal scorers were: Corbet 1, Lowe 2, Cohen 3, Bliss 4.

## BOOK REVIEWS

**THE STAMMERER'S CHOICE**, by H. St. John Rumsey. Methuen, 1950, pp. ix + 134. Price 7s. 6d.

In his introductory remarks to a most interesting and carefully written book the author says his book is a serious attempt to solve a very difficult and a very ancient riddle, that of the stammer; perhaps as old as the riddle of the Sphinx. The opinions as to the cause of a stammer by different authors and the various ways to treat it are described in a most interesting manner and as these treatises go back to Herodotus it will be appreciated that a very thorough investigation of ideas, which are brought up to date, has been made and the study of them is well worth while. The author is to be congratulated on the results of his painstaking and successful research work which will be read with great interest and profit by Speech Therapists and by stammerers. One is impressed by the great attention to, and study, of the stammer given by men of authority on the subject in the past and this is admirably recorded by St. John Rumsey in Chapter 3.

I strongly recommend Chapter 4 which deals with the twentieth century writers and in it are the views of men and women experts. In this chapter St. John Rumsey has set out the way in which I regard and treat a stammer when he says, "He (Cortlandt MacMahon) has studied scientific breathing from every angle, voice production and voice control and he has a knowledge of phonetics. He gives as the cause of stammering 'over stimulation of the part of the brain that controls the (motor) nervous power of speech.' As the habit develops it is complicated by anxiety, fear and later, in severer cases, by habit spasms, and he gives warning against the worst possible advice 'to take a long deep breath.' Cortlandt MacMahon builds up his system of correction through re education first of all of the system of breathing. To this he attaches great importance. He advises a rather deep pitch for the voice with full resonance. He looks upon speech as a muscle habit control; if and when the automatic control breaks down the logical remedy is to retrace one's steps and learn it over again as in the first instance."

Chapter 5 on Twentieth Century Developments is another full of interest and sets out what St. John Rumsey rightly thinks the reader should investigate and reason out. He emphasises the enormous part personality plays in the successful treatment of a stammer. No one will dispute this very important qualification who has any experience of the subject.

There are chapters on Cleft Palate, Laryngitis and Aphonia, Backward Speakers, London Speech Clinics, The Demand, Training and Qualifications of Speech Therapists and the Conclusion which again sets out his own strong and very sensible advice and conclusions. This book cannot fail to interest and instruct every reader of it, and I strongly recommend all who are interested in disorders of the speech to read it most carefully.

Cortlandt MacMahon.

**THE THYROID HORMONES AND THEIR ACTIONS**, by G. Mansfeld, translated by E. Pulay. Frederick Muller, 1949, pp. xii + 157. Price 24s.

In this account of research extending over many years, Professor Mansfeld casts at least a little doubt on the adequacy of orthodox views of thyroid function. Based on animal work, his main conclusions are that the gland secretes a "myelotropic hormone" and "thermothyrins A and B" in addition to the more familiar active principle. A section is devoted to the action of thyroxin, and evidence is presented to suggest that the hormone is carried by the peripheral nerves to the tissues, but this is not convincing. The final chapter consists of a discussion of Graves' disease and is speculative: further work will be necessary before the conception of new thyroid hormones can be applied to the human subject.

The experiments are presented in considerable detail and many references are given. The book may interest physiologists, but it will scarcely repay study by the clinician.

**OCCUPATIONAL THERAPY**, published by the Association of Occupational Therapists.

This small booklet deals briefly with the possibilities and scope of occupational therapy. It is available from the Association.

**PHARMACOLOGICAL PRINCIPLES OF MEDICAL PRACTICE**, by J. C. Krantz and C. J. Carr. Baillière, Tindall and Cox, 1949, pp. xv + 980, with 94 figures. Price 55s.

The evaluation of new drugs is a difficult task, and one for which the practitioner requires guidance. This text-book of pharmacology fails in this respect, and while describing many recently introduced preparations, it is uncritical in approach and gives the impression of lacking authority. The accounts of standard drugs are well done, and there are stimulating historical sections, but for undergraduate purposes there is too much detail, and for those interested in more academic pharmacology the descriptions of drug action will appear superficial. The transatlantic idiom is strongly in evidence, and the British reader suffers also from the exclusive use of American drug nomenclature. On the whole the book cannot be recommended in place of works already available.

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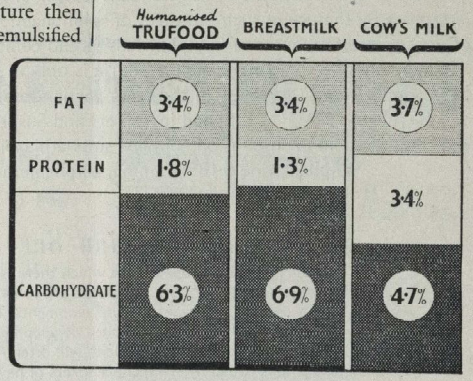


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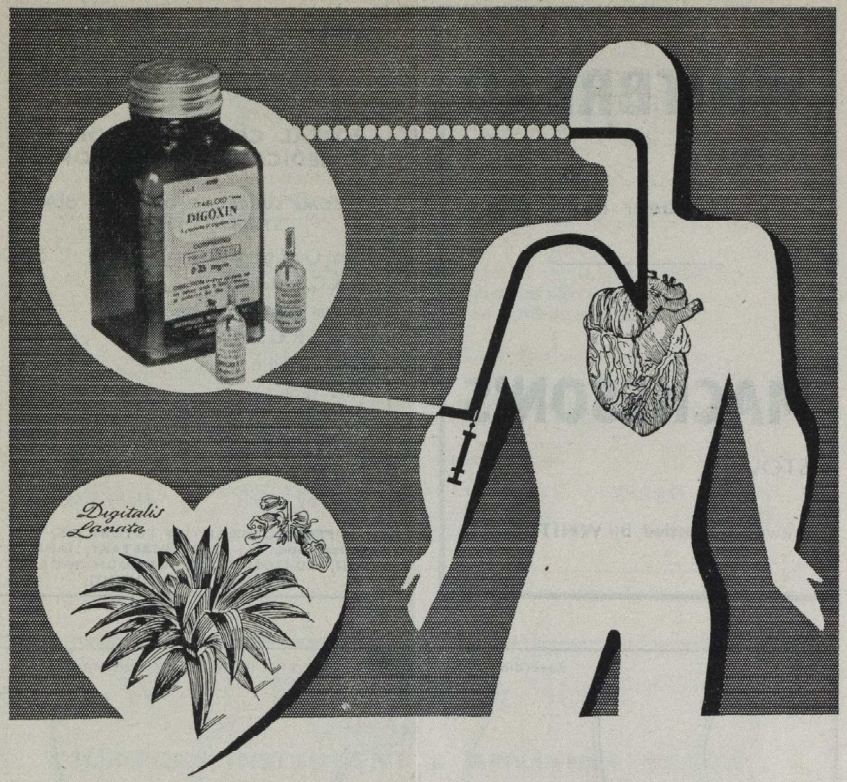


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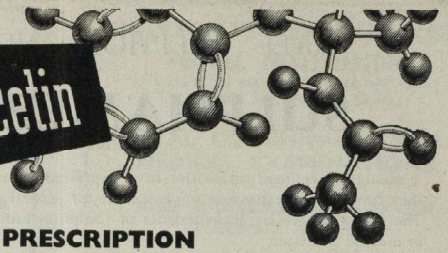

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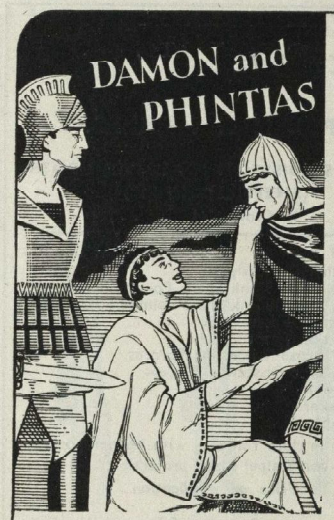


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# SAINT BARTHOLOMEW'S HOSPITAL JOURNAL


FEBRUARY 1951

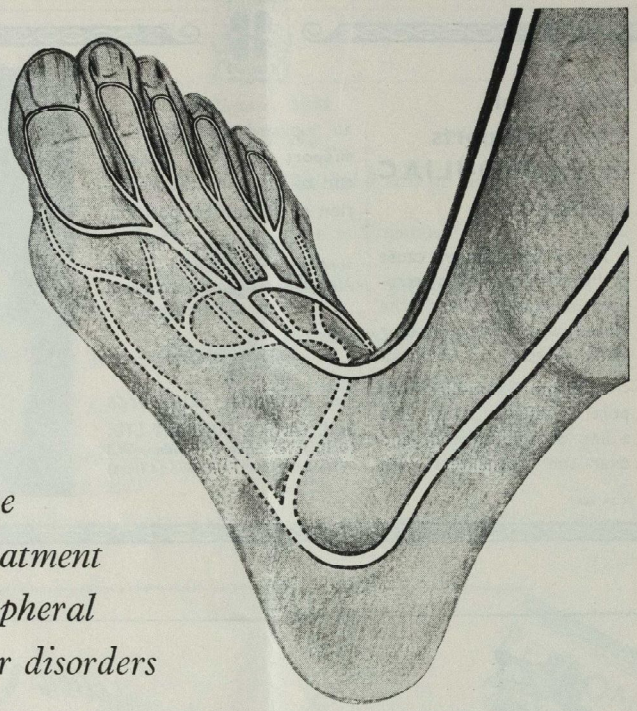
VOL. L V No. 2

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

*Editor:* M. B. McKERROW. *Manager:* E. A. BOYSE.
*Assistant Editor:* A. N. GRIFFITH.

**February, 1951**


**CONTENTS**



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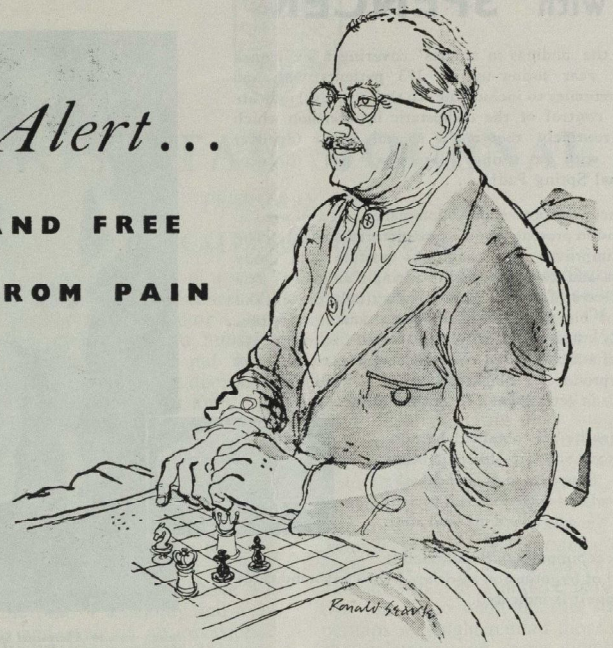

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# ST. BARTHOLOMEW'S

# HOSPITAL JOURNAL

Vol LV FEBRUARY 1951 No. 2


## ON CALLING THE TUNE

It is perhaps impossible to answer in a way acceptable to all the question "What sort of a JOURNAL do we want?" Each editor as he has begun his new task has asked himself this question; each has tried to put into effect any changes he has felt to be due; and each has probably been somewhat awed by the difficulties which his far abler and more distinguished predecessors have surmounted so much better than he ever can. The diversity of opinion expressed by our readers only emphasises the fact that no wholly satisfactory answer can be given to our question. The size and lay-out of the JOURNAL, its contents—from the historical articles to the humorous matter and its absence—have all at times been the butt of a healthy and welcome criticism, and even of an occasional word of praise. The size of the JOURNAL and the paper on which it is printed are dictated by what we can afford, and it is felt that a monthly number of the present size serves its purpose better than something more pretentious which would appear less frequently. The choice of contents must partly be determined by what we can get, but we are guided, in matters of broad policy, by the expressed opinions of our readers and by those precepts under which this JOURNAL first appeared in 1893 and which still seem to have general approval. The purposes of the JOURNAL were set out with admirable conciseness by the first Editor. They have often been "summarised" since, usually at a length greatly exceeding the original, and so we here content ourselves with attempting merely to illustrate some of their basic points.

As the JOURNAL is the organ of the Student's Union, one of its functions must be the expression of student opinion, the reporting of student activities and the publication of students' contributions. It is these contributions which have in the recent past been so sadly lacking. Of more than 600 students at present in the Hospital only about twenty have ever written anything for their JOURNAL. While we admire the modesty of the remainder and indeed welcome their criticisms and suggestions, we feel sure that their contributions would often show their modesty to be false and make their criticisms groundless. We depend particularly on the contributions of students to provide our lighter material. A glance through *Round the Fountain* will quickly show that the JOURNAL has a heritage of humour which it would be hard to surpass. Our aim is to maintain this standard, and perhaps we might remind those who deplore the solemnity of some numbers of the JOURNAL that the humorous writer is no less essential to the production of a funny article than is the hen to the production of an egg. Such writers are scarce, and if the inborn aptitude for humorous writing is absent no amount of hard work can take its place.

The JOURNAL has however other functions, not incompatible with these, but more difficult to achieve. It is now, since the termination of the Hospital Reports in 1939, the only regular Bart.'s publication, and it should therefore be a mirror of all aspects of the Hospital's activities. Its circulation extends far beyond these walls, and it must therefore not be of interest only to students. Of our outside readers, who outnumber the students by two to one, the majority are old Bart.'s men, and in attempting to keep them in touch with their Hospital the JOURNAL is fulfilling one of its basic functions. Other copies go, under various exchange arrangements, to hospitals and colleges in many parts of the world, where,

it is hoped, they do something to show the present life and work, the past history and the traditions of Bart.'s.

It would be idle to pretend that these objectives can be approached, far less attained, by the efforts of students alone, and so we offer no apology to the Staff for our frequent incursions into their time, but only our sincere thanks for the help we have always received. We extend this word of thanks also to our readers outside the Hospital who send us their contributions. These are always welcome and are often appreciated more than their writers realise, for they help to show us in a clearer perspective the medical world as a whole.

Ever since the foundation of the JOURNAL its readers have been divided into two great bodies, those who subscribe for their copies and the students who receive them free. How long rapidly rising costs of production will allow this division to be maintained it is hard to say. But it is perhaps well that the demands of these two bodies are not so diverse as they may seem at first sight, or an editor might find himself wishing he had lived in that simpler world where unchallenged right of choice lay with him who paid the piper—and where there was apparently no shortage of tunes.

## BART'S

Garrod, Drysdale, Morley Fletcher,
Horder, Thursfield, Graham, Gow,
Hartley, Howell—men of stature—
Geoffrey Evans—mercy, how
Soon they leave and pass the torch on
In the medical relay
For the prize of fame, not fortune,
For, whatever be our pay,
Ruthless Income Tax and Bevan
Rob us now of all but heaven.

Waring, Eccles, Gordon-Watson,
Rawling, Roberts, Dunhill, Gask,
Ball and Vick I could add lots on—
Name on name—a pleasant task,
And yet sad, for death is busy
Reaping in these gallant sheaves
At a rate which makes us dizzy.
Yet we're lucky, since he leaves
Still a splendid Staff at Bart.'s
To attract our heads and hearts.

A.E.R.

## APPOINTMENTS

Dr. E. Wittkower has been appointed Assistant Professor in Psychiatry at McGill University, Montreal, Canada. He will take up this appointment on March 1, 1951.

Dr. J. E. Cates has been appointed Lecturer in Medicine at Bristol University from January 1, 1951.

We wish them every success.

## THE EDITOR OF THE JOURNAL

J. A. Williams, who, on December 31, 1950, completed six months as Editor of the JOURNAL, has resigned. He is succeeded by M. B. McKerrow. A. N. Griffith is Assistant Editor.



# REST AND INFLAMMATION

*By* L. R. H. GRACEY

### Historical and Introductory

ONE hundred and fifty years ago, the curriculum of a medical student was not the highly organised thing it is today. Lectures, for instance, were few and far between, so when one did come about there was good occasion for celebration. A dinner would be held in honour of the lecturer, and much wine drunk.

It is related that before giving one such lecture John Abernethy (1764-1831) in whose name we are gathered here tonight, had been indulging rather too freely in the preliminaries. When the time came for his discourse, he was in no fit state to deliver it. He staggered into the theatre, stumbled to the dais, and paused. Then he said, "Gentlemen, remember, rest the inflamed part." There was another pause, and Abernethy slowly collapsed to the floor, whereupon he was carried in all dignity from the room.

About fifty years later the immortal John Hilton (1863) expanded this idea of rest in his classic work *On Rest and Pain.* It is appropriate that his book is sometimes called "The Surgeon's Bible," for it has been treated with a reverence not often accorded to scientific works.

Hilton in his book, and Abernethy more concisely in his lecture, summarise what is even now regarded as the cardinal principle in the treatment of inflamed tissues. Rest is still the basis of treatment of inflammation.

### Purpose of this Paper

This paper is based on the observation that the above principle of rest cannot be employed beneficially in the treatment of certain "closed soft tissue inflammations," as defined below. Its first purpose is to explain, from an examination of the pathology of inflammation, why rest in such cases is useless. Secondly a modified principle of rest, based on these pathological considerations, is propounded. Thirdly the successful practical application of this modified principle is shown, and finally some current ideas about the function of rest in inflammation are noted, and their origins examined.

### Definitions

Soft tissues are here defined as the muscles, fasciae, connective tissues, ligaments and joints of the body. These tissues may become inflamed as a consequence of injury by physical trauma. Examples of such inflammations are pulled and partially ruptured muscles, strained ligaments and dislocated joints. These lesions are called "closed" lesions when the skin surface covering them remains intact. The essential pathology, common to all of them, is a tearing of the soft tissue fibres, haemorrhage, and an inflammatory response with much exudation. These closed lesions are henceforward referred to collectively as "soft tissue traumatic inflammations."

### Rest and soft tissue traumatic inflammations

It has been generally found that resting such inflamed tissues tends to delay their repair, and furthermore to result ultimately in a functionally less efficient tissue, mainly because of adhesion formation. Thus Salisbury Woods (1950) quotes the case of a steeplechase rider, who, following a thigh injury "had been kept lying up for six weeks, by which time the quadriceps muscle presented much scar tissue and brawniness, while the knee joint was limited to 30° flexion by (extra articular) adhesions." This is a particular and striking instance of the generalisation that the resting of patients with such soft tissue inflammations impedes the rate and efficiency of tissue repair.

### Pathology of Inflammation

How can this be so when rest is so manifestly beneficial for so many other inflamed tissues? The explanation comes from an understanding of the purpose of inflammation. Perhaps no subject in medicine has been more thoroughly studied than the processes of the inflammatory response. But the study has been so detailed that the underlying purposes of inflammation have been rather overlooked. The wood has been missed for the trees.

First, however, it is necessary to define inflammation. For the ends of this paper, the best definition is that of Burdon Sanderson (1883), who defined inflammation as "The succession of changes which occurs in a living tissue when it is injured, provided that the injury is not of such a degree as at once to destroy its structure and vitality."

But what is the purpose of this reaction? Clearly it has a threefold purpose, though this is not always realised. The first purpose is to *localise* the extent of the injury. The second purpose is to *remove* dead tissue and foreign bodies, and the third purpose is to *repair* the damaged tissues.

As a consequence, the inflammatory response shows three distinct stages. Initially there is the stage of localisation. This consists of a vascular hyperemia, the production of an inflammatory exudate, and emigration of the leucocytes. Secondly there is the stage of removal of dead tissues and foreign bodies by phagocytosis, and thirdly comes the stage of repair, through the formation of granulations which organise into scar tissue. Now repair cannot occur until the extent of the injury is localised, and destroyed tissues and foreign bodies removed. Inflammation, then, always occurs in the order of localisation, removal of dead tissues and foreign bodies, and then repair.

### Causes of inflammation in soft tissues

Bearing in mind that inflammation is the response of living tissue to an injury, and that the response occurs in three distinct stages, we arrive at a fundamental concept. The degree to which any of these three stages occurs in response to an injury, *depends on the nature of the injury.*

Now the injuries causing inflammation of soft tissues are of two main types. The first type is physical violence, for example kicks and blows, which give the sort of lesion that has earlier been defined as soft tissue traumatic inflammation. In this type, the injury is momentary in duration. All the damage to be done, is done in an instant. It can be localised rapidly, and repair is soon begun.

The second type is bacterial inflammation. The injury here, henceforward referred to as bacterial injury or infection, continues for as long as the bacteria are multiplying and producing toxins. Inflammation is first concerned only to localise the damage. Repair cannot start till this is done. But localisation is not complete till all the bacteria are destroyed. This may take days in an acute infection, and weeks or months in a chronic infection such as tuberculosis. Localisation may never even be achieved. The injurious bacteria then gain the upper hand and kill their host.

### True function of rest and movement in soft tissue inflammation

The true function of rest in inflammation now becomes more apparent. Rest is only required when the injured area is being localised by the inflammatory response, for until this is done, movement will break down the localising processes and spread the damage. On the other hand when repair has begun, movement is beneficial, for it assists in the drainage of effusions, which if left undrained, organise to form crippling adhesions.

Let us apply this concept to the two types of inflammation provoking injuries. In infection, the inflammatory response is continued as a localising process for as long as the bacteria are active. The natural way to stop the activity of the bacteria is to rest the part. This enables the localising effects of the inflammatory response to occur most efficiently. Movements serve to break down the localising barriers, and spread the bacteria both locally and generally. In infective inflammation, therefore, rest is the most important single principle of treatment, and without it, even the modern antibiotics may be ineffective.

When the inflammation is due to physical trauma, however, localisation of damage is rapid, because the injury is momentary. Repair by organisation of the inflammatory exudate soon begins. Should such a part be rested, this organisation will inevitably result in crippling adhesions. The part must in fact be actively moved. Movement encourages the draining of the exudate, and hence prevents the formation of adhesions. It is proposed therefore, that in soft tissue traumatic inflammation, early movement is the fundamental principle of treatment.

### Support

Two objections, however, at once arise, which would appear to limit the application of this proposition. The first objection is that in traumatic soft tissue inflammation, early movements might quite easily break down even a healing lesion, for to start with, at any rate, granulation tissue is delicate, and easily damaged. In this way relocalisation and further repair would have to be begun once again *ab initio*.

This is a valid objection, which must be negotiated. It can in fact be negotiated by introducing the idea of support. Support, by various means, can stabilise the healing tissue sufficiently to prevent any breakdown of granulations, and yet not interfere with normal movement; for it is only movement beyond the normal range, resulting in stretching, which will break down granulations. The purpose of support, then, is to allow the normal movements of an injured part to occur, but to prevent any abnormal movements of that part. A most useful means of providing such support is the elastoplast bandage.

An example will make this idea of support clearer. Consider, for instance, a sprained ankle. This is essentially a rupture of some fibres of the external lateral ligament by forced inversion. Elastoplast, properly applied, will prevent any further damaging inversion, though allowing other active movements which will assist in draining the inflammatory exudate.

Sometimes the support has to be applied internally. An example of this is the ruptured supraspinatus tendon, first described by Codman (1934). For anatomical reasons, the ends of the tendon cannot reunite unaided, and approximation is necessary. This is done as soon as possible after the injury, by suturing the two ends of the tendon together.

### Pain

The second objection is that soft tissue injury is painful, and the pain tends to prevent the patient moving the injured part. This, too, is a valid objection, but again one which may be circumvented.

Leriche (1930) quotes Sappey to show that soft tissues are richly provided with sensory nerve endings. He considers (Leriche and Fontaine, 1932) that the effusion which is so profuse in most soft tissue injuries is caused in part, at least, by reflex vaso-dilatation locally, in response to prolonged stimulation of these soft tissue sensory nerve endings. He therefore suggests the use of novocaine to stop the pain and consequently the effusion in such soft tissue injuries. Whatever the basis for this treatment, there is no doubt of its effectiveness. Thus "five to ten c.c. of one per cent. novocaine are injected at the site of maximum tenderness. Effusion is thereby controlled; walking in moderation may be allowed immediately, provided the injured ligament is supported by strapping. Pain—sometimes really bad pain—may return after a few hours; but very often all pain and swelling have gone in one or two days." (Stone, 1947).

### Summary of principles

So far we have shown that while rest is the essential basis of the treatment of all infective inflammations, such is not the rule in closed soft tissue traumatic inflammations. We have further explained, from pathological considerations, *why* rest is wrong treatment in these cases, and so should not be used.

We have next proposed that such lesions should be treated in the main by early movement, assisted by support, internal or external, and by local anaesthesia. It now remains to show that this proposition can be successfully applied in practice, for when all is said and done, the proof of a pudding is in the eating.

### Practical applications

I cannot call on much personal experience of such practical application, however, and so I have had to look critically at the experience of others. For this purpose I referred mainly to Stone (1947), Cyriax (1947) and Salisbury Woods (1950). Stone and Cyriax both realise the pathological basis for rest and movement in inflammation, and advance substantially the same propositions as I have put forward in this paper. They justify the propositions with innumerable examples of successful applications.

Woods, on the other hand, arrived at the propositions mainly from the clinical "necessity of restoring the injured athlete (often a probable or actual 'Blue' or 'International') as soon as possible to an important series of contests." From an experience "derived in the main from the undergraduate section of a practice in the University town of Cambridge, extending over twenty-five years, and comprising many thousands of cases," Woods shows clearly that the most efficient healing of soft tissue traumatic lesions follows immediate restoration of natural function, assisted usually by support.

For what it is worth, I have gained further evidence of this from enquiring of the people most prone to soft tissue traumata how they tend to treat themselves. I confined my investigation to athletes and professional dancers. Their almost unanimous opinion (I cannot provide statistics) is well summed up by one such dancer, who said: "We

always work off such an injury; if we lie up it takes longer to heal."

### Some current ideas

Despite their truth, the above principles have not been widely advocated. As Woods says: "Hospitals, in their overburdened teaching curriculum, have had little time to spend on ordinary sprains, strains and bruises, and old methods have been perpetuated in the text books." This is evidenced by reference to the standard surgical text books. In general, the teaching there is characterised by both brevity and confusion.

Thus Wakeley and Hunter (Rose and Carless, 1943) dismiss the subject of sprains and strains in eleven lines, which include the advice that the first treatment is rest and firm pressure. Romanis and Mitchiner (1946), when treating of joint injuries in general, and sprains and sprain fractures in particular, suggest an X-ray, and the putting of the joint in a position of ease. This not only gives comfort, but *should ankylosis occur*, also gives a good functional result. Illingworth (1947) talking about muscles and tendons says: "in partial rupture rest in bed for a few days is often advisable." Pannett (1947) suggests light movements for an injured ankle joint, but not for an injured knee. Mekie and Mackenzie (1949) say the treatment of a partially ruptured muscle is "complete rest of the part, secured by splinting or strapping, until healing has occurred." Porritt and Paton (Handfield-Jones and Porritt, 1948) recognise the apparently conflicting claims of rest and movement in treating joint injuries, and suggest a compromise. For partial tears of muscle Handfield-Jones (Handfield-Jones and Porritt, 1948) advises that the patient be "kept at rest for five days." Bailey and Love (1949) refer to the work of Leriche, but still advise a delay of two or three days before beginning active movement of an injured joint.

### Their origins

What are the origins of these ideas, with their unanimous insistence on rest? Probably the most important influence has been that of John Hilton. In 1860, 1861, and 1862, Hilton delivered at the Royal College of Surgeons some eighteen lectures on "The therapeutic influence of rest, and the diagnostic value of pain." These lectures were printed and published in book form as the classic *On rest and pain*. This book, a newly edited version of which has just been published, has exerted a powerful influence over the mind of the medical profession. Hilton's theme was that pain is the monitor, and rest "a most important therapeutic agent in the cure of accidents and surgical diseases." This idea is still deep rooted in the medical mind.

But what the profession has overlooked is that most of the cases Hilton quoted to show the beneficial effects of rest were cases of tuberculous diseases, usually of joints. Hilton was indeed wise in treating such disorders by rest. He realised clearly that by resting the joint, cure occurred by ankylosis, but by movement came "death from prolonged suppuration and exhaustion." (Stone, 1947).

The misuse of the principle of rest has come about when rest has been used to treat inflammatory disorders which are not infective in nature. The medical mind has failed to distinguish between inflammation and infection, regarding the two as synonymous, and treating both in the same way.

It would have been better if Abernethy had said, "Gentlemen remember, rest the *infected* part." But neither he nor Hilton could say that for the very simple reason that they had never heard of bacteria.

### Conclusion

It is hoped that by showing you the pathological basis of the error of resting traumatic soft tissue inflammations, you will modify your ideas on the subject, and be converted to the proposed principle of support, local anaesthesia, and early restoration of function. In order not to obscure this principle, I have purposely made little reference to the detailed methods whereby the principle is applied in practice. Hence no mention is made of the use of manipulations, ice applications and such like, for they are, after all, only detailed methods. It is the principle which is most important. The details may be found best by reference to Cyriax (1947).

Finally it is suggested that should any doctor apply the principle here propounded to the treatment of those of his patients with soft tissue traumatic inflammations, he will be gratified by the good results he will obtain. Incidentally, he will at the same time put many an osteopath and bone setter out of business.




### Summary

"Closed soft tissue traumatic inflammation" is specifically defined. It is shown that cases of such inflammation are wrongly treated by rest. The pathological basis of this error is explained. A modified principle of rest and inflammation is then propounded. The successful practical application of this modified principle is shown by reference to the literature. Present misconceptions and their origins are analysed. Finally, it is urged that practitioners should base their treatment of soft tissue traumatic inflammation on the proposed principle.



### Acknowledgments

I am deeply grateful to Prof. Sir James Paterson Ross, who inspired this article and kindly criticised it for me. I would also like to thank Mr. D. H. Rushton, Mr. John L. Thornton, Librarian, and Miss B. Birkett for assistance.


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*A paper read before the Abernethian Society on November 9, 1950*

## PART OF A G.P.'S LIFE

*By* E. W. BURSTAL

TIME 4.30 p.m. on a winter's afternoon.

Urgent phone call from the Food Office which happens to be only 50 yards away and used to be a large private house. "Would the doctor come at once there is a fox in the house!" This sounded interesting so round I went.

"Oh, Doctor, a fox has just run in the front door and up the stairs. What shall we do?"

I went up two flights of stairs to a top room, and there sure enough was a large fox slinking under a chair.

From my point of view this was a delicate situation. Everyone else was gaping out of their office doors. No-one would go into the room—and I was obviously expected to do something. I knew that if I moved the chair he would dash off round the room or jump up the walls. If we shoved him out of the room he would not know the way out, so I mentally blessed the chair and left him there while I put on my gloves.

Then, thinking he must surely be more frightened than I, I seized his brush, dragging him out, and then grabbed him by the scruff of the neck—getting a severe bite in the process. However, I was determined to have him, and got him securely at arm's length and marched him down the stairs. I was surprised how heavy and strong a fox is.

"Ooh, ain't he loovely—look at his tail." as I went down. In the street two children rapidly became six, and off I went to a chorus of "A fox—a fox—tally-ho!"

I just reached my own gate when the brute gave a great wriggle. I could hold him no more so I launched him down the garden with a kick in his pants, thinking "We'll renew acquaintance next week—you varmint—when you can give us a good hunt!"

# SOME NOTES ON GOUT

*By* G. D. KERSLEY*

THE importance of gout rests not on its incidence, though this is greater than many think, but on the need for better and earlier diagnosis, the great clinical improvement to be expected in the majority of cases with adequate treatment and the light this condition throws on other syndromes in the rheumatic group of diseases.

## Diagnosis

Points that will assist in diagnosis may be summarised under the following headings, none of which are in themselves diagnostic or exclusive, but which, when considered together, will nearly always make the diagnosis clear.

1. The *early* attacks are usually very acute in onset, often starting in the night, and they are, as a rule, followed by a complete remission. The joint is usually hot, swollen and often red.
2. The diathesis is usually sthenic.
3. A family history of the disease is found in 50-60%.
4. Tophi often occur late.
5. The plasma uric acid level is usually raised *at some stage* of the disease.
6. Anaemia is absent or slight in the earlier phases.
7. The sedimentation rate is apt to vary rapidly.
8. X-rays may show punched-out areas, but very similar areas may be seen in certain cases of chronic rheumatoid arthritis.
9. There is nearly always a clinical response to Colchicine if the dose is pushed to the degree of slight toxic symptoms.

## Aetiologic and trigger factors

In order to understand and treat gout, something must be known of the factors which help to produce it. Under this heading we must consider:—

1. The hereditary hyperuricaemia. The P.U.A. is found to be increased in 25% of the non-gouty relatives of gouty patients and of this 25%, 80% are males.
2. The ratio of males to females suffering from gout is approximately 10:1 and the great majority of cases occur after puberty in the males and after the menopause in the females. This age sex incidence also corresponds closely with that of the hereditary hyperuricaemia.
3. A diet high in fat and purine content tends to production of gout in susceptible individuals.
4. Stress and strain will produce attacks in gouty individuals, though each case may be particularly susceptible to a particular stress. Cortisone or A.C.T.H. will usually terminate an attack, but 4 days after A.C.T.H. there will usually be a severe recurrence, due to a lag phase in the production of endogenous cortisone.
5. Many cases of gout are allergic to certain foods or drink, quite irrespective of their purine content.
6. The stress factors of sepsis, worry, fatigue, sexual intercourse, and trauma (either injury or cold) will frequently act as the trigger factor in producing an attack.

## Treatment

From the above remarks a great deal of the principles of treatment becomes obvious, but some of these, in view of the very satisfactory results of adequate therapy, may be further stressed and classified.

1. General treatment consists of insistance on plenty of fluids, regular but not too strenuous exercise, and a rather low "non-aldermanic" diet should be advised with some restriction of fats and purine high foods (fish roes, liver, kidney, sweetbreads, meat extracts) and usually rhubarb and strawberries. All stress factors, and in particular foods to which the patient is allergic, must be avoided.

2. Drugs. (a) In an acute attack Colchicine grains 1/120 three hourly, until slight diarrhoea or nausea, and aspirin. (b) Between attacks, if they are frequent, Colchicine grains 1/120 should be given twice daily and aspirin grains X three times a day for three days each fortnight will increase the excretion of uric acid. Cincophen grains 7½ three times a day for three consecutive days each week is worth a trial in obdurate cases, but it is extremely toxic to the liver of a small percentage of patients.

3. Physical treatment.
(a) sweating—vapour and turkish baths.
(b) local—either hot poultices and mud packs or cold compresses. Anodal galvanism. In the subacute stage low pressure contrast douches will help to clear up oedema.

* Director of the Rheumatism Research Unit, Bath, and Adviser to the S.W. and Oxford Regions.



# MY TOE-NAILS

*By* R. C. H. LEDELL.

THE hiss of the application of hot iron to hoof, with the accompanying evolution of pungent smoke conjures up visions of the village blacksmith at his forge. I am not a blacksmith, however, and the operation, though having certain features in common with that of fitting of horses' shoes, is on a much smaller scale. You see, I was treating my ingrowing toe-nails.

For months I had suffered torment as the medial edges of my big-toe nails curled mercilessly under, until at last my wife could bear it no longer. "For Heaven's sake, don't sit there exhibiting signs and symptoms of acute dolour! Do something about it!"

Having been well instructed in the practice of approaching problems from a logical and scientific angle, I started by experimenting with a nail paring. I found that on being heated, this retained any desired shape, and moreover, it had a strong tendency to curve towards the heated surface. So I decided to try the application of heat to my offending nails.

The surgical instrument for this, my first operation of this description, consisted of the spoke of a ladies' green Humber bicycle (1934 model)*, but subsequently I used a heavier piece of iron with a 3/16in. face edge, and this retained a more even heat.

With forceps the ingrowing corner was raised, with a slight twist tending to uncurl the scroll-like edge. At the same time the hot iron was momentarily touched along the *whole* length of the nail close to the skin (which had been protected with a strip of plaster). The edge lifted, and exposed part that had been deeper in the sulcus. Thus a fresh area was available for uncurling, and this was treated in the same way. So I "permed" my nail into shape, and the result was perfect. My other big toe was relieved in the same way.

The temperature of the iron is important. If too hot it merely burns away the nail, and if not hot enough, the heat is conducted through to the sensitive nail-bed if the iron is held long enough to be effective. In my case it only just hurt.

My next case was my wife. Here it was more difficult, as she had cut away much of the nail edge to obtain relief. However, I was able to uncurl what was left. I am afraid I applied the heat rather too enthusiastically—but I am much better now, thank you, and she says that she really didn't mean to hit quite so hard. (And anyway, it gave the kids a good laugh.)

No doubt a digital nerve block would have helped, and as long as the touch of the iron is as brief as it would be without anaesthetic, I suppose there is no objection.

Naturally, the cause must be sought and dealt with. In my case holes in my socks indicated that my shoes pressed on the medial corner of my nails.

Though the operation sounds crude, the condition was cured, with no loss of tissue, no trauma, and no subsequent discomfort or inconvenience.

Now I am looking for others to try it on. Any toe-nails for "perming" please?

* The original instrument will unfortunately not be available for the Museum as it has been used to repair my aunt's umbrella.

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## BART'S. MEN IN SOUTH AFRICA

During July, 1951, the Joint Congress of the Medical Association of South Africa and the British Medical Association is to be held. The Bart.'s men of this city have arranged a Bart.'s Dinner which will take place on the evening of July 19, 1951, at the Rand Club, Johannesburg.

Bart.'s men who may be visiting South Africa at that time—whether to attend the Congress or not—are asked to communicate with Dr. J. Gluckman, P.O. Box 455, Johannesburg. At the same time, this will afford an opportunity for compiling a complete register of all Bart.'s men in this subcontinent.

# MEDICAL RESEARCH IN THE LATE 1890's

## AN ASPECT

*By* W. A. MITCHELL.

A DEFINITION of Scientific Research, attributed to one who today spends his working hours organising Medical Research, set my mind on the days in the '90s when I was engaged in the laboratories of St. Bartholomew's Hospital Medical School and College. It is said that this eminent research worker defined Scientific Research as "Organised Play for Adults."

### The Scientific Work Room

In 1894 I first became acquainted with Scientific Research, and on the door of the laboratory was painted in large letters "SCIENTIFIC WORK ROOM." The room was a large, but ordinary enough one, with benches and with shelves for bottles, a stink cupboard in which was kept a floating population of cats, a small gas-driven hot-air engine for driving a kymograph, and a small tank for the accommodation of frogs. Here I became "Chief Assistant"—known to everyone else as the "lab boy"—but, in my sphere, monarch of all I surveyed.

Throughout the country all laboratory employees were Royalties, for we were known as Charles, William, George, Henry or James. My parents had christened me Walter; in the Scientific Work Room I became William—the second at least, possibly the tenth. I was told by my employer that I could charge stated prices for animals and other supplies, and that the abdicating William would put me wise to the business. A wicked system, now, I hope and believe, quite dead.

Scientific Research as applied to Medicine remained unorganised till the introduction of the National Health Act in 1911, with the consequent formation of the Medical Research Committee, later the Medical Research Council. Until that time medical research was an individualistic and amateur occupation, and its followers, including the laboratory servants, would need to have or to find some other source of income in order to "keep the wolf from the door." For years after the formation of the M.R.C. there were very few sources, other than his own bank account, from which a research worker might, with difficulty, and some influence, receive a small grant, perhaps for as long a period as three years, and he might even be allowed £50 per annum for wages and apparatus.

My first lesson in research came from F. S. Locke, whose isotonic saline solution is still used. He was a very interesting character; in the middle of an experiment he would suddenly start to declaim, with appropriate action, Blanco White's "Ode to Night." On one occasion he suddenly stopped writing in his note book and said, "Now, look here, William! Never say you see or do not see a thing because I say so! If I publish a false observation people who try to repeat my work will call me a 'silly ass.'" Very sound advice which I have always stood by.

My immediate employer was a different sort of man. He used to figure out his results before he started his experiments! An excitable little fellow he would come rushing into the laboratory just as I was starting my lunch. (My nominal hours were from 9 till 6 with no break for lunch while work was on; my lunch was partaken of on the bench.) "Put a cat in the box," was his first remark after his bright and cheerful "Good morning." Often in the middle of an experiment (blood pressure) the cat would get, together with "William," too much A.C.E., and would commence to struggle. "More A.C.E. William," he would say. "Cat's getting too much, sir," would be the reply. "No! Give more A.C.E.! Cat's coming round." And so the sleepy "William" was able to get his long delayed lunch!

I remember one occasion when our research equipment was put to practical application; the President of the Royal Academy was a patient of Dr. Lauder Brunton's, and one day we set off in a "growler" (a four wheeled horse-drawn cab), with a rather weighty, cast-iron piece of apparatus, to visit him and take a record of his blood pressure.

### The Pathological Laboratory

From the Scientific Work Room, I graduated via the Museum, to the Pathological Laboratory under Dr. A. A. Kanthack. Here I had as colleague one Frank, who later came with us to Cambridge. (All the "Royaltics" had been used up at Bart.'s Medical School). Kanthack was working on snake poison. In one of his experiments he was feeding kittens with milk heavily dosed with cobra poison, to determine whether the kittens acquired any immunity by this means. My lunch was now taken in a semi-public goods lift room, and I sometimes found, when I came to make my tea, that my milk had been "pinched"! Naturally, I was annoyed, and, of course, I had my suspicions. On one such day, we made a very hurried tour of the different laboratories, expressing the hope that no one had drunk the missing milk, because it was heavily dosed with cobra poison. "Straight, Frank," said the suspect, "I don't know nothing abaht it! What should a bloke do if he had drunk it?" Frank advised a handful of salt dissolved in a pint of warm water, to be swallowed at a draught. I never had any need to hide milk afterwards.

Dr. Kanthack was, I believe, the first laboratory worker in Britain to wear a laboratory coat and there was some excitement among patients and visitors when he first appeared in the Hospital grounds in this short white coat. We in the Path. Lab. wore khaki lab. overalls provided and laundered at our own expense. I have been assured that in 1895 many surgeons still used an old and blood-stained coat (which was hung on the theatre door when not in use) when performing operations.

Kanthack was, I think, responsible for the first Kaiserling preparations to be made in England: Strangeways Pigg, later Pigg Strangeways, was his Curator. I remember, too, some of the beautiful preparations they produced with the aid of Ernest Shaw, the Museum Technician, who later became qualified in medicine.

In 1896 we were working, under the Royal Society, on a Colonial Office enquiry into N'gana (Tsetse fly disease), and it may well be that I am the sole survivor of the excited little band, which included Dr. J. W. W. Stephens, that had the first peep in Britain at the n'gana trypanozome under a 1/12in. lens. The arrival of the strain was somewhat dramatic. On the landing outside the Path. Lab. at Bart.'s two men waited with a very sorry looking dog. It seems that the supply of dogs, shipped to keep the strain going, gave out before the ship arrived at the Canary Islands, and that the Captain of the ship sacrificed his dog, in order to keep the strain going till they reached land. I'm not a dog lover, but I feel that that Captain was not nice to know!



### Laboratory equipment

Laboratory equipment at the end of last century was very primitive. There was an original Hearson incubator at Cambridge, which I think we brought down with us from Bart.'s, several wonderful German ones, with brass bound asbestos lagging, and mercury thermostatic regulators, and a bimetallic tripping apparatus which turned off the gas when the temperature of the incubator approached boiling point; there were also a hot air steriliser, a small steamer, and a small autoclave. This autoclave was imported from Paris some time in the 1880's, and was still in use when I retired in 1942.

I still remember the excitement when a hand-operated centrifuge of German manufacture joined the apparatus at Bart.'s; we used to see who could make the highest number of turns per minute using a stop watch. Fortunately, we never had a bucket come adrift; there was no protection against the results of such a happening.

It was with a "now for it" feeling that one asked for more test tubes! "Why! It's only six months since you had the last gross," would be the sure answer. It might be pointed out that media stocks were higher, and stock cultures increasing. Another gross would be ordered, and at the same time I would be enjoined to be more careful in future.

Before the introduction of the modern syringe, syringes were among the most inefficient tools used in a Pathological and Bacteriological laboratory. For much work Pasteur pipettes were the most reliable. Some syringes were provided with a rubber ball, and fitted with a tap. The syringe content was ejected by squeezing the rubber ball. Professor Kanthack favoured this type. Others had plungers of rubber or asbestos, which could be compressed by means of a screw threaded washer at the top of the piston rod. Before the days of stainless steel, there was much trouble with syringe needles; platinum-iridium needles were commended by the best people.

Much section-cutting was done on the Cathcart ether spray freezing microtome,

and the Cambridge rocking microtome with its movements carried on trunnions, instead of the modern knife edges, was just coming in. When I was at Bart.'s Mr. Waring, as he then was, used from time to time to steal off to his little lab. in the Scientific Work Room, there to cut sections on one of these early "rockers."

Before Dr. Durham invented his "gas culture" tube the evolution of gas in culture media was demonstrated by the use of tubes mounted on wine-glass stems and feet, or in "shake" culture in solid media. The air in the first Durham's inverted tubes was evacuated by vacuum pump until, slowly, we came to realise that routine sterilisation was sufficient for the purpose.

Facing Tennis Court Road in Cambridge, on one of the sills of the old medical school building, now the frontage of the Department of Zoology is a quotation from Pasteur, which, interpreted, reads "in the field of observation, opportunity comes to the mind that is prepared." Even before the beginning of the present century, every worker in bacteriology, from Professor to "Lab. Boy" had noted the inhibitory effect which certain colonies in mixed or contaminated plate cultures had on the growth of neighbouring colonies. I believe Pasteur recorded this observation in 1880. No one did any research on the phenomenon, for all believed that the dominating organism was quicker off the mark, and had absorbed necessary nutrient material before the slower moving organism could get to it! Many years had to pass before the problem could be tackled by one whose mind was prepared, and he was indeed fortunate in the time of his coming. The world needed penicillin, and penicillin was added to the triumphs of research in what may well be record time.

## THE DRAMATIC SOCIETY

### LOT'S WIFE

In November of last year the Dramatic Society of St. Bartholomew's Hospital gave performances of "Lot's Wife," a comedy by Peter Blackmore, at the Cripplegate Theatre.

Only the very grey or the very bald can still remember the days when male members of the Society donned skirts and titupped—and how well they did it, mostly. And now, once more, the women, real ones, were better than the men, mostly.

The best performance was given by Ann Gordon-Watson in the part of Lot's wife; only she displayed any ability to act with her face as well as her voice. This may seem unfair to Edward Boyse, who played Lot, but his make-up was so heavy that little expression could penetrate it; in all other respects he did extremely well in a difficult and exacting part. Of the others it may be said that they either smiled or they did not. Pamela Matheson, however, who took on the part at very short notice, admirably conveyed the necessary impression of sourness and did herself great credit in the part of Lot's elder daughter.

Robert Roxburgh, it must be admitted, presented the male juvenile lead with a degree of woodenness unsurpassed since the days when the female ditto was really a man. Future casting directors should ignore the handsome exterior and enquire about the emotional interior.

There was something engaging in the performances of Rosemary Hurst, Graham Thompson, Helen Meredith, Margaret Staley and Lowell Rees. The last-named was forgiven, by the young lady behind me, for his ridiculous cigarette-holder because he had "such heavenly legs"!

Mr. Blackmore turns "the one righteous man," whose presence in Sodom preserved it, into the one self-righteous man, and neglects to give any reason why he or it should have been preserved at all. In her new book, "The Feast," which can be warmly recommended, Miss Margaret Kennedy makes one of her characters suggest that it was unkind of Lot to leave Sodom since, as long as he stayed there, the city was safe. "I shouldn't wonder," he says, "if the entire human race isn't tolerated simply for its innocent minority."

G.E.

### DEATH

We announce with regret the death, on August 12, 1950, of Dr. Norman Glover of Brailsford House, near Derby.



## JOHN CLARKE M.D.

### c. 1583-1653

*Physician to St. Bartholomew's Hospital,* 1634-1653; *President of the College of Physicians* 1645-1650.

*By* CYRIL HART

In spite of his eminence within the profession, to the modern eye the life of John Clarke shows no evidence of distinction in matters of learning. As far as is known he made no contribution to medical knowledge; he did not publish a single treatise, and records of the details of his practice are scanty and uninspiring.

His whole outlook and activities were, therefore, in sharp contrast to those of William Harvey, his illustrious contemporary and fellow physician at St. Bartholomew's. They must often have encountered each other in the course of their duties, but they remained acquaintances rather than friends, and as the years passed their differences became more sharply defined.

In faith and politics they held opposing views, and when the Civil War came Harvey the Royalist followed the King as physician on his wanderings, while Clarke the Puritan remained in London on the side of Parliament. In the year 1643 when Harvey was attending the Princes and cavaliers of the Court at Oxford, Clarke was busy at the College of Physicians helping to organise medical aid for the Parliamentarian army.

This was described by the Speaker as "an acceptable service to the Commonwealth," and shortly afterwards the House of Commons tried to get Clarke's son-in-law appointed as Physician at St. Bartholomew's in place of Harvey, "who hath withdrawn himself from his charge and is retired to the party in arms against Parliament." This was unsuccessful, but Harvey's salary was discontinued and three years later when Oxford surrendered and Harvey returned to London, he did not resume his duties at Bart's.

Whereas Harvey now found his own reputation in eclipse, the war had brought great prestige to Clarke, who was installed the President of the College of Physicians. There can be little doubt of the animosity between them, and Harvey refused to attend the meetings of the College during Clarke's presidency, in spite of the latter's threat to take action "for the preventing the absence of fellows, w$^{ch}$ frustrateth many of o$^{r}$ meetings." It was not until 1650, when Clarke was succeeded as President by Dr. Prujean of St. Thomas's, that Harvey resumed his association with the College. That Christmas one of the fellows named Dr. (later Sir George) Ent, paid a visit to "that great man, the chief honour and ornament of our College, Dr. William Harvey, then dwelling not far from the City," which he described in a letter to the new President.

Dr. Ent wrote that when he saw Harvey he asked if all were well with him. "How can it be," Harvey replied "whilst the Commonwealth is full of distractions, and I myself am still in the open sea? And truly, did I not find solace in my studies, and a balm for my spirit in the memory of my observations of former years, I should feel little desire for longer life. But so it has been, that this life of obscurity, this vacation from public business, which causes tedium and disgust to so many, has proved a sovereign remedy to me."

This "life of obscurity" resulted in the publication of Harvey's *Exercitationes de Generatione Animalium*, a profound work which could never have been compiled had he been engaged in busy practice. It may be argued that it is to Clarke's vigorous opposition at the Physicians College and at St. Bartholomew's that we owe Harvey's early retirement, and so indirectly the production of this fundamental essay in observation and experiment. It is because of his association with Harvey and his influence in medical politics, rather than any eminence he achieved in the practice of his profession, that the life of John Clarke merits the attention of the medical biographer.

#### The Family Background

Arms of Clarke of Wethersfield: *Chequy argent and sable, two chevronels or. Crest, a blackamoor's head couped at the shoulders proper.*

John the son of Clement Clarke gent. of Brooke Hall in Wetherfield, co. Essex, was born in or about the year 1583 at Northend in the neighbouring parish of Great Waltham.

Brooke Hall was a substantial farming estate which was sometimes claimed to be a manor, and Morant the Essex historian refers to deeds which show that the family had been established there for three centuries or more before young John arrived in their midst. He was not the eldest child, for Clement's first son William was born in 1561 and went to Gonville and Caius College, Cambridge at the age of sixteen, after which no more is heard of him.

It is not known whether there were any more children in the family, but John appears to have been the second son, for he inherited the estate from his father some time before his thirtieth birthday[1]. At about this time he married a sister of his friend Samuel Collins, the puritan vicar of Braintree. When John Clarke died forty years later, his estate was of far greater extent than the modest farm which had formed his inheritance. With the money which had accumulated from his city practice, he had purchased Great and Little Codham Hall from Anne Viscountess Dorchester, and the manor of Wethersfield from Thomas Allen of Finchley.

All this property passed to his second son Joseph, who followed his father to the grave within the next three years[2]. His daughter Jane married John Drywood, Esq., of Upminster[3], but the estate did not descend to them. It seems to have come into the possession of another Joseph Clarke, who matriculated from Trinity Hall, Cambridge in Easter 1647, graduated LL.B. in 1653, and was a Fellow of his college from this date until his death nine years later. For the last two years of his life, this Joseph was vicar of his native parish of Wethersfield, a living in the gift of the Master of Trinity.

The descent of the manor within the family can be traced for a further century until we reach John Clarke of Wethersfield, who had his estate surveyed[4] in 1768. The map shows that it still comprised the whole of the manors of Codham and Wethersfield. It descended to his son Josiah[5], who died in 1790. His son Charles sailed with Captain Cooke on three of his voyages and died at Kamtschatka.[6]. The estate then passed out of the male line to Sarah Clarke a spinster, who died in 1814 leaving an endowment for a charity school in the parish.

This long recital of family history has been pursued deliberately through nearly five centuries. It serves to show that the career of John Clarke, M.D., was of some importance for the history of his family, whose status he raised from tenant farmers to lords of the whole of the parent manor.

**Rise to Fame**

John Clarke's progress was slow but steady. After studying at Brentwood School under Mr. Greenwoode, he was admitted a fellow commoner at Gonville and Caius on May 21, 1600. Dr. Perse, one of the fellows, acted as his surety. In 1603 he obtained his B.A. at Christ's. He proceeded M.A. in 1608 and M.D. in 1615, at the age of 32. For most of this time he was enjoying the life of a country gentleman on his estate in Essex.

He continued this leisurely course at the College of Physicians, where he took his first examination on December 6, 1616, his second on February 7, 1617, and his third and final one in August of the same year, when one of his examiners was Dr. Goulston. He was proposed as a Candidate on September 5 following, and Dr. Harvey was one of the Fellows who gave his assent.

It was not until November 28, 1622, that Clarke was finally admitted to the Fellowship of the College, an honour which was then limited to a very small elite, less than forty strong. So jealously were the numbers restricted that shortly before Clarke's admission a nominee of the King had been refused a place because there was said to be no vacancy. Evidently Clarke had access to powerful influence, but it is not known who was his benefactor.

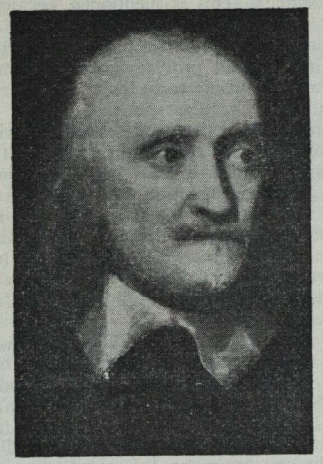
The organisation and activities of the Physicians College at this early period, and the careers of its individual Fellows, form a topic which would repay a much fuller and more critical investigation than has been devoted to it in the past. The attitude of

[1] *Essex Review* IX 189.
[2] Will proved at the Prerogative Court of Canterbury 1655 fo. 20.
[3] *Visitation of Essex* 1 390 (Harleian Society 1878).
[4] *Catalogue of Maps at the Essex Record Office* (1947) p. 156.
[5] *European Magazine* (1790) p. 238.
[6] His epitaph is in the parish church.



those medical historians who gloss over the rents in the unity of the profession of past centuries has little to commend it. Accounts which suppress what is inconvenient and laud the mediocre leave thoughtful readers with a worse impression than if the truth were told.

It is of course well known that there were differences between the Fellows on subjects relating to medicine—experimental medicine had few champions other than Harvey, and many bitter opponents. The small circle of more progressive members which formed round Glisson found it necessary to meet outside the College to pursue their investigations, so small was the support for their endeavours. But the main division was upon the great questions of religion and politics of the day, a subject of enormous interest to the social historian, yet little touched on so far by those concerned with the more restricted fields of medical history and biography.

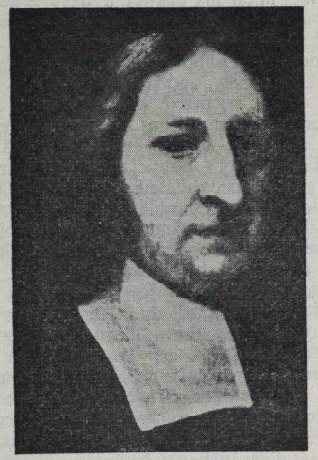


*John Clarke, M.D.*

*(From a portrait at the Royal College of Physicians, circa 1650. Artist unknown.)*

At the outbreak of Civil War, Fellows of the College, then as now leaders of the profession, had to decide like the rest of the population which side of the fence they were going to jump. So far little is known of the relative parts played by tradition and expediency in influencing their individual decisions, and whether there was any correlation between their views on faith and politics and their attitude to the new trends in medicine.

It is clear from the College Annals that the Fellows were already divided into several factions on these issues long before the war began, and it is against this background that the entrance of John Clarke to the College must be placed.



*Sir John Micklethwaite*

*(From a portrait at the Royal College of Physicians, circa 1670. Artist unknown.)*

There are very few details of his activities during the following decade, but it seems that he soon built up a flourishing practice in London and the neighbouring parts of Essex. It was customary for a Fellow to be chosen each year for the honour of providing a Feast for the College at his own expense. Dr. Clarke's turn came in 1631, and on April 4 he was warned by the President to make preparations "providing the plague does not prevent it." Plague was then endemic in London, and it was usual for the more wealthy members of society to flee the city in bad years such as 1625, when nearly one tenth of the total population of half a million died from the disease.[7] The

[7] W. G. Bell *The Great Plague in London* (1924) p. 7.

year 1631 did not fulfil its early threat to be a bad one, and after some delay it was decided to hold the feast after all, no doubt to Clarke's annoyance.

On November 2, 1631, to quote the Annals, "Mr. Prsident propounded to the Coll. Dr. Clark's proffer to give £15 to the Coll. to bee excused of his feast; but the Coll. would not accept his offer, but will that hee ether paye £20, or make his feast, for wch upon his answer a daye is to bee appointed him by Mr President, when he shall make his feast at the Coll."

One of the Fellows whom Clarke feasted was Dr. Harvey, and it was about this time that events occurred which were to have important repercussions upon the lives of both of them. Harvey was appointed one of His Majesty's physicians in ordinary, a post which necessitated his absence from London for considerable periods. On April 25, 1631, one Dr. Andrewes was appointed to the reversion of Harvey's place as Physician to St. Bartholomew's Hospital. On January 19, 1633, the surgeons at the hospital complained that Harvey was not attending to his duties there because he was so often at Court, and Dr. Andrewes was appointed to deputise for him when necessary. On October 15 later that year it was decided that for the period of Harvey's Court appointment the number of physicians at Bart.'s should be increased to two, and Dr. Andrewes was therefore made a full physician. On July 24, 1634, Andrewes died, and on August 7 following Dr. Clarke was appointed Physician to St. Bartholomew's Hospital in his stead. From this time onwards Clarke's career was firmly established.

### The College of Physicians

Some time before Andrewes's death he became involved in a ridiculous quarrel between John Clarke and Laurence Wright, another Essex doctor. Dr. Wright had been elected a Fellow of the College on the same day as Clarke, and later he became physician to Oliver Cromwell and the Charterhouse.

To digress for a moment, Wright had an estate at Romford which was used by Pepys in later years as a pleasant retreat from the Plague;[8] its modern name is Dagnam Park. It was only a mile or so away from another estate called Sutton Gate,[9] which was then the property of Dr. Prujean, who became President of the College in 1650. A third manor nearby was Marks Hall, owned by a branch of the Harvey family who strange to say were puritans. Sir Gawen Hervey of Marks died in 1627 and his will reveals that on July 1, 1622, he had appointed "Mr. William Harvye, Doctor of Phisicke" to be an executor of his estate.[10] This is mentioned because it does not seem to have been noted by William Harvey's biographers in the past, and it may well provide the clue to much information on his early life.[11]

Returning to the quarrel; Clarke and Wright had both good practices which covered that part of Essex, and it was their custom to call in each other on consultations. It was upon one such occasion that their difference arose. The point at issue was trifling enough, but it took a full assembly of the College, with the President himself in the Chair, to settle it. It is sufficiently entertaining to merit a full transcript from the Annals:

"5 Sept., 1634. The difference between Dr. Clarke and Dr. Wright, who have often contested about the unkindnes that Dr. Wright should refuse disgracefully a Cataplasma wch Dr. Clarke had appointed for a patient, and prohibited the Apothecary to make the same, was this daye heard.

"Dr. Wright in his defence sayeth, that hee was called to Consult wth Dr. Clarke and others, and that before his coming such a Cataplasma was prscribed wch he disliked before Dr. Clarke and the rest of the Drs prsent, aduising rather a playster to bee used. Yett he coming to the Apothecaryes founde a Cataplasme directed to bee made, wch he prohibited, willing for the Apothecary to show the receipt to Dr. Andrews, and not to make itt wthout Dr. Andrews his approbation; wch was done; and Dr. Andrews approved therof.

"Dr. Gifford, Concilarius, doth conceive this difference might bee fairely composed between them; and hee conceaved that fellowes in Consultation maye bee of

[8] George Terry *Memories of Old Romford* (1888) p. 198.

[9] *Ibid* p. 191.

[10] *Ibid* p. 154.

[11] For muniments of the Herveys of Marks, see the Mildmay Collection at the Essex Record Office.



different opinions wthout any offence, but for any fellowe to lett fall any, by speeches tending to the disgrace of ane other fellowe, or to Confide in Apothecaryes themselves or their bills, that he should dislike.

"After some Altercation, the Drs being sent apart, it was agreed by the Prsident, Consilarius and Censors that for this tyme a fayre reconciliation should be made, and that Mr. President should admonishe Dr. Wright not to bee to forward in Censuring other men, to wch hee is ovr apt. The Drs. being called in again, the Prsident admonished Dr. Wright kindlye to bee respectfull of his Colleagues, and so this difference is accorded, and they reconciled."

It is clear that Clarke emerged from this affair with colours flying, and the next indication we have of his growing prestige is that on April 3, 1637, he was warned by the President that he had been chosen to read the Anatomy. This appears to have been an appointment to deputise for Dr. Harvey, who was Lumleian Lecturer from 1615 until his death in 1656. It was during Harvey's early anatomical lectures at the College of Physicians that he announced his discovery of the circulation of the blood. Clarke was at that time preparing for his examinations as Candidate at the College, and there is no doubt that he was present on that *dies mirabilis*, as Osler has called it.

Harvey's discovery led to great controversies, both in England and in the rest of the civilised world. The division of opinion was just as marked within the College as elsewhere, and Clarke's position as substitute lecturer was a delicate one. It is not known which side he took, but we can sympathise with him on reading the note in the Annals for March 9, 1637. "Dr. Clarke craved further Tyme, and promised to read the Anatomicall lecture the next yeare if lyfe and health served him." Nothing more was heard of this proposal.

In 1639 Clarke was elected a Censor of the College. The Censors were four Fellows appointed annually to supervise all who practised physic in London, to search the apothecaries' shops and to test their drugs. Two years later he was created to the office of an Elect. The Elects were eight Fellows appointed to examine for licences to practise physic. They selected a President from their number annually. By the outbreak of Civil War, Clarke was therefore one of the most influential persons at the College.

### The Civil War

Dr. Clarke had a house at "blackfriers" within the gate of the parish of St. Martin Ludgate. It was a substantial building, and in 1638 he paid a rent of £30 for it.[12] One of his nearest neighbours within the parish was Dr. Simeon Fox, the youngest son of John Fox the martyrologist, and President of the College of Physicians from 1634 to 1640. There is no doubt that Clarke's acquaintance with Fox is part of the clue to his rise in prestige at the College. Both were ardent puritans,[13] and as the war progressed Clarke became deeply involved in the religious controversy of the times.

On October 8, 1643 the parish vestry decided to eject the Rector, Dr. Jermin, because he would not subscribe to puritan doctrines. At a general vestry of the parish [14] held on the 9th of the following month, it was agreed "that the persons hear under written should be a committee to make Choice of an able divine to supply the Cure of this parish in the Rome of Doctr Jermin who was lately voted from this place." Dr. John Clerk was appointed to chair the committee, and six days later they chose a gentleman called Mr. Gowre to be their new Minister. Against the report of this decision in the vestry minutes appears the following post-restoration ballad:—

*Jermin depriv'd is because he dared to keep*
*The fox and wolfe from preying on ye sheep.*

When Gowre died six years later, it was again ordered by the vestry "yt the Parishoners whose names are subscribed (are) made chosen of to doe ther indever to hurken outt a Godly Minister for our Cure & acquaintt ye Parish ther with," and Dr. Clarke's name once more headed the list. On November 15, 1649 a Mr. Nalton was chosen, to which decision in the minutes the same rhymster added:—

*Twas Jereboams practice and his sport*
*Priests to elect out of the basest sort.*

Clarke's activities in this direction were not confined to his own parish. By an ordinance of the Long Parliament, the diocese of London was divided into twelve sections called "classis" for the purposes of

[12] Lambeth Palace Library MS. 272, fol. 224a.

[13] As a boy, Clarke came under the spell of Richard Rogers, the puritan lecturer at his native parish of Wethersfield. Rogers and his successors are denounced in contemporary reports as being "famous for conventicles and nonconformity."

[14] Vestry Minutes of St. Martin Ludgate, at the Guildhall Library.

administering the new ecclesiastical regime. On October 20, 1645 Dr. Clarke's name appears[15] as one of the six persons in his "classis" who were "ordained to be Tryers and Judges of the Integrity and Ability of such as are to be chosen Elders . . . and of the Dueness of their Election." He was re-appointed on September 26, 1646 and again on August 29, 1648.

All this was but a sideline to his main activities. At the Physicians College he held the following appointments: Censor 1641-2, Counsellor 1642-4, Treasurer 1643-4, and for the whole of this period he was an Elect. His share in arranging the provision of physicians for the Roundhead forces in 1643 has been mentioned already. During the same year, on his appointment as treasurer, he was instrumental in freeing the College from the weekly assessment of £5 with which it had been burdened to help pay for the Parliamentarian campaigns. At the same time John Clarke was able to save the College still further expense. The building was part of the St. Pauls' estates, which had been taken over by Parliament during the general sequestration of all deaneries. On May 6 that year, "Answere was given to the collector of rents for the deane and chapter of St. Pauls, who came to demand the Colledge rent (then sequestered *in usum Reipublicae*) for them, that we durst not deny the Ordinance of Parliament." This rent was eventually bought from Parliament by Dr. Baldwin Hamey, the first historian of the College, who leased it to Dr. Clarke and other Fellows in 1651.

On February 12, 1644, the House of Commons made the recommendation already referred to, that Dr. Micklethwayte be appointed a Physician at St. Bartholomew's in the place of Dr. Harvey. Micklethwaite had studied at Leyden, and while he was there he became acquainted with Dr. John Clarke's eldest son, who was also named John. John Clarke junior had studied at Queen's College Cambridge, but he did not take his degree there. He went over to Leyden instead, where he entered the University on June 1, 1639 and obtained his degree the following month. They were the good old days.

The way in which this was accomplished was to print a sort of thesis, termed a disputation, which was defended on an appointed day before a full assembly of the faculty. The disputation of John Clarke junior was dedicated to his father, to the Rev. Geo. Bardsey his Cambridge tutor, to yet another John Clerk "a vigilant pastor and loving friend" of his father,[16] and to Samuel Collins his worthy uncle on the maternal side, a "most faithful dispenser of the Divine Mysteries." The thesis is a worthless set of quotations in Latin from the works of Hippocrates and Galen. According to John Clarke junior, *Volvulus* and *Eileos* were essentially synonymous. For defending this small quarto pamphlet of eight pages, he was awarded the degree of M.D. on July 29, 1639.

In 1641 he passed the three examinations of the College of Physicians in London (his father was one of the Censors) and on October 22, 1642, he was admitted as a Candidate for the Fellowship of the College. Before this could be granted, however, he fell sick and died on September 1, 1643, "so," according to one of the Fellows, "frustrating the hopes of his father and all his friends." His death must indeed have been a heavy blow for his father, especially as his second son Joseph had not entered the profession. Joseph had chosen the Law, and after matriculating from St. Catherine's, Cambridge, he had been admitted at Lincolns Inn[17] February 3, 1635, and called to the Bar on June 21, 1642.

In these circumstances, it is only natural that Dr. Clarke senior should have transferred his benevolence to his son-in-law Dr. Micklethwaite, who had taken the College examinations on the same dates as young John, and finally married his sister. The recommendation by Parliament that Micklethwaite should be appointed Physician to Bart.'s is almost certainly the first evidence of Clarke's powerful patronage.

Dr. Clarke was elected President of the College of Physicians in 1645, a post which he held for the following five years. There was a great deal of business attached to the post, and it seems that Clarke was unable to fulfil his duties at Bart.'s, for in the hospital journal as entry dated April 9, 1648 reads:—

"It was thought fitt & ordered that Doctor Clark Phisicion to this Hospitl shall upon mondaies & thursdaies evry weeke in the fore noone visit the patients under his charge & prscribe such medicines as may be thought meete, that the poore may be wth more expedicion cured & soe dismissed the howse that others may be admitted. And the said Doctor being prsent did willingly agree & promised to performe this Order wthi Care."

It was clear, however, that he could not cope with all his duties. One imagines that Harvey would have been glad of the opportunity to return to Bart.'s from his enforced retirement, but instead Micklethwaite was appointed Assistant Physician on the 26th of the following month, with succession to the full post after Clarke's death. It may be noted that after the Restoration Micklethwaite turned royalist and was knighted for his services to the king. He was one of those who are alleged to have deserted their posts at the hospital in the year of the Great Plague. A descendant of Micklethwaite presented to the Royal College of Physicians the portrait of John Clarke which has been reproduced here. Micklethwaite's own portrait was given to the College by Sir Edmund King.

There are many records in the College Annals of Clarke's activities during his presidency, but few of them are worth describing here. One of the first things he did after his election was to arrange a meeting between representatives of the College and the Sheriffs of London to tighten control over the numerous quacks or "Empiricks" who then flourished in the City. In 1647 he proposed to bring out a new edition of the College Pharmacopoeia, which finally appeared in print three years later. It contained few amendments to the edition produced by Harvey and his colleagues thirty years previously, but it formed the basis for the first pharmacopoeia of St. Bartholomew's Hospital, prepared in 1670.

In his last year of office, John Clarke had the honour of appending his *imprimatur* to one of the most remarkable works of an English physician during the seventeenth century, Glisson's treatise on rickets.[18]

[15] *Acts and Ordinances of the Interregnum* (1642-1660) C. H. Firth and R. S. Rait, 4 Vols. 1911.

[16] Probably the puritan Vicar of East Ham, Essex, who was the son of the Rev. Samuel Clarke of St. Benet Fink, famous for his *Lives of Eminent Persons*. Their relationship to the Wethersfield branch of the family is not known.

[17] Records of Lincolns Inn, kindly supplied by the Librarian.

[18] F. Glisson *De rachitide; sive, morbo puerili.* 1650 (B.M. 1178. b. 7).

[19] Churchwardens Accounts of St. Martin Ludgate, preserved at the Guildhall Library.



### Decline and Fall

*Even the dignity of the presidential chair does not suffice to float a man down the few centuries that have passed since the foundation of the College.*—Osler.

Dr. Clarke resigned his presidency in 1650, the second year of the Protectorate, at the age of 67. For a short while he continued to attend the meetings of the Fellows, but soon it became too much for him. In 1652 he was in arrears for his pew money at St. Martin's,[19] and appears to have been confined to his home by illness, but on September 15 that year he was able to attend the "view" of the patients at Bart.'s, which was made by five governors with the physician, the three surgeons and the apothecary. The last record of his work at the hospital appears on January 3, 1653:—"All patients to have the house diet, except those the doctor reports to be feverish."

He died on April 30 that year, and he was followed to his grave in the churchyard of St. Martin's Ludgate by the President and Fellows of the College in their robes, who formed a solemn procession. There is no trace of his memorial, for it was destroyed in the Great Fire of 1666.

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References to individual works and manuscripts are given in footnotes to the text. The court rolls of Wethersfield, now preserved in the Essex Record Office, would no doubt have provided much additional information if time had been available to examine them.

*(Concluded on page 47)*

# THE POT-POURRI OF THE WARD-SHOWS

## CHRISTMAS 1950

THE Pot-Pourri of the 1950 Christmas Ward-Shows was held at the Cripplegate Theatre on December 29 and 30. The high general standard of the shows made the selectors' task an unenviable one, but the audience were able to enjoy a performance of a highly original nature given by a talented group of students, nurses and house-men. I think top marks must be given to that glorious gynaecological Roman riot, "Tiber Rag,' which was brilliantly written and arranged musically, a production conceived by the gynaecological firm. Gobert Jones, as Caesar, was admirable, and his solo "I am the very model of a model gynaecologist" brought the house down. The costumes in this show were most convincing. Mr. Naunton Morgan's firm gave a very spirited show called "Larks at St. Marks" depicting some very bloodthirsty young girls of the St. Trinians category and their somewhat obese headmistress; a good performance in the latter role by J. Jarvis. The Outpatient Firm presented a farcical melodrama from "Basil on the Razzil" called "Who is Fanny" and I liked the villain played by B. Hick, and also the Hairy Godmother and the Awful Mother. The best small act was given by Boomla and Barber, who with a truly professional slickness and polish, did a burlesque on a couple of Cockney organ-grinders and sang "The Old Kent Road."

The Hill End Theatre belts sang some amusing choruses about life in the Bart.'s country seat. I liked the duet sung by Barber and Mellows "Have you got any dirty work to do?" out of the Surgical Unit show "Twist and Bust."

The Children's Firm presented an excellent pantomime called "Snogood and the Seven Dwarfs"; E. Boyse was in his element as the Queen-turned-into-Witch and gave a good performance. The Seven Dwarfs were most amusing and hurled themselves about the stage in a delightfully uproarious manner, only pausing to sing a grotesque song accompanied by saxophone, flute and an ancient motor-horn!

I was much intrigued by the remarkable "ballet en volte-face" performed by the Medical Unit. Several of the performers danced with their backs to the audience while wearing a lifelike mask over the occipital region; the resultant effect was so weird that no description could really convey any idea to anyone who did not see it.

Finally, the Residents' show was called "Houseman's Progress," an uninhibited and hilarious Rake's Progress from student to doctor.

All concerned with the Christmas shows of 1950 are to be congratulated on having succeeded in producing shows of great originality and some of the individual performances were quite excellent. John Pittman and Christopher Todd bore the burden of arranging and producing the Pot-Pourri.

R.C.R.

# SO TO SPEAK . . .

**Christmas Priorities**

"If you are seen at an operation when you should be at a rehearsal there will be a dreadful row"

*—Heard in the refectory.*

**If . . .**

"Now if you had been a little girl you wouldn't have had to have this done."

*—Mother to small son in Minor Ops.*

**Honesty in Practice**

"This patient has one of those things with a crust on which bleed when you knock it off. I can't remember what it's called, but I expect you can"

*—From a doctor's letter.*

**Status Acrobaticus**

"He spent July and August partly in and partly out of bed."

*—From a student's history.*



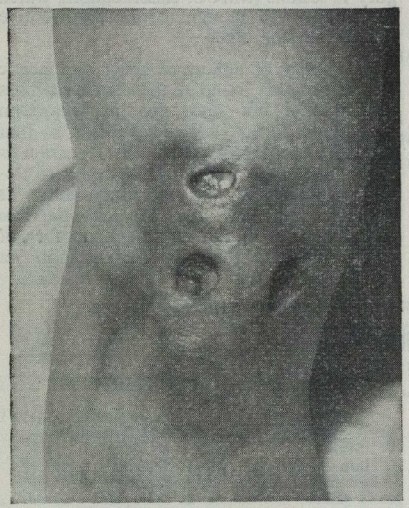
# CLINICAL CASE-BOOK

Mrs. K., aged 82.

Admitted as a duty case in heart failure, but also complained of "sores" on R. knee. It is with the latter condition that this report is concerned.

**History of present condition**

1891. "Abscess in private parts" unsuccessfully treated with hot fomentations.



1894. R. knee became greatly swollen but was painless.

1908. Knee "burst."

1934. Attended U.C.H. for "bursas of the knees." L. knee swollen; aching pain not related to exercise: no weakness. Swellings also on R. thigh and back.

1943. The swellings on thigh and knee discharged.

1947. O.P. at this Hospital c/o swollen knees and hips.

*Treatment*: 15 gr. KI daily. Some improvement.

**On examination**

*Eyes* react sluggishly to light and accommodation.

*Thigh and buttock*: Irregular thinly covered scars with brown pigmented margins.

*Lower limbs*: Diffuse infiltrations around both patellae. Three gummatous ulcers on R. knee (see photograph). Ulcers have a base of pink granulation tissue covered in part by a yellow slough; sides steep; surrounding margin discoloured crown.

Ankle-jerks absent. Sensation in tendo Achilles diminished. Cutaneous sensation normal.

**Special investigations**

W.R. positive.

**Diagnosis**

Syphilitic bursitis.

**Treatment**

Penicillin 150,000 units intra-muscularly daily. Eusol and paraffin dressing to ulcers. Healing was fairly rapid.

**Points of special interest**

1. The syphilitic bursitis of the knees, a rare condition most frequently involving the prepatellar bursa, and usually, as here, bilateral.

2. It is interesting that the ulcers are still present at age of 82, as they usually heal spontaneously.

3. It is also of interest that KI did not cause healing while penicillin given slowly led to rapid healing.

I wish to thank Dr. Scowen for permission to publish this case and for his helpful criticism.

L.F.

# QUESTIONS ANSWERED

*Of what value is mass radiography in the detection of pathological conditions other than tuberculosis?*

A great variety of non-tuberculous lesions are found annually amongst the many thousands of persons examined by mass radiography for the primary purpose of detecting tuberculous lesions.

The clinical benefit resulting from the detection of these non-tuberculous abnormal shadows has been variable. At this hospital, a patient once had to endure bronchoscopy for the exclusion of a foreign body diagnosed by a Mass Radiography Unit—the shadow subsequently proving to be that of a calcified gland. Many normal people have had their fears aroused by the

report of a shadow in their miniature film; and have suffered unnecessary anxiety until a full-sized film has proved that they have no active lesion.

On the positive side, a few cases of early bronchial carcinoma have been detected, although not all could be resected. Several innocent mediastinal tumours and lung cysts have been found and successfully removed. Some of these would perhaps have been eventually detected when they produced symptoms, and the total benefit of their earlier removal is difficult to assess.

Looking at the matter the other way round, it can be said that the use of mass radiography for the detection of early lung and mediastinal tumours would be extremely costly, probably in the order of over £1,000 per treatable case. Large numbers of persons would require examination twice yearly from the age, say, of 40 until 70 or 80, by which time the chance of successful resection might be too small to justify the expense of the examination, or a calculating Government might decide that available beds should be reserved for the productively working population. It must also be remembered that many cases of bronchial carcinoma do not in their early operable stage give any indication of their presence in a routine anterior view.

The method is successfully used for the detection of pneumoconiosis amongst the Rand miners. If applied to English coal miners, it would suffice to show most category II lesions (M.R.C. classification), which would be early enough to allow preventive measures to be taken.

A number of abnormal heart and aortic lesions are also found in the course of mass radiography; but since they are symptom free, many do not require treatment, so that the benefit obtained from their detection is not considerable. Mass radiography to detect opacities of the maxillary antra is feasible; but how the Medical Services would cope with the enormous number of opaque sinuses thus revealed is not yet known.

G.S.

*Readers are invited to send in questions for answer in this series.*

## HOUSE APPOINTMENTS

JANUARY 1 TO JUNE 30, 1951

**At St. Bartholomew's Hospital**

| | Senior | Junior |
|---|---|---|
| **Dr. Bourne** | G. C. R. Morris | Miss E. S. Tomlinson |
| **Dr. Cullinan** | G. W. Marsh | J. G. Wallace |
| **Dr. Scowen** | J. F. Hale | G. C. Jenkins |
| **Prof. Christie** | P. J. Lawther | C. C. Molloy |
| **Dr. Spence** | J. M. L. Gilks | H. E. Milligan |
| **Mr. Hume** | R. P. Holmes | W. V. Brooks |
| **Mr. Corbett** | J. L. Milligan | P. C. Steel |
| **Mr. Hosford** | N. A. Green | J. C. M. Currie |
| **Prof. Sir James Paterson Ross** | N. G. Rothnie | Miss I. G. Smith |
| **Mr. Naunton Morgan** | Miss H. E. Bambridge | I. Blakeway |
| **Casualty House Physician** | D. P. Smyly | |
| **Children's Dept.** | Miss J. Wheelwright | E. J. Griffiths |
| **E.N.T. Dept.** | J. L. Godden | |
| **Skin and V.D. Depts.** | N. P. Bhandari | |
| **Eye Dept.** | M. Reckless | |
| **Intern** (Midwifery) | J. D. Cairns | |
| (Gynæcology) | B. M. Hibbard | Miss A. S. Fowkes |
| **Anæsthetists** | C. Todd (S.R.A.) | |
| | W. J. Wright | |
| | A. M. Baker | |
| **Dental Department** | J. M. Leitch | |
| **Orthopædic Dept.** (Accident Service) | D. L. Pedersen | |
| **At Hill End Hospital** | | |
| **E.N.T. Dept.** | R. C. Hale | |
| **Orthopædic Dept.** | M. Wise | D. F. A. Aubin |
| **Thoracic Dept.** | J .D. Griffiths | |
| **Neuro-Surg. Dept.** | G. Kazantzis | |
| | J. D. W. Tomlinson | |
| **Anæsthetists** | J. C. S. Ainley-Walker | |
| | P. J. Roffey | |
| **At Alexandra Hospital** | | |
| **R.M.O.** | B. J. Hovenden | |



## EXAMINATION RESULTS

### UNIVERSITY OF OXFORD

**2nd B.M. Examination**

**Michaelmas Term, 1950**

**Medicine, Surgery and Midwifery**

Denny, I. B. Hadley, D. L. Milligan, H. E. Tomlinson, E. S. (Miss)
Wallace, J. G.

### UNIVERSITY OF LONDON

**Examination for the Postgraduate Diploma in Psychological Medicine**

**October, 1950**

Warren, H. de B.

**Part A only**

Moynagh, D. W.

### SOCIETY OF APOTHECARIES

**Final Examination**

**November, 1950**

**Pathology**
Wallace, J. R. C.

**Midwifery**
Denny, I. B.

### CONJOINT BOARD

**First Examination**

**December, 1950**

**Anatomy**
Cuthbert, E. R. Cook, W. A.

**Physiology**
Cook, W. A. Foulds, H. P. S. Wilson, D. M.

**Pharmacology**
Arthur, B. K. Jenkins, D. G. W. Stoke, J. C. J. Venables, P.
Coole, C. W. Painter, N. S. Thomas, B. D.

## CORRESPONDENCE

### THE CAMBRIDGE GRADUATES CLUB

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

Dear Sir,

We would be grateful if you would allow us the hospitality of the JOURNAL to say that the Cambridge Graduates Club of St. Bartholomew's Hospital will be holding its 61st annual dinner (for MEN only) on Friday March 9, 1951, at Frascati's Restaurant, Oxford Street, W.1. All Cambridge-Bart.'s men, both qualified and unqualified, are automatically eligible for the dinner, and notices will be sent out in due course to all concerned; however, should anyone not receive a card, we would be grateful if he could let us know.

Yours faithfully,
H. JACKSON BURROWS,
R. C. ROXBURGH.
*Hon. Secretaries.*

### THE SKIN MAN

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

Sir,

In reply to Dr. MacKenna's letter in the December number of the JOURNAL, although I cannot tell him who was the author of "The Skin Man," I can perhaps indicate its original source.

Rather more than half a century ago I learnt the following description of the advantages of being a skin doctor:—

1. He is never called up at night.
2. His patients never die, and
3. They never get well.

But X-ray treatment, possibly vaccines, the various drugs advertised in the St. B.H. JOURNAL (intravenous and otherwise) and, shall I say, psychological therapeutics, have modified No. 3 to the advantage of the patient.

Yours, etc.,
H. G. ADAMSON.

The Abbey,
Bourne End, Bucks.
December 19, 1950.

### CHRISTMAS WARD-SHOWS

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

Dear Sir,

We would much like to thank all those people who took part in the Christmas

Ward Shows, a large factor in giving both patients and staff such an enjoyable time.

So high was the standard, that for the first time it was difficult to know what to leave out from the Pot-Pourri, rather than what to put in.

The co-operation we received from all the individual shows was remarkable, and made our job much easier.

I am sure we may say on behalf of the entire Hospital "Thank you, to everybody connected with Christmas, 1950."

Yours sincerely,
C. TODD, *Senior Resident.*
JOHN PITTMAN,
*Hon. Sec. Dramatic Society.*

St. Bartholomew's Hospital,
London, E.C.1. January 8, 1951.

# SPORT

## HOCKEY CLUB

A review of this season's results shows considerable improvement on last year. The club has reversed its worst defeats by beating Sevenoaks 3-1 and London Hospital 3-1, but the highlight occurred when, for the first time since the war, Lensbury was defeated 3-2. This game was played under adverse conditions of cold and driving rain. Neither side let up in a hard-fought game and the last few minutes were hectic indeed.

Although the 1st XI has changed little since last season this improvement is due in the main to practically the same team turning out from week to week. John Mellows was tried at centre forward and has been very successful together with J. Batterham at inside right.

This season has seen the formation of a 3rd XI for the first time since before the war. The 2nd XI under the leadership of A. Baker has done well and it is due to the support of all that it has been possible to run an additional side.

It is with much regret that we say goodbye and good luck to that indefatigable half-back John Platt and also John Dossetor who leaves a very big hole in the forward line. We shall miss them both.

Results: **Won**

Lensbury 3-2; Sandhurst 5-4; London Hospital 3-1; Sevenoaks 3-1.

**Lost**

Orpington 3-1; Lensbury 3-1; Emmanuel 3-0; K.G.S. 5-1, Birmingham University.

**Drawn**

University College 0-0; Ealing Dean 3-3; R.N.C. Greenwich 2-2.

## FENCING CLUB

The Fencing Club continues to flourish, and now that we have an instructor, Professor Delzi, for part of the year, there is quite a regular attendance on Wednesday afternoons, which holds out great promise for our team in the future. At the moment we are short of Epéeists and Sabreurs, as a reasonable standard in Foil is necessary before learning the other two weapons. However, some of the senior members are now taking up Epée and Sabre, and later in the season we should be able to field a team strong enough to challenge any other Hospital with confidence. It is hoped that the Inter-Hospital Fencing Championships will be resumed soon.

Last term we fenced Imperial College "A" team and won after a close match, 11-9. Our foilists should have done better and lacked determination in their attacks, but will improve with experience. The individual scores were as follows:

**Foil** (team of 4): W. M. Beatley 4 wins; D. Eaton 3 wins; G. Middleton 1 win; E. Henderson 0 wins. Total 8 wins, 8 losses.

**Sabre** (team of 2): W. M. Beatley 2 wins; D. Eaton 1 win. Total 3 wins; 1 loss. Result: match won by 11 fights to 9.

## WOMEN'S HOCKEY CLUB

Saturday, November 11, 1st XI v. Lensbury (home). Won 13-0.

Wednesday, November 15, 1st XI v. Royal Free (home). Lost 4-7.

Saturday, November 18, 1st XI v. Royal Holloway College (away). Lost 2-10.

Saturday, November 18, 2nd XI v. Royal Holloway College (home). Lost 0-4.

Saturday, December 2, 1st XI v. Charing Cross and Royal Dental (home). 1st round Hospital Cup. Won 7-0.

Saturday, December 9, 1st XI v. Dickinson's Ladies (away). Lost 1-5.

# BOOK REVIEWS

**PAIN AND ITS PROBLEMS,** edited by Sir Heneage Ogilvie and William A. R. Thomson. The Practitioner Handbooks, Eyre and Spottiswoode, 1950, pp. 194. Price 12s. 6d.

This book is written by a galaxy of well-known medical men. Names like Professor E. D. Adrian, Dr. Gordon Holmes, Lord Morland, Dr. Evan Bedford, Sir Charles Symonds, and 13 others of equal standing, guarantee that every one of them is an expert in his field. As the Editors stress in their preface, the book is written primarily for the practitioner. Accordingly, emphasis has been laid upon the practical aspects of the problem, and also upon treatment. Most of the chapters have already been published in "The Practitioner" as a series of monthly articles on "Pain and its Problems," but several new chapters have been added.

The list of the names of the editors and contributors is proof of a very high standard. Certain minor details which may be gently criticised are the lack of uniformity in giving references at the end of chapters. Some authors do so and others do not. Minor omissions, such as that of the interesting, and clinically and theoretically, important "A symbolia for pain," may be excused by its rare occurrence. Objective measurements may not always be helpful, but they do exist to a limited extent, for skin pain (Wolff, H. G.); finally, the interesting studies of Macdonald Critchley are worth mentioning. In spite of these very minor blemishes, the book can be thoroughly recommended to busy practitioners and medical students.



**PRACTICAL BIOLOGY,** for Medical and Intermediate students, by C. J. Wallis, 3rd Edition, 1950. William Heinemann, pp. x + 404, illus. 213. Price 21s.

To the solitary student working without teachers this book would be a valuable friend. As well as guiding him step by step through his entire course with admirable attention to detail Mr Wallis spares a thought for his clothes and his comfort, urging him to wear a white coat and to draw with his notebook to the right of his microscope.

To the young teacher without experience or its substitute a seasoned technician, the book is indispensible, giving full and good advice on the proper running of a laboratory, including the ordering of material and the treatment of casualties.

To the more gregarious type of student, too, the author offers much of very real value. The information given is adequate, lucidly expressed and well arranged, with a generous lacing of diagrams, but these, though an improvement on those of the second edition, are not good. The drawings of microscopical preparations, for instance, are frequently below the standard usually required of the first year student, but this may be due in part to over-reduction.

One is grateful for the inclusion of the rat as an animal for dissection, and for the index, which is excellent.

**PRINCIPLES OF PATHOLOGY,** by R. A. Willis. Butterworth, 1950, pp. xi + 722, figs. 288, plates 10. Price 50s.

As the author states in the preface, this book is of the nature of a comprehensive outline of pathology. As such, much of the detail necessary for the proper understanding of the subject by the young undergraduate student is lacking. Thus the book is not suited for those commencing the study of pathology, but it is indeed a comprehensive outline and may be useful to the more advanced student or to the candidates for higher degrees who wish a text-book for rapid revision for examination purposes.

The author has attempted to cover nearly the whole field of pathology in a volume of about 650 pages and, after reading the book, one is left with the impression that the writer has attempted too much in so limited a compass. For a proper understanding of the bacteriology and pathology of infection, the student would require to supplement this subject by wider reading if he were to appreciate the pathology and bacteriology of infections.

As would be expected from the author who has written one of the standard text-books on tumours, the sections in the present book dealing with neoplastic diseases are well presented and very informative and this is the most desirable feature of the work. The rest, however, is not of the same high standard.

**FAVOURITE PRESCRIPTIONS,** edited by Sir Heneage Ogilvie and William A. R. Thomson, 1950, *The Practitioner*, pp. 76, 1 fig. Price 4s.

This is substantially a re-issue in book form of the symposium on Favourite Prescriptions appearing in *The Practitioner* in July 1950. One article, "Favourite Prescriptions in Physical Medicine," and also an index have been added. The articles now total nine, and in subject their scope is wide. Although some of the prescriptions have been in use for many years they are not mere placebos; they have stood the test of time as effective therapeutic agents, and the modern science of Pharmacology is often only now beginning to explain why. Antiquity is, however, not a passport to this collection, the writer on ophthalmology does not hesitate to condemn silver nitrate prophylaxis against ophthalmia neonatorum and to recommend penicillin treatment instead, and in the dermatological article the advantages and disadvantages of the antibiotics in this field are discussed.

There are few medical men who will not find something of value in this symposium, and to put new heart into the weary practitioner there is perhaps no better prescription than the stories related in Lord Horder's section of the book.

**SAVILL'S SYSTEM OF CLINICAL MEDICINE,** edited by E. C. Warner, 13th Edition, 1950. Edward Arnold, pp. xxviii+1,198, 7 colour plates, 195 Figs. Price 35s.

The form of this book, now in its thirteenth edition, will be familiar to many readers. To the others it may be explained briefly by saying that disease is here classified by its symptomatology rather than by its supposed underlying pathology. The author realised forty years ago that the so-called "systematic" method of classification is not that by which the practising physician reviews a case at the bedside. He rather selects the cardinal symptoms and by integrating these with the other features reaches his diagnosis. It is upon these lines that Dr. Savill constructed his System. Each chapter (e.g., that on Lungs and Pleurae) is divided into three unequal sections dealing respectively with cardinal symptoms, physical signs, and finally with the diseases themselves, their diagnosis and treatment.

The complexities of modern medicine are so great that a classification in this way is no easy matter. Much cross-reference is necessary, and the reader will not immediately find the book easy to use. But on longer acquaintance its value should be appreciated. It cannot be recommended as a sole text-book, but to the senior student it should prove useful in making him alive to the possible alternative diagnoses of his cases, and to his junior colleague in making him realise the importance of an accurate appreciation of symptoms and signs.

In this edition alterations too numerous to list have been made, and no effort has been spared to bring the book up to date.

**R.R.A. REVIEW,** Quarterly Journal of the British Rheumatic Association. Vol. 1, No. 1. August 1950. pp. 32, Illustrated. Price 2s. 6d.

The increasing interest taken in the general welfare of the sick or disabled, and the increasing appreciation of the importance of the "rheumatic diseases," led to the foundation, in 1947, of the British Rheumatic Association, a lay body concerned with the social effects of such diseases. This association has produced the first number of a quarterly review which explains the history and objects of the association, describes various aspects of physical restoration—home treatment, industrial employment, the almoner's work—and provides much current information about the social aspects of rheumatism. To the medical student the only value of this publication would be as a reminder of the social background and implications of chronic illness, and as an example of the work of the many voluntary bodies, chiefly of laymen, which are tackling this aspect of disease.

**JOHN CLARKE, M.D. (continued)**

**Acknowledgements**

To the Treasurer and Registrar of the Royal College of Physicians for permission to reproduce the portraits of Clarke and Micklethwaite, and to make abstracts from the College Annals. To the Archivist of St. Bartholomew's Hospital for permission to make abstracts from the Hospital Journals.

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# SAINT BARTHOLOMEW'S HOSPITAL JOURNAL




MARCH 1951

VOL. LV No. 3

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

*Editor*: M. B. McKERROW. *Manager*: E. A. BOYSE.
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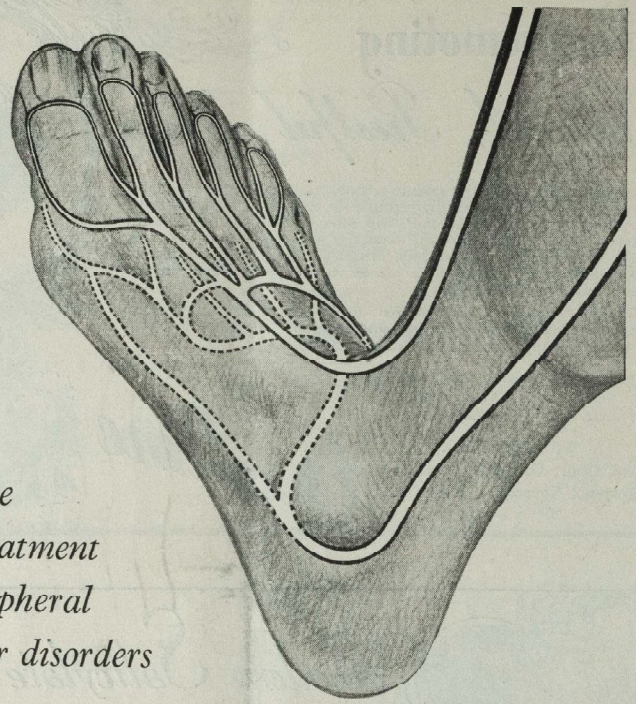
March, 1951

CONTENTS



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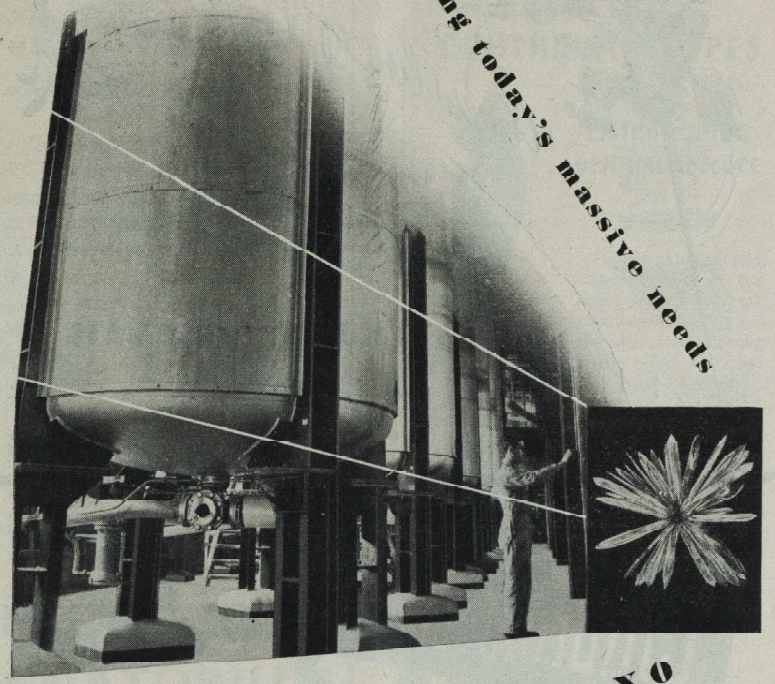

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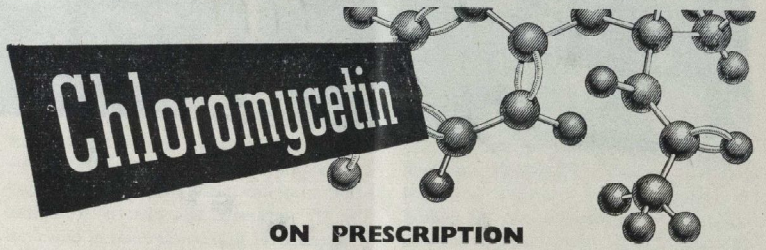

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# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LV MARCH, 1951 No. 3


## THE LIBRARY

"To study the phenomena of disease without books," said Osler, "is to sail upon an uncharted sea." This now famous dictum loses none of its truth by the inclusion of its corollary: "To study books without patients is not to go to sea at all." We need little convincing that books are essential to the study of medicine, however much we may try to persuade ourselves to the contrary. We see the glorious, though brief, moment of life our text-books enjoy. Their latest editions are awaited with eagerness, heralded with almost regal pomp and welcomed to the libraries of the medical schools and to the shelves of those students who can afford them. There they live their life of brief authority and then follow their predecessors into a premature, unhonoured old age.

There are, however, books other than text-books which come under the care of the medical librarian. There is that vast and luxuriant pabulum of the elect, which, for want of a better name, has become known as "the literature." These papers are the true stepping-stones upon which modern medicine has progressed. Then there are the ancient books, some of which repay attention scarcely less now than when they marked the furthest boundary of human knowledge. For the advance of medicine is a continuous process, and he who hopes to gain a clear understanding of present knowledge must give at least a fleeting glance towards the past. He will then not only find that he can see his subject in a truer perspective, but he will come upon countless instances when the chance and unrecognised observation of an ancient writer has played a part in solving a modern problem.

The library of this Hospital has grown from a few books belonging to the Medical and Philosophical Society (the forerunner of the Abernethian Society) to a collection of over 21,000. These books are housed in the main Hospital library and in the branch library at Charterhouse Square. The present remarks apply chiefly to the former, but this is in no way to depreciate the latter, for its prefabricated walls encase an interior of solid worth and lasting value. We are glad to publish this month an article by the Librarian giving "Hints on the Use of the Medical College Library." This we hope may do much to render the library more accessible to students, not only as a place of hurried reference or intensive study, but also for the leisurely reading of our more erudite colleagues who succeed in regarding their next examination as a milestone rather than as a goal-post. It may also help to dispel the occasional criticisms of the working of the library, many of which arise from misunderstanding.

Apart from the recurrent complaint about the poor lighting, criticism is centred on three points. Firstly, there are the locked cases, which stand in marked contrast to the open shelves of the smaller—and also less valuable—pre-clinical library. One feels, however, that in leaving unlocked those cases in most frequent use and allowing individual readers free access to the remainder, the Librarian has found a reasonable compromise which should satisfy most critics.

Secondly, the method of classifying the books has been called to question. It has been felt that some classification could be devised which would bring into a smaller compass all the books on each subject, and so make the reader less dependent upon the catalogue index.

The third criticism, which commands more general support, concerns the facilities for borrowing books for reading at home. The privilege of taking out books overnight is not one long possessed by the students, but the present high price and short life of text-books makes it greatly appreciated. An arrangement would therefore be welcome which would allow books to be taken out of the library earlier in the evening, and so would reconcile the needs of the comparatively few who read late at the Hospital with those of the many who wish to read at home.

However, criticism must not be the key-note of these remarks on the library, for there cannot be many of our institutions which provide less food for the critics. There cannot on the other hand be many users of the library who have not cause for gratitude to the Librarian for help which often goes far beyond the mere finding of a book. Perhaps, though, a little criticism may itself be a tacit acknowledgement of the importance of the library in our daily lives.

## ST. BARTHOLOMEW-THE-LESS

This photograph was taken at Christmas soon after the completion of the extensive repairs made necessary by war damage. The church was officially opened on January 11 when a service of rededication was attended by the Lord Mayor, Lady Mayoress, Sheriffs of London and a full congregation from the Hospital. The sermon was preached by the Dean of St. Paul's, Dr. W. R. Matthews.



# THE SIGNIFICANCE OF EMBOLISM IN FORENSIC MEDICINE

*By* DONALD TEARE.

ONE of my earliest recollections in my six months as a house surgeon is of a rather heavily built middle-aged woman who had sustained a fractured patella as the result of being knocked down by a taxi. After a suitable period of immobilisation, my "Chief" chose to demonstrate the case on a teaching round, and after having discussed the treatment he said, "Now we must start a little movement in the limb," and gently raised the leg and flexed the knee. The ward round passed on to the next case and the patient to the next world, for when I was hurriedly summoned by the staff nurse back to the patient's bed, she was dead—dead, as was shown at autopsy, of a pulmonary embolism resulting from thrombosed veins in the bruised and immobilised leg. I was, I will admit freely, rather shaken by the rapidity of death in an apparently healthy woman, and it was a lesson which has made me keep the possibility of embolism as a cause of sudden or unexpected death in my mind ever since. Here was a case where a relatively minor injury had suddenly become the subject of a coroner's inquest, and possibly of a charge under the Road Traffic Act, and almost certainly of a claim for compensation.

Little did I think then how many more cases of embolism I was to see, for looking through my files to-day, I find records of 255 cases of ordinary blood clot embolism, 32 cases of air embolism and 7 cases of fat embolism, and I sometimes wonder how many cases of air or fat embolism I may have missed. For, of course, it doesn't take much air or fat to kill, providing it is in the right (or wrong) place.

Not all these cases have been of true forensic significance—but the field of the forensic pathologist is not to-day confined to cases where criminal charges or civil charges for negligence may result, and indeed it falls to our lot to investigate cases of sudden or unexpected death, even though there is no suggestion of accident or criminal interference.

### Pulmonary Embolism

In the causation of ordinary pulmonary embolism, immobilisation of the lower limbs or limb, either by confinement to bed or some form of splinting, is undoubtedly the most common factor, and when this immobilisation is accompanied by infection or trauma, particularly in the pelvis or legs, then the chances of embolism are increased. A heavily built person in the latter half of life is also the more likely subject.

The emboli which result are easily distinguished from post-mortem clots by the fact that they are frequently coiled within the lumen of the pulmonary arteries, that they bear no relation in shape or size to the pulmonary artery, and that they are of a much more homogeneous colour than post-mortem clot and also are considerably firmer. One can generally pick up a pulmonary embolism by one end and all its ten or twelve inches will remain in one piece. A post-mortem clot would, of course, disintegrate under such treatment.

My first example, as I have told you, only converted an apparently simple accident into a coroner's case, but by the same token, an assault which has resulted in a charge of grievous bodily harm will, if the patient dies of pulmonary embolism resulting from the injury, become a case where a charge of murder may result. Some years ago, an East End jeweller was attacked in his shop by a youth, who inflicted severe head injuries on the old man. These were not immediately fatal and indeed, after three weeks in hospital, he appeared to be going on reasonably well, when suddenly he died of a pulmonary embolism and the youth was charged with murder. Some weeks ago, I performed a post-mortem on a man of 52, who had received a kick just below the right knee during the course of an altercation at his work. This injury did not confine him to bed. He had merely attended hospital, where he was given physiotherapy for his painful knee. Twelve days later, however, he had a sudden pain in the chest. He was admitted to hospital and died a few hours later of a second and larger pulmonary embolism. At autopsy, the deep veins of the right calf were found to be thrombosed. Those of the left calf contained fluid blood. There was considerable bruising around and below the right knee, but no trace of varicose veins, and the valves of his femoral veins were intact and healthy. In this case, the deceased man

was definitely known to have been the aggressor and no charge resulted, but had the boot, both metaphorically and literally, been on the other foot, a serious charge might well have resulted.

### Air Embolism

Air embolism is a more subtle and probably more interesting variant of the wide subject of embolism. I have seen it occur in many cases of operation on the chest, but particularly during artificial pneumothorax. I have also seen examples of air embolism in insufflation of the Fallopian tube, pneumoperitoneum, intravenous infusion, craniotomy and perforation of the lungs during intercostal block anaesthesia, as well as suicidal cut throats. It is, however, in criminal abortion that we meet air embolism most frequently, and it is of particular significance in this respect since, as it kills quickly, the deceased person is unlikely to have performed any but the most simple acts after the introduction of air into the pregnant uterus. In other words, she will die on the premises in which she has been aborted or rather, where an attempt has been made to abort her. One pleasant August morning some years ago, a young woman was found dead on the pavement of a street in Willesden by the local postman. She was fully clothed except that only one arm was through the sleeve of her jacket. The police noticed some marks on her throat, and asked me to examine her. The marks on the throat were actually on the upper part of the chest and proved to be second degree burns, which showed a lattice pattern, peculiar to a type of Utility hot water bottle, a sample of which I happened to have at home. It seemed unlikely that anyone carried a full hot water bottle about the streets of Willesden on an August night, on the off-chance of resuscitating some poor young woman who had had a heart attack in the street, and we not unnaturally thought that she had died in a house and that attempts had been made to resuscitate her before she was dumped on the pavement. The only other noticeable external finding was the presence of a little, slightly blood-stained froth about the mouth and nostrils. This I have found to be a not uncommon sign of death from air embolism, and I approached the autopsy with this in mind. Opening the skull first, I gently sawed through the outer table and tapped through the inner table and so exposed the inner arteries and veins with the minimum disturbance. Bubbles of air were clearly seen in the cerebral vessels and an incision in the lower abdomen then enabled the uterus to be felt. It was not only enlarged to a size in keeping with early pregnancy, but was definitely crepitant. This incision was then enlarged and the chest opened with a minimum of damage to the large vessels, and the heart examined *in situ*. Frothy blood was present on the right side and in the pulmonary arteries. The uterine veins, inferior vena cava, etc. were then examined and a continuity of bubbles was demonstrated between the uterus and the heart. In many of these cases, the air bubbles are peculiarly widespread, and it would appear that the pressure exerted by the Higginson's syringe, which of course is the usual instrument in these cases, is sufficient to drive air up the superior vena cava against the stream, and that also it is possible for air to pass through the pulmonary capillary barrier from the pulmonary to the systemic circulation. This young woman came from Clapham and in her possession was found a diary containing an address in this street in Willesden. Observations were kept on that address, and eventually after three young women had called at the address and had been intercepted by the police, the owner returned. When confronted with what little information the police already had about the deceased woman, she made a full statement in which she confessed to having used a Higginson's syringe on this poor girl. After introducing the nozzle into this girl's cervix, she had squeezed the bulb three times. The girl had got up and got as far as putting on her jacket, when she suddenly collapsed, and despite the remedial measures which had been applied, she had died almost instantly. The rubber hot water bottle was found in her kitchen together with a note in the deceased's handwriting, asking for an appointment for a fitting for another new dress, and expressing satisfaction with the results of a previous fitting.

This case illustrates very well the amount of voluntary movement of which a woman is capable after having had air introduced under pressure into the pregnant uterus. It must not be forgotten, however, that a woman, particularly a multiparous woman, is capable of introducing the nozzle of a syringe into her own cervix and so causing her own death. I have seen at least two examples of this happening, where there could not possibly have been any outside interference, and in one case, I am quite sure that the woman's death was an entire accident. In this case, every preparation had been made for the birth of a second child, but the woman had acquired a habit of douching herself for hygienic purposes while serving in the hot climate of the Middle East. One evening while alone with her small son aged 18 months, she had clearly carried out her hygienic routine with fatal results.



### Fat Embolism

I cannot say that I have seen a case of fat embolism which has had direct forensic significance, but since fat embolism is generally associated with fractures or damage to other fat depots, it can obviously have a potential forensic significance. About two years ago an Austrian cook aged 40 was brought into hospital, having jumped off the top of a two-storey house and landing on the soft earth of the front garden. She had sustained amongst other injuries a fracture of the left femur and a crush fracture of a lumbar vertebra. She was not unconscious and after her shock had been treated, she was very distressed and confused but otherwise mentally normal. She was given an anaesthetic for the treatment of her fractured femur and recovered consciousness after this manipulation. About two hours later, however, she had a fit of a generalised convulsive nature. This was followed by other fits increasing in severity and frequency. She lapsed into coma and died about 24 hours later. At autopsy, apart from her injuries, she was found to have multiple haemorrhages up to 3 mm. in diameter throughout her brain substance. They were particularly noticeable in the white matter of the hemispheres. Microscopic examination showed the presence of globules of fat within the vessels and the typical ring haemorrhages, which are characteristic of this condition. I have also known fat embolism to occur after electric convulsion therapy, and am particularly interested in investigating post-operative deaths where there may have been considerable trauma to fatty tissue, in the hope that fat embolism may be the explanation of an otherwise unexplained post-operative death.

Paradoxical embolism may be considered somewhat of a rarity. About 25% of adults have some degree of patency of the foramen ovale. In the majority of cases, of course, the patency is purely a valvular one, but, of course, it takes a much smaller quantity of embolus, whether it be clot; air or fat to kill on the systemic side of the circulation if it finds its way into a coronary or cerebral artery.

Embolism may, of course, also be the cause rather than the result of an accident. That is to say, a person with mitral stenosis may have a sudden cerebral embolism in the course of his daily life, which may cause him to fall in front of a vehicle or become caught up in any machinery at which he is working. Such cases must, of course, be rare, since the person who has had a recent myocardial infarct or is suffering from mitral stenosis or thrombosis of the left auricle is rather unlikely to be placed in such a position that an otherwise unfatal embolism would endanger his life.

It has been said that there are three types of post-mortem: An ordinary post-mortem, where the pathologist confirms the clinician's findings; an unsatisfactory post-mortem, where neither the pathologist nor clinician is able to explain the cause of death; and a satisfactory post-mortem, where the pathologist is able to explain circumstances which, to the clinician, were wrapped in mystery. So the finding of embolism may convert an ordinary or unsatisfactory post-mortem into a satisfactory post-mortem, for everyone except the deceased person and forensically speaking, for the person responsible for that death.

## ROUND THE FOUNTAIN

### INCREASE IN PRICE

**We give notice that the price of "Round the Fountain" is to be increased by one shilling from April 1, 1951. The new price will be five shillings and ninepence, post free. Copies may be bought before April 1 at current prices.**

# SOME NOTES ON RHEUMATOID ARTHRITIS

*By* G. D. KERSLEY

RHEUMATOID arthritis is now considered to be one of the " collagen " diseases or diseases of adaption. It is probably caused by some abnormality in the collagen matrix of connective tissue occurring in susceptible subjects when they undergo stress, whether shock, worry, infection, fatigue, or exposure. The symptoms and signs of the disease disappear on administration of large doses of A.C.T.H. or cortisone, but the disease does not appear to be caused by any deficiency of the adrenal cortex.

**Histology**

Changes are found throughout all the mesodermal tissues of the body. In the joints there is engorgement and lymphocytic infiltration of the capsular structures, a pannus of granulation tissue creeps in over the cartilage from the periphery and a similar granulation tissue erodes the cartilage from the cancellous bone below. Nodules consisting of areas of fibrinoid degeneration, surrounded by a palisade layer of fibroblasts are the most specific lesions and foci of lymphocytes together with degenerative changes in the small blood vessels occur in the muscles, fat and connective tissue of the body.

**Cortisone and A.C.T.H.**

Cortisone (17-hydroxy 11-dehydrocorticosterone) is a secretion of the adrenal cortex produced when the adrenals are stimulated by A.C.T.H., the adreno-cortico-trophic hormone of the anterior pituitary.

The adrenal cortex secretes three types of hormones: (1) the sex or progesterone like hormones; (2) the electrolytic (mineral or salt) hormones of which D.O.C.A. is the main example: and (3) the cortisone type or sugar (gluco-corticoid or 11-oxysteroid) hormones. The D.O.C.A.-like hormones are those that control salt and water metabolism in Addison's disease and they are partly antagonistic to the " sugar " hormones, which cause glycogen to be laid down in the liver at the expense of protein metabolism. It is this latter group which have such a dramatic effect in the collagen diseases, rheumatoid arthritis, rheumatic fever, spondylitis, lupus erythematosus, periarteritis nodosa, and dermatomyositis, and also in asthma, certain types of hypertension and in the allergy of ophthalmic and skin conditions. They seem to act as a brake on any over-reactive process of the body and, possibly through their effect on the matrix of connective tissue, appear to reduce the permeability of synovial membrane.

*Etiology.* From the above it may be surmised that a hereditary factor together with stress is significant in the causation of rheumatoid arthritis. These factors are, therefore, not dissimilar to those previously noted in gout.

**Diagnosis**

Rheumatoid arthritis is a generalised disease of which the presenting symptom is frequently a polyarthritis, which is apt to progress with partial remissions. The disease may, however, start and remain for several years confined to one joint and at times there may be complete intermissions (the episodic type). The tendency for the disease to progress with waves of remissions, and the fact that some 25 per cent. will improve and proceed to an almost complete recovery—whatever treatment is given—must be borne in mind in the assessment of therapy. The condition may commence in childhood (Still's disease), but the greatest incidence is after puberty and again at the menopause. Women are more commonly affected than men. There is a loss of weight, except in the menopausal type, anaemia is present and the sedimentation rate is raised. Both the latter features only vary very slowly with any treatment other than cortisone.

The activity of the disease process, the fire rather than the ashes, is gauged mainly on the presence of pain at rest, heat and swelling of joints, fever and loss of weight when present, the degree of anaemia and the sedimentation rate of the red corpuscles.

**Treatment**

Cortisone and A.C.T.H. cause a temporary damping of the fire of the disease, but general treatment is necessary to allow for any reasonable chance of the fire staying damped, and also the ashes require attention by orthopaedic and physical methods. Success depends on early treatment, a wide view of treatment and the treatment of each patient as an individual.

*Cortisone.* The essence of treatment with cortisone or A.C.T.H. is to give enough to produce a clinical remission and to tail off the dosage very carefully and slowly. In severe rheumatoid arthritis it is usual to start with 200 mgm. of cortisone or 100 mgm. A.C.T.H. for the first day and then gradually to reduce the dosage. Cortisone is given intramuscularly once or twice a day and A.C.T.H. eight-hourly. Within twenty-four hours the patient feels " better " and spasm and pain are eased. Within a week there is often a 75 per cent. recovery, mental stimulation, enormous appetite and increase in weight, lessening of swelling and tenderness, increase in movement and reduction of anaemia and sedimentation rate—the sedimentation rate is usually the last to normalise. If cortisone or A.C.T.H. is stopped suddenly, symptoms usually start to recur in about two days and may be very severe. Any psychotic tendency may be increased in degree.

*General Treatment,* which is so essential, consists of rest, both physical and mental, analgesics, good food, correction of any abnormality, possibly transfusion and especially removal of any trigger, which has helped to provoke the attack of rheumatoid arthritis.

*Gold* is still recognised as the most useful " semi-specific " treatment of active rheumatoid arthritis. Copper is less toxic but less powerful and only useful where there is a sensitivity to gold. With gold, the end result of treatment is probably upgraded by about 10—20 per cent. If a dosage of 10 mgm. x 2, 25 mgm. x 2 and then 50 mgm. weekly is employed and the clinical condition of the patient and especially the skin and urine watched there is little danger. BAL inactivates any gold in the system at once and penicillin controls infection during any temporary agranulocytosis. After 1 gm. of gold has been administered with benefit, it is often better to increase the interval between injections rather than to discontinue them enirely. 2 c.c. Colossol calcium given at the time of each gold injection may be of assistance.

**Physical treatment**

*The balance of rest and movement* is the first principle. Any inflamed hot swollen joint should be rested, if possible splinted, but should be put through as full a range of movement as possible once each day. Splintage for knees may consist of rest plasters as straight as possible from the toes to the upper thigh, and plaster or a perspex splint is used for the wrists during the day and for the whole hand at night. Slings and springs are useful for shoulders. Exercises in a warm pool or in slings or springs are necessary to retain mobility and promote circulation.

*Heat* may be used in the form of infra red, radiant heat, short-wave, diathermy, mud, wax or hot baths to improve the circulation and relax spasm.

*Counter Irritation* to relieve pain and improve the circulation may take the form of a blister, embrocation, the cautery, galvanism or ultra violet light.

*Contrast baths* of hot and cold water, commencing and finishing with heat, help to re-educate the circulation.

*Orthopaedic Surgery* plays its part, but lack of space forbids a discussion of this aspect of treatment. Much can be done to help the sufferers from rheumatoid arthritis. It is, however, by individual care, encouragement and perseverence that the best results can be obtained.



## OLIVER-SHARPEY LECTURES

Professor K. J. Franklin will deliver the Oliver-Sharpey Lectures at the Royal College of Physicians on March 13 and 15. His subject will be "Aspects of the Circulation's Economy."

Professor Franklin has also been appointed Visiting Professor of Physiology in the University of Illinois, Urbana, Ill., U.S.A. This appointment will last ten months from September 1, 1951.

## ELEVENTH DECENNIAL CLUB

The sixteenth Annual Dinner of the Eleventh Decennial Club will be held at Simpson's-in-the-Strand on Friday, April 13 at 7.15 for 7.30. Dr. K. W. D. Hartley will be in the chair.

Although 77 members attended the Dinner in 1950, it is hoped that Bart.'s men who entered the hospital between 1915 and 1925 and who subsequently qualified, but who have not attended meetings of the Club, will communicate with the Hon. Secretaries :—

Wilfred Shaw,
109, Harley Street, W.1.
F. C. W. Capps,
16, Park Square East, Regent's Park, N.W.1.

# A GENERATION OF MEDICINE AT BART'S

*By* GEOFFREY BOURNE

WHEN I was a house physician the treatment of diabetes was by diet alone, and of pernicious anaemia by transfusion. Coronary thrombisis was unknown, and psychiatrists almost unheard of. Before attempting to classify my impressions of a period so rich in advances in medical knowledge, two main principles, or generalisations, deserve consideration. The first is that our predecessors whose diagnostic and therapeutic facilities were so few as compared to ours, were every whit as able intellectually as any of their present-day pupils. The second is that a belief that we now know so much, whereas they knew so little, is fallacious. I suggest that whereas the knowledge available to them was one per cent. of what will be known in five hundred years time, that available to us is perhaps three per cent. of what will then be known. Therefore we, by our distant successors, will be regarded as being only slightly less ignorant than our teachers. A realisation of the extent of one's present-day ignorance is therefore a salutary antidote to any pride arising from the contemplation of those many and great advances in medical practice which have marked the last thirty years. Lack of knowledge so often engenders, as a defence mechanism, self-sufficiency and complacency.

The structure of medical practice at Bart.'s has become far more complex. In 1917 there were five medical firms, staffed by senior physician, assistant physician, and senior and junior house physicians. There were in addition two medical registrars who circulated widely round the wards, and whose chief duties were to make sure that the clinical notes were properly kept and properly collected and stored. There is some evidence that the Ministry of Health retains this archaic concept of the duties of these officers. They also performed the post-mortem examinations. The house physician's post was thus one of great importance and responsibility. He had either to importune his chief persistently or face his daily problems squarely and make up his own mind, helped by reference books and talks with his fellows. Dr. Drysdale, my chief, had no telephone, and stimulated the growth of this intellectual independence. "Your opinion, in a Court of Law, is as good as mine," he once said to me with a dry smile, over a case of heart failure in which I wished to do a venesection. The decline in the status of the house physician is, of course, an inevitable consequence of the increase in the number of chief assistants and registrars, which in its turn is a direct consequence of the ever increasing complexity of medical practice.

Another change very visible in the medical world is the increase in specialisation. If a specialist is one who knows more and more about less and less, it follows that great multiplication of factual knowledge, along widely diverging lines, will almost inevitably breed a race of doctors increasingly ignorant of general medicine. So greatly, for instance, have electrocardiography, phonocardiography, kymography, cardiac catheterisation, and radiography extended the province of this branch of medicine that Paul White now half-seriously describes himself as a general practitioner in cardiology. Such a statement is, of course, an expression of the fact that for medical practice to continue, with safety to the public, specialisation must be controlled by intelligent co-ordination. Co-ordination of this type is visible in a hospital like ours, in which the main medical firms are run by physicians who, although they may have a specialist knowledge, yet are in charge of, and teach on, cases of general medical interest in addition to those illustrating their particular speciality. The other type of hospital where selected cases are segregated under the care of pure cardiologists, pure enterologists, pure urologists, and so on, are valuable as research institutions, but they are probably less desirable from the point of treatment of the average medical case, which so often does not fit into an exactly defined category.

A contrary process of simplification is now fortunately visible in medicine. The antibiotics for example have rendered obsolete large tracts of painfully acquired knowledge. The exact classification of the pneumococci and meningococci is no longer essential, for treatment of these diseases by serum has nearly vanished. Similarly the pyogenic



complications of surgical conditions, gynaecological disorders, and gonorrhoeal disease, are rare. A really efficient cure for active rheumatism would similarly prevent much chronic valvular disease, and change the clinical landscape of cardiology.

Another new institution is the Professorial Unit System. This has injected into the clinical side an academic outlook on medicine, which has proved an invaluable corrective for the otherwise uncontrolled practising clinicians, and a potent stimulus to research and to scientific teaching.

The practising physician in his turn is valuable to a medical school, because he is trained to give an immediate opinion, on the available evidence. He cannot say to anxious relatives, "A correct diagnosis is impossible, we must wait for the post mortem." A combination of both types, professorial and consultant, is mutually beneficial.

In 1917 physicians regarded surgeons as uneducated boors, and surgeons regarded physicians as helpless highbrows. The attitude of the surgeons was founded partly upon the old tradition of Abernethian rudeness, partly upon the feeling that they at least did something for the patient; that of the physicians arose partly from a feeling that they had to treat cases, often incurable, which the surgeons could "do nothing for," and partly because in fact many surgeons knew little outside their somewhat limited field. I remember one cranial surgeon who was vaguely interested in the possible thermal effects of a lesion in the Rolandic area. He gave instructions that not only was the temperature to be taken on each side of the body, but the pulse rate also! Things have changed. Medicine has acquired far greater therapeutic power, and surgery has become as devoted a servant of physiology and biochemistry as her sister art. The present closeness of medical-surgical combination is perhaps seen at its best in cardiac, thoracic, thyroid, and nervous system therapeutics.

Since the old medical and surgical blocks opened directly onto the Square, it was here at 1.30 that the house physicians and clerks used to meet their chief. The wards themselves were airy, light, comfortable, and beautifully proportioned architecturally. Great coal fires provided in winter time an irresistible magnet for patients who were up and about, and added a homelike feeling of warmth and cosiness, contrasting delightfully with the London fogs which then either seemed to be, or were, more frequent and more suffocating.

On his round the physician was accompanied from bed to bed by house physician and clerks, and also by sister, blue-belt or staff nurse, and probationer. The round proceeded from bed to bed, and often lasted from 1.30 till 4.0 p.m. There was no sitting. It often became difficult to cerebrate after two and a half hours standing, and the more recent custom of sitting by the side of a patient and discussing his case and condition at length is a sensible innovation. Lack of cerebration in the clerks now is more apt to be due to sleepiness than to cerebral anaemia, and for this the physician may have only himself to blame. The clinical teaching itself was very thorough. A full and accurate history was insisted upon—it is no less important now. A detailed physicial examination from the scalp to the soles of the feet was required, and any sketchiness or slovenliness was strictly discouraged. Clinical pathology was a live and accurate adjunct to diagnosis, but the X-ray films were often so blurred and impressionistic as to be useless.

The nursing staff was as devoted and meticulously thorough as it is today. Sisters slept in a bed-sitting room suite next to the ward, and were thus tempted, in critically ill cases, to be on duty by night as well as by day. Chemotherapy has to some extent changed the character of the actual nursing. I have heard sisters regret the absence from the wards of the bad pneumonia cases, which used to run a full seven-day course from initial rigor to crisis, because of the magnificent scope they gave for the teaching of nursing details in acute and dangerous illness. Typhoid fever also, now less common, gave similar opportunity for arduous and skilled nursing.

Even students have changed. In 1914 there was still a stock of hardy perennials, habitués of the local bars and dives, and cognoscenti of Leicester Square and the music halls, who took twelve years or so to attempt and sometimes to achieve qualification. On any morning a few of these old soldiers, heads bivouacked under newspapers, could be seen in the Abernethian room, sleeping off the campaign of the night before. Today the pressure of serious matters, aided by the discipline committee, has nearly banished

this once characteristic type of medical student.

The actual practice of medicine during this period has been influenced partly by changes in the incidence and nature of diseases and partly by therapeutic advances. Many were the cases of severe rickets and of infantile scurvy I used to see at the East London Hospital for Children, to which hospital I was attracted early by the unrivalled opportunity of studying severe rheumatic heart disease. The disappearance of nutritional disorders, and the diminution in the violence of rheumatic carditis over the last twenty-five years, have corresponded to the development of welfare work, school medical inspections, and a general improvement in the standard of living over the same period. Bronchial carcinoma, now comparatively common, used to be rare. Coronary thrombosis, although now recognisable as such in some of Mackenzie's published records, was unknown to him, and to his successors up to about 1925. Only three members of the staff understood what auricular fibrillation was in 1917.

In this interval of time diabetes has become treatable by insulin, pernicious anaemia by liver and its successors, B.coli infections by sulphonamides, general paralysis by malaria, thyrotoxicosis by thiouracil, tuberculous meningitis by streptomycin, bacterial endocarditis and pneumonia by penicillin; and this incomplete list is added to almost weekly, as antibiotic therapy advances.

In the old days the outcome of a bad case of lobar pneumonia would depend upon the most careful medical judgment and the most devoted and skilful nursing. The patient's strength had to be husbanded for the inevitable seven to nine days' struggle. At the onset morphia might be given for sleep, or to alleviate pleural pain. For a day or two it would not dangerously inhibit cough, since the superadded bronchitis had not yet developed, and sputum whose retention might later accentuate pulmonary collapse and anoxaemia was as yet scanty. After that brief period morphia would do harm, not good. The issue in a critical case might depend on the correct use of this drug. A pneumonic, previously used to considerable alcohol, would do better if the accustomed quantity were not withheld. Here again the restlessness and sleeplessness due to alcohol withdrawal might just load the scale against recovery. The value of digitalis, as a support to the heart in the later stages of the disease, was much debated, some authorities giving it from the start as a routine, others withholding it but using strophanthin intravenously later if an emergency arose.

The paucity of really efficient remedies was the true reason for the wide use of so many pharmacological preparations now recognised as being inactive. To do something was better than to do nothing, both from the patient's and from the doctor's point of view. Strychnine and arsenic were used as tonics, citrates and acetates were used as febrifuges, camphor by injection was employed as a cardiovascular stimulant, copaiba and buchu as urinary disinfectants, dilute hydrocyanic acid as a gastric sedative, and iodides as inhibitors of arteriosclerosis. Thus many remedies were used optimistically by those whose critical sense was overpowered by the exigencies of practice or the importunities of patients.

Severe diabetes in a young individual could be helped by careful dieting. I recall a young city clerk, aged about 25, who was admitted twice, at intervals, in a pre-comatose state. He had the greatest courage, and had always tried intelligently to follow the advice he was given. On admission he would be placed on a diet beginning with one or two starvation days, during which he was allowed water, tea without sugar, meat extract in hot water, and other similar calorie-lacking substances. The next two days would be "vegetable egg days" in which he was allowed greens and salad with, I think, two or three eggs. Subsequently he followed a "ladder" diet which was so designed that it contained a minimum of protein and fat, and substances whose carbohydrate percentage content was low, although as day followed day, the total amount of carbohydrate was progressively raised. The rationale of this programme was that the starvation days, and the early days when the diet was nearly devoid of carbohydrate, provided a period of rest for the islets of Langerhans. The low percentage of carbohydrate throughout the treatment presumably insured a slow rate of sugar absorption and therefore prevented the blood sugar remaining at a figure which would of itself inhibit pancreatic function. These theories were correct, and the treatment, however



long and wearing, did enable such cases to be helped over crises in their disease, and kept them alive. The young clerk, a severe case, hung on, although very thin and gaunt and slightly yellow from carotinaemia, until insulin rose like a sun upon the diabetic scene. His was the first case treated on our firm, and well he deserved the reward of his faith and courage. Within three months he had nearly doubled his weight. This example can never be out of date. No condition should nowadays be regarded as hopeless. Provided life can be maintained, an effective cure of almost any disease may at any moment be imminent.

In certain respects medical practice will not change. A full history, the fullest and most detailed possible, is the most valuable preliminary. It will not only reveal in many cases the correct diagnosis and prognosis. It will enable the physician to make that close contact with the patient which is so essential for mutual confidence. The physical examination also should still be as thorough as possible.

It is in relation to accessory methods of investigation that two schools of thought have developed. My chiefs and teachers were loth to ask for blood counts, agglutination tests, or X-ray examinations unless they had a clearly formulated question to which they required a positive or negative answer. This is the selective method.

There is now a tendency to employ every conceivable and available accessory aid, however remote the possibility of usefulness may be. This is the dragnet method. It should always be remembered that special tests may be incapable of giving an answer in a hundred per cent. of instances, that technicians may err, that reports may get shuffled, and finally that a positive answer may mislead. For instance, a patient with cardiographic evidence of a coronary occlusion may in fact be suffering from gallstone colic; or a tabetic may actually have a penetrating duodenal ulcer. The history in such cases is the better guide. In a word mechanisation is no substitute for cerebration. Both methods have disadvantages. The dragnet method is limited by considerations of finance, and by the size and the technician population of special departments. The selective method is limited by the clinical skill and experience of the physician employing it. Thirty years ago the dragnet was smaller and its meshes wider.

But then, as now, whatever the approach to a clinical problem, the best doctor will be persistently and intensely intellectually cynical, never accepting as evidence anything that he or she has not adequately checked and cross-checked. Furthermore he will be insatiably curious, always trying to elicit the smallest details of information about symptoms, physical signs, investigation results, and theories. This attempt to direct medical practice in accordance with the fundamental criteria of the scientific method characterised the clinical activities of the best of my teachers a generation ago. It remains the guiding principle of the best of my contemporaries and will inspire those who follow us. The words of the Latin poet are as true of intellectual climates as they were of the geographical world, "Coelum non animum mutant qui trans mare currunt."

But in another respect also it is to be hoped that the tradition of our hospital will never change. There have of course always been bad doctors, and doctors whose first thought is their own comfort and interest. The percentage of these among Bart.'s men is, we always like to feel, small. But recent events have done much to intensify a sense of personal frustration and irritation throughout the population, and the medical profession is not immune to this influence. As a result the sense of professional duty is sometimes in danger of replacement by more personal and selfish feelings. I recently was told by a physician that he made, after much cancellation and reorganisation of his programme, a long country visit to see a friend who was dangerously ill, in a provincial hospital. On arrival he received the message "Dr. Lumbricus"—the only resident medical officer who knew anything about the case—"has his day off today, so he could not wait in." "I has my rights" might serve as the motto and the moral creed of the present day. Duties are unfashionable. The proud boast of St. Bartholomew's is, and has been for generations, that the patients' interests and comfort come before every other consideration. My teachers, and their nursing colleagues, accepted this living article of the Religio Medici, and transferred its flame, brightly burning, to their pupils. May we in turn transmit it, exposed though it is to the blasts of selfishness and ignorance which moan and bellow round the world today, vivid, lucent, and undimmed to our heirs.

## HINTS ON THE USE OF
# THE MEDICAL COLLEGE LIBRARY

*By* JOHN L. THORNTON, Librarian.

ALTHOUGH most of the book-cases in the main Medical College Library are locked, this is not to prevent the books being used, but to preserve them for the use of all interested in their contents. It will be appreciated that in a library that has existed for 150 years, there must be volumes of high monetary value, and even text-books in current use must be preserved, for their replacement is not merely a question of payment. Editions are still comparatively small, and popular books quickly become out-of-print, so that grave inconvenience can be caused to large numbers of readers if these volumes are illegally removed from the library.

It has been suggested that readers would be interested to know how the books are arranged in this library, for although an annotated diagram is displayed, one tends to wander round the alcoves looking at the backs of books, and perhaps wondering if there is any methodical arrangement. There is, and the diagram printed here will assist readers to appreciate a description of the arrangement of the stock.

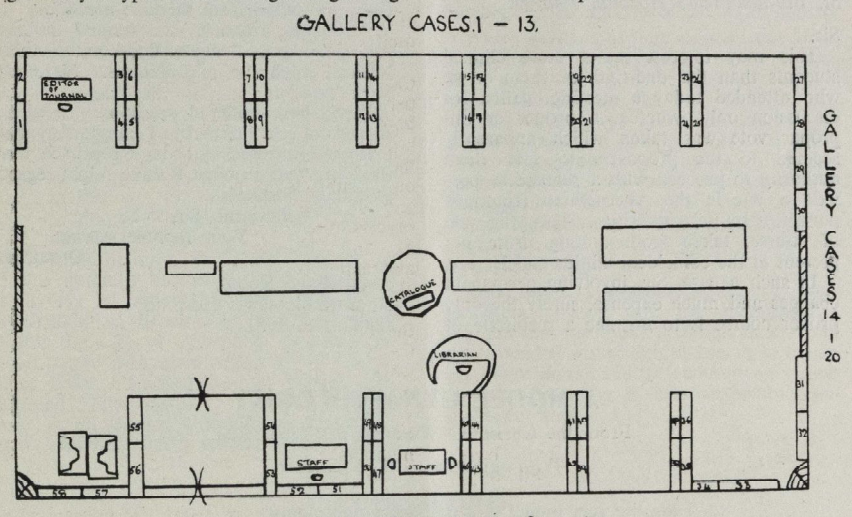
The contents of the library may be divided into four groups : (a) current text-books and reference books ; (b) periodicals ; (c) Athenae Collection of writings by Bart.'s men : (d) historical writings and older text-books. A tour of the main body of the library will introduce one to these in the following order. Cases 1 to 13 (the first 3 alcoves) house the Athenae Collection of Writings by Bart.'s men. The books are arranged in alphabetical order, so that all the writings of an author are together. Our aim is to collect every book, medical and non-medical, in every edition, by Bart.'s men, and authors have been most generous in presenting us with their writings to be housed in this Collection. It presents a record of our contribution to literature and medicine, and an examination of the books reveals many prominent men who have been associated with this Hospital, some as members of the staff, and others as students. We also collect reprints of articles by Bart.'s men published in periodicals, these being eventually bound, and shelved in the Athenae Collection. Complete coverage is impossible, but the Collection is three times as large as it was ten years ago, and has been used extensively.

Generally speaking, the upper shelves of Cases 14 to 26 contain volumes of periodicals, and the lower shelves house text-books grouped by broad subjects. These books are arranged alphabetically within these subjects, but the most popular books on all subjects are housed in Cases 45 to 46 and 48, these being unlocked to permit readers direct access to the books. Cases 41 and 42 contain bibliographies and abstracting periodicals, and are unlocked, as also are Cases 30 and 32 containing recent volumes of the *British Medical Journal* and the *Lancet* respectively. An entire alcove, Cases 49 to 54, is devoted to biography and works on the history of medicine. All the other cases downstairs contain bound volumes of periodicals, together with unbound parts, with the exception of current numbers. These latter are found in covers on the tables.

In the Gallery will be found the older books, together with certain periodicals no longer current, and early volumes of the *Lancet* and the *British Medical Journal*. The books are arranged chronologically by centuries, and alphabetically within those periods, with the exception of the writings of pre-seventeenth century authors, which are more strictly chronological. These are found in Case G.1 and are grouped as Egyptian, Greek, Byzantine (A.D. 476—732), Mohamedan and Jewish (732 — 1096), Mediaeval (1096—1438), and Renaissance, *etc.* (1453-1600). Case G.2 houses the seventeenth century material arranged alphabetically by authors, and later centuries follow on in similar array. It is impossible closely to classify medical books, and our arrangement ensures (a) that an author's books are together ; (b) that they are in proximity to books published during the same century. Folio volumes too large to shelve with normal sized books are housed in the large cupboards beneath the cases in the main body of the library. Where these, and also books in the Athenae Collection, should appear in the normal chronological arrangements, red-backed guides refer one to their actual location.



The key to any library is not found in the arrangement of the books on the shelves, but in the catalogue. For some years re-cataloguing has been in progress, and gradually a typed card catalogue is growing.




This consists of an alphabetic arrangement by authors, and an alphabetico-subject arrangement using headings adopted from the *Quarterly Cumulative Index Medicus*. Entries are arranged chronologically under these headings, so that those in search of the most up-to-date information, and also the historian, are catered for.

In addition to books, the library houses a large collection of prints, and also of reprints from periodicals. Two series of the latter devoted to biography and the history of medicine prove very useful to those interested in these subjects. Readers can have access to all this material upon application to the library staff, and those desiring to " browse " can borrow a key that will give access to all the bookcases.

The library regulations are brief, and are here reproduced from the Medical College Handbook :

1. The Library is open to all students of the Hospital.
2. The Library is open daily from 9 a.m. to 7 p.m. (Saturdays until 12 noon).
3. While primarily a reference library, books may be borrowed overnight (from 6 p.m. until 10 a.m.).
4. Borrowers must sign tickets for books removed from the Library, and return all books to the Librarian's desk when done with.

Smoking is permitted in the Gallery of the Library, in those alcoves where ash-trays are provided.

While it is impossible within the limits of a single article to provide exhaustive information on the Library and how to use it, the above hints should enable readers to find requisite material, and the Library Staff can be consulted if difficulties arise.

## THE VICAR

Everyone connected with Bart.'s will learn with regret that Canon E. F. Donne has left to take up an appointment as Vicar of St. Peter's, Cranley Gardens, S.W.7.

Canon Donne came to Bart.'s in 1933 as Assistant Hospitaller. He was granted leave of absence in 1939 to join the R.A.F., and returned in 1945 as Vicar and Hospitaller. He held this position until the middle of January this year.

## CORRESPONDENCE

### BAR IN THE A.R.

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

Sir,

This may interest rather more clinical students than the one-sixth of them or so who attended today a meeting, called for discussion only, whereat a proper or improper vote was taken which apparently seemed to the proposers to give them authority to proceed with a scheme to provide a bar in the Abernethian Room, if permitted by the authorities. This vote was, of course, taken from among those not present at the coincident clinics and lecture.

In such a case, Sir, involving permanent changes and much expense, surely the only proper course is to arrange a plebiscite of those to whom the Medical College has given the privilege of a Common Room. Concern is felt when privileges possessed by a democracy are taken from them *in absentia.*

Advisably, fractures are treated on one side of Giltspur Street and thirst on the other; reversal might be unpropitious. *Ne sutor ultra crepidam.*

I may be considered reactionary, even be accused of eclecticism, but I cannot deny that I am unimpressed by today's reproach that there are bars in what Rahere might regard as cottage hospitals.

Believe me, Sir, to be
Your humble servant,
DIOGENES

Abernethian Room,
St. Bartholomew's Hospital
January 8, 1951

## A MODEL GYNAECOLOGIST

From the Christmas Ward-Show "Tiber Rag."

*With apologies to W. S. Gilbert*

I am the very model of a modern gynaecologist
In feminine pathology I am no mean apologist,
In matters appertaining to the arts that are obstetrical,
I'll have you know I have a flair that's really quite theatrical.
My surgical technique you'll see is something most sensational
With lots of witty back-chat that is semi-conversational,
I can perform efficiently a Wertheim's hysterectomy
As fast as anybody else can do a tonsillectomy.

All clinical conundrums I can solve with great agility,
For problems diagnostic I've exceptional ability.
In fact as doctor, counsel, friend and practical psychologist,
I am the very model of a modern gynaecologist.

With knife in hand I am prepared for anything abdominal,
For range and versatility my repertoire's phenomenal.
I am not loth to implement those measures thought heroical
And then ignore my critics with a sangfroid that is stoical.
I woo my patients skilfully with tact that is traditional,
But anything I do outside, of course, that comes additional.
My private clientèle I count in numbers astronomical,
Its only on my teaching rounds that people find me comical.

In my blue book the facts I've laid in order categorical,
For future generations in a manner quite historical.
In fact as doctor, counsel, friend and practical psychologist
I am the very model of a modern gynaecologist.



## THE STUDENTS' UNION ANNUAL BALL

Held at the Dorchester on Friday, January 26, 1951

Oh for a classification which would enable us to assess a social function with pathological accuracy!—or should I say with the accuracy of a pathologist? We toyed with the idea of adopting such criteria as, for instance, sustained verticalness on the part of those attending. The at-some-time-horizontal group (we feared many would fall into this category), might be subdivided into those attaining this position by virtue of:—

1. Inadequate or over-ambitious floor technique ("hitting the floor"), and
2. Hitting the bottle.

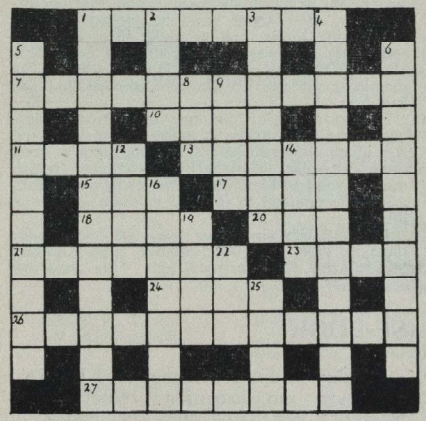
It should be noted that 1 and 2 are by no means mutually exclusive. With regard to 1, it may be remarkable that not all scars attributable to the surgeons have their origin within the walls of a hospital. In future we shall regard with some suspicion any below-knee lesion displayed for our benefit with a proud "That was Mr. . . . in 1951." However, in all fairness it should be stated that it was the high spirits accompanying a large proportion of the more energetic dance numbers which constituted the major hazard.

Which reminds us that we were not alone in feeling a trifle cheated by the capricious order and grouping of the dances. We personally like to take the floor fortified with (among other things) at least a vague notion of what the next five minutes will bring forth. We should resent any suggestion that our view that "from waltz to polka without warning can become rather wearing" is merely indicative of premature senility. We might of course admit to being a little conservative, perhaps . . .

This minor complaint aside, we were genuinely pleased with the arrangements. We feel that the many members of the staff who attended would like to join us in thanking John Pittman and the committee for their part in providing a most enjoyable and successful evening.

E. A. B.

## CROSSWORD



**Clues Across**

1. Used as a stretcher (8).
7. Reserved for the use of members of an older University? (5, 4, 3).
10. Appropriate wear (4).
11. Its prophyeactics are often spheroidal (4).
13. Congestion of this will cause slow progress (7).
15. The affirmative part of the subject of ophthalmology (3).
17. Hidden space in a bare abdomen (4).
18. Toast without tea makes unattractive diet (4).
20. In short, take away the last letter and a metal becomes incorporated (3).
21. Goes with a bhang! (7).
23. In little Edward it indicates myopia (4).
24. Suffering from severe dehydration (4).
26. COCOANUT PAIL (anagram) (12).
27. Shepherd smitten by the gods (8).

**Clues Down**

1. Ten breakfast cups or eight tumblers (6, 6).
2. Attractive birds (4).
3. War-time habitat of the nightingale? (7).
4. These therapeutic agents really make one blush (12).
5. The offspring of an incompetent valve? (6, 4).
6. Steeple head (10).
8. Sounds as if it were said in Latin (3).
9. Change of Rome (4).
12. To do this you need it beheaded (4).
14. Morasses (4).
16. Secure a piece surrounded by pus (5, 2).
19. Sap of the coco-palm (4).
22. Sink to the bottom (3).
25. Laid up on the telephone (4).

L. J. C-W.

# OBITUARY

## CHARLES ERNEST WEST, F.R.C.S.

Mr. C. E. West, who died at his home at Budleigh Salterton, on January 1, aged 77, was Consulting Aural Surgeon to this Hospital, and will be remembered by many of our readers also as an outstanding operator, a fine teacher and a man of exceptionally wide interests.

*Photo by courtesy of The Lancet*

He was educated at the Merchant Taylors' School, Crosby, and at Balliol College, Oxford, which he entered with a classical scholarship. He gained a first in classics, and then, turning to chemistry under Sir John Conroy, he obtained another first in natural science. He decided then to enter medicine and remained at Oxford to read anatomy and physiology. In 1897 he won an open scholarship to St. Bartholomew's Hospital. His career as a student there was a distinguished one, and before he qualified in 1900 he had won the Brackenbury surgical scholarship and the Sir George Burrow's prize in pathology. His first appointment was as House-Surgeon to Mr. Alfred Willett, and in 1902 he was made a junior demonstrator in anatomy. It was probably due to the influence of Sir Holburt Waring, then head of the Anatomical Department, that West turned his attention to deseases of the ear rather than to more general surgery.

While holding his anatomical appointment West became chief assistant to the Aural Surgeon, Mr. A. E. Cumberbatch, whom he succeeded five years later. His early work, under Sir Frederick Andrewes and Lord Horder, was concerned with the bacteriology of the ear, a field hitherto little explored, and the results of his research are contained in several papers published in the Hospital Reports and elsewhere. Perhaps his greatest contribution to aural surgery arose from his skill in the operating theatre; he was neat in his work, fearless in undertaking the almost hopeless case, and where necessary extraordinarily swift. But this Hospital has especial cause for gratitude to him for his work in reorganising the Aural Department when it moved from the old surgery to the out-patient block. Some of the difficulties under which the department had worked at the time when West joined it were described by Mr. A. E. Cumberbatch, "Hearing tests are handicapped by the re-echoing din of the surgery, babies are screaming in the hollow distance, through the open doors comes the crash and rattle of traffic over the stone setts in Smithfield . . ."

As a teacher West possessed great ability, for he thought clearly and could pass his ideas on to others in phrases which were always well-chosen and memorable.

In addition to his hospital work to which he devoted so much of his energy, West built up a large private practice. He retired in 1921 at the age of 48, and was elected Consulting Aural Surgeon and Governor of this Hospital, but he went to live at Falmouth where he was able to pursue one of his favourite hobbies, sailing and motor-boating. After some years he moved to Sturminster in Dorset, and he lived there until the end of the late war. During the war he became Medical Officer to the local Home Guard. The remaining years of his life were spent at Budleigh Salterton.

He never lost his life-long interest in gardening, in the countryside, in music and in literature. A brilliant conversationalist, a connoisseur of good things, a man of strong convictions, though reserved and modest about his own accomplishments, he retained to the end his keen interest in life.

His first wife died a few years after their marriage in 1908. He later married Miss Kathleen McCrossan who survives him. He had no children.

# CLINICAL CASE-BOOK

Mr. M., aged 34, an engineer. Admitted as a duty case.

**Presenting symptoms**

3 days' epigastric pain;
2 days' constipation;
1 night's continuous vomiting.

**On examination**

Tongue dry and furred.

Rigidity in upper abdomen; no localized tenderness; no distension; bowel sounds present. P.R. tenderness in pouch of Douglas. T 96°F; P 128/min.; R 30/min.

**Differential Diagnosis** on above findings

1. Intestinal obstruction. *For:* pain, vomiting, constipation. *Against:* absence of excessive bowel sounds.
2. Appendicitis. *For:* furred tongue, vomiting, pain. *Against:* absence of localised tenderness, raised pulse-rate.
3. Peritonitis (e.g., following either of the above). *For:* rigidity, vomiting, raised pulse-rate. *Against:* presence of bowel sounds.

It was decided to admit the patient at once as an acute surgical emergency, and another surgeon was called in for consultation. He observed (1) the patient looked dehydrated, and (2) acetone in the breath. It was decided that nothing could be done until the acidosis and dehydration had been corrected. A fuller history was taken from patient and his parents.

**History of present condition**

Patient quite well until:—

*6 weeks ago*—gradual onset of thirst, polyuria, sore throat. Friends noticed his getting thin and eyes becoming sunken. Began to pass urine half-hourly during day and 1—2 hourly during night.

*3 weeks ago*—developed pustular follicular rash and muscular cramps.

*2 weeks ago*—increasing constipation.

*3 days ago*—2 premolars removed, and house-surgeon noticed peculiar smell in breath. Epigastric pain that evening. It was now established that vomiting had occurred several days before the epigastric pain.

*24 hours ago*—increasing depth of respiration and drowsiness.

**On re-examination**

*Head and neck.* Eyes sunken; looks dehydrated; skin elasticity greatly reduced; thin; colour excellent; condition of teeth—poor; tongue dry and furred; fauces dry; acetone in breath. Trachea central, cranial nerves N.A.D.

*Pulse.* Fast, small volume. B.P. 112/76.

*Chest.* Breathing deep and regular.

A.B. sixth space, 4 inches from mid-line, heart over-active. First sound split at apex and P.B. Otherwise N.A.D.

*Abdomen.* Excessive movement; localised tenderness; no true rigidity; muscles become taut on expiration (which is forced), but go slack on inspiration. No distension; bowel sounds present. P.R.: rectum empty, no tenderness.

*Limbs.* Hands and forearms cold, no sweating. Reflexes all brisk.

*Urine.* Yellow-red reduction with Benedict's; albumin and ketones present. Sp. G. 1027.

**Special investigations**

Blood sugar 610 mg.%.
Blood urea 56 mg.%

**Diagnosis**

Diabetic ketosis.

**Points of special interest.**

1. Presentation of the early diabetic ketosis as an acute abdominal emergency.
2. Insidious onset of the diabetic coma.
3. Its precipitation by dental extraction.
4. The importance of taking an adequate history and testing the urine.

I wish to thank Dr. Morgan for permission to publish this case and for his helpful criticism.

L. F.



## DEATH

We announce with regret the death, on December 31, 1950, of Dr. G. W. Parry, M.C., of Abergavenny, Monmouthshire.

# EXAMINATION RESULTS

## UNIVERSITY OF LONDON

### Special First Examination for Medical Degrees

**December, 1950**

Blake, H. V. Hewer, R. L. Stainton-Ellis, D. M. Williams, J. C. L.
Henderson, E. E.

**The following External Candidates have completed First Medical**

Dale, S. L. Gray, J. Michael King, H. A. P. Wood, P. H. N.
Damment, J. F. D.

**The following Higher School Candidates have qualified for exemption from First Medical**

Taylor, J. K. Walton, W. J. Womersley, B. J.

### M.D. Examination

**December, 1950**

**Branch I (Medicine)**

Campbell, F. G. Howells, G. Kok, D'A. Routh, C. D.
Claremont, H. E. Jackson, P. E. Macauley, J. C.

**Branch II (Pathology)**

Hanbury, W. J. Le Bouvier, G. L. Reese, A. J. M.

**Branch IV (Midwifery)**
Leverton, J. C. S.

**M.S. Examination** **December, 1950**

**Branch I (Surgery)**
Rowntree, T. W.

**Examination for the Academic Postgraduate Certificate in Public Health**
**December, 1950**

Fawkes, M.A.

## SOCIETY OF APOTHECARIES

**Final Examination** **December, 1950**

**Surgery** Wallace, J. R. C.
**Medicine** Wallace, J. R. C.

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

Wallace, J. R. C.

## ROYAL COLLEGE OF SURGEONS

**The following are entitled to the Diploma of Fellow:—**

| | | | |
|---|---|---|---|
| Armstrong, J. H. | Jamieson, J. G. | Manning, C. W. S. F. | Richardson, J. W. F. |
| Bentall, H. H. | Katz, A. | Moffat, J. R. | Routledge, R. T. |
| Burwell, H. N. | Kingdom, L. G. | Owen, K. | Siegler, I. |
| Dobree, J. H. | Madan, J. K. | Perkins, F. S. | Thompson, M. R. |
| Hurt, R. W. L. | | | |

## SO TO SPEAK . . .

**. . . or your money returned.**

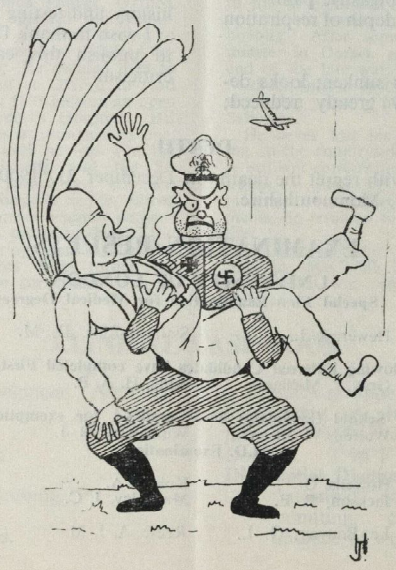
"MIDWIFERY FORCEPS, forged from finest Sheffield stainless steel . . . Prompt delivery guaranteed."

*From an advertisement in a medical periodical.*

**Held, Sir!**

"He . . . was dropped three times in France and caught once by the Gestapo."

*—From a clinical lecture.*





# SPORT

## RUGBY CLUB

**Rugger Notes, January.**

A special word is, I think, due to the "A" XV who, after a shaky start to the season, seem now to have found their form. This month they have just lost to Blackheath "A" 6-8, beaten London Hospital "A" 8-0, taken an unbeaten record off the Radcliffe Infirmary by defeating them 14-9 at Oxford, and beating Catford Bridge "A" 22-0.

January 27 was quite a red-letter day for the rugger club. All four teams won, amassing a total of 101 points for to nine against.

**v. CHELTENHAM,** January 13.
Result: Lost 0-20.

Bart.'s lost to Cheltenham at Cheltenham by 4 goals to nil this afternoon. Cheltenham were the better side both forward and back, and indeed must rank as one of the strongest sides in the country, though the margin of their victory was nevertheless flattering on to-day's showing.

Bart.'s kicked off and after a forward rush Fitzgerald intercepted a Cheltenham pass. He kicked ahead and arrived across the Cheltenham line at the same time as a covering opposition forward. Cheltenham then attacked and after 15 minutes crossed the Bart.'s line for a try. This was brilliantly converted from the touch line by the Cheltenham full-back.

Ten minutes later as a result of a forward rush De Nobriga the Cambridge blue and Cheltenham lock-forward crossed for a try ten yards in from the touch line. This again was converted.

In the second half play was pretty even until the Cheltenham wing took an excellent cross kick from his fly half and went over to score.

The Bart.'s forwards played well against a heavier pack, and made many gallant loose rushes but they failed to gain possession by heeling from the loose scrums.

In the last minute of the game the Cheltenham wing forward scored as a result of a break-through from a line-out on the Bart.'s 25. This, too, was converted into a goal at the hands, or should I say the feet, of Walters, the Cheltenham full back.

It was a fast and excellent game and the Bart.'s team put up a good fight against a better side.

**Team:** J. M. Kneebone—J. K. Murphy, K. A. Clare, V. P. Caiger, A. D. M. Thomas—M. J. A. Davies, A. Mackay—T. M. Pearce, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.), D. W. Roche, M. V. J. Fitzgerald, G. W. Mears, J. Tallack.

**v. LONDON UNIVERSITY** at Motspur Park, January 17.
Result: Won 3-0.

St. Bart.'s beat London University by a try to nil; this result was most encouraging for two reasons—first it was time that the Hospital did win, and secondly because of the favourable comparison of the result with those of the University against St. Mary's and Guys.

The weather was fine and crisp, and the pitch heavy as a result of its being devoid of grass. For the first quarter hour the play was even, neither side obtaining more than a brief foothold in their opponents' 25. Then Bart.'s heeled from a series of scrums and line-outs and took the play within a few yards of the University's line, only to be forced back to the half-way line. The reason for this failure to press home their advantage was twofold; the forwards were not binding in the loose scrums and line-outs, thus permitting their opponents to descend on Mackay, the scrum half, just as he got the ball and then when the ball did get to the outsides they were so slow in their stride that they could not help but be caught in possession. A notable exception to this was Davies who always looked dangerous and was playing really well, his only fault being the fatal fascination the opposing full back had for his kicks ahead.

Half time came with no score but Bart.'s were morally on top. When play was resumed, the game developed into a forward battle with very little constructive outside play. Bart.'s were just the superior side forward but did not look like scoring until a quarter of an hour before time, when a good outside movement broke down just short of the University's line, and from the resulting scrum Bart.'s pack almost scored a push-over try, only being thwarted by the scrum collapsing just short of the line and the just award of a penalty against them.

Soon afterwards Baker, at full back, caught a kick ahead by one of their three-quarters and ran down the middle of the field, selling a series of brilliant dummies (or did the anxious expression on his face denote a real intention to get rid of the ball?) and finally passing to our ubiquitous secretary who appeared from nowhere to take the pass and cut his way through; just short of the line he was tackled and passed to Mears who crashed over for a try.

Davies was the outstanding player, showing a welcome return to form after a disappointing start to the season, and the return of the captain, Havard, to the pack inspired them to show a fire and life which had been lacking in previous games. Corbet's second appearance of the season promised well, and we hope to see more of him.

**Team:** M. Baker—J. L. M. Corbet, K. A. Clare, V. G. Caiger, J. K. Murphy—M. J. A. Davies, A. Mackay—J. F. Pearce, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.), D. W. Roche, M. V. J. Fitzgerald, G. W. Mears, J. Tallack.

**v. TAUNTON** at Taunton, January 20.
Result: Lost 3-16.

It was a very heavy ground on which Bart.'s took the field this afternoon, in fact for the two previous weeks the ground had been under water.

The first half consisted of much scrappy forward play on both sides, and though we were awarded several penalties within easy kicking distance of the goal, unfortunately none were converted. The half-backs were combining well and shortly before the end of the first half Davies found a gap in the Taunton defence and passed to Clare who, defeating his man, sent Corbet over to score between the posts—once again the kick was unsuccessful.

The second half was not a happy one for the Bart.'s forwards who lacked co-ordination and failed to heel in the loose. Because of the superiority of the Taunton pack in this department their three-quarters were given the opportunity to

score three tries, two of which were converted. During this half a little light entertainment was provided by our touch-judge who slipped in the mud and fell flat on his face, much to the delight of the crowd.

Just before full time a Bart.'s infringement in front of the posts gave Taunton an easy penalty which brought the final score to 3-16.

**Team :** J. M. Kneebone—J. L. M. Corbet, J. K. Murphy, K. A. Clare, G. Picthall—M. J. A. Davies, A. Mackay—J. F. Pearce, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.), D. W. Roche, J. Tallack, G. W. Mears, M. V. J. Fitzgerald.

**v. CATFORD BRIDGE,** January 27.

Result : Won 22-3.

The Hospital XV were in great form this afternoon when they defeated Catford Bridge at Chislehurst by two goals, two tries and two penalties, to a penalty. It was a dry, crisp, sunny afternoon, and conditions were ideal for open football; it was an open game the Hospital played, and the ball was being slung about in delightful fashion.

Bart.'s attacked from the start and after a few minutes Davies converted a penalty for the Hospital. Play continued in the opponents half and it was not long before Davies landed a second penalty.

The forwards were playing well and giving the backs plenty of the ball. It was encouraging to see the Bart.'s pack such masters of the quick heel from the loose—a factor which has been the weak point in their armour for too long.

Towards the end of the first half Baker ran up from the full-back position, made the man over in the centre and went through to score. This was not converted. A few minutes later Catford Bridge attacked and were awarded a penalty just outside the Bart.'s 25; this was converted.

It was not till the second half that the Bart.'s backs really showed what they could do, and tries were scored by Mackay, Picthall and Taylor ; two of these tries were converted by Baker.

Handling in the centre was not at its best today—though a dazzling sun may have been partly responsible for this—and the backs did tend to run across too much, but apart from this they acquitted themselves magnificently. The forwards were sound and in addition will have learned what quick healing in the loose can do—a factor which is not sufficiently appreciated or practised in first-class football to-day.

We look forward to more such exhibitions at Chislehurst—and we hope at Richmond this season.

**Team :** A. M. Baker—G. Picthall, M. G. Taylor, K. A. Clare, J. L. M. Corbet—M. J. A. Davies, A. Mackay—T. M. Pearce, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.), D. W. Roche, D. M. Cuthbert, J. F. A. Maskell, G. W. Mears.

### "A" XV

**v. RADCLIFFE INFIRMARY,** Oxford, January 24.

Result : Won 14-9.

This game, played at Oxford, resulted in a win for Bart.'s of 14 pts. to 9 pts. On a surprisingly dry ground, the game was played all through at an extremely fast pace, and the two teams were really very evenly matched, although—*mirabile dictu*—Bart.'s were the fitter team at the end.

It was unfortunate for Bart.'s that our outsiders on the whole, seemed to have struck an off-day. Although the ball was light, this was not a sufficient excuse for the bad giving and taking of passes. In defence, however, they were good, and this coupled by the fact that the Bart.'s forwards were right on top of their form, was enough to save the day.

Scoring was opened by the Radcliffe who kicked a very fine penalty. A few minutes later, however, a Bart.'s forward broke away with the ball and made for the line. Just when the opposing full back seemed likely to spoil things, up raced A. R. Jones who dashed over in no uncertain manner. This try was converted by an extremely good kick by M. Roberts.

With R. C. Cochrane hooking the ball almost continuously, all that the Bart.'s backs could manage was a series of pitiful drops at goal. Suddenly from a loose scrum right on the line, L. Cohen wrested the ball from an opponent and popped over the line so quickly that the Bart.'s scrum leader didn't have time even to reach the scrum. The conversion was missed and Bart.'s were two points up. But not for long, however, for a jinking run by Stobic, our opponents' fly half, and an old Oxford blue, sent another Radcliffe man over for a try which again was not converted.

Half time came with the score at 9-8 against Bart.'s When play was resumed, we seemed to settle down and our play was better. Although the handling was still not good, the defence was tightened up, and the wing forwards began to mark the opposing fly-half very closely indeed. The forwards were working well in the tight and loose scrums holding their heavier opponents, but line-out play was not so good.

After a long period of no scoring Bart.'s were awarded a penalty, and G. I. Small, who had all afternoon played an extremely good game, scored the goal from a tricky position. This put Bart.'s ahead, and in the closing minutes, just to make assurance doubly sure, D. M. Cuthbert condescended to take the ball across the line and score as a result of some pretty inter-passing amongst the forwards. Bart.'s thus won by 14 pts. to 9 pts. an extremely exciting and exhausting game—and the first defeat the Radcliffe had suffered this season.

**Team :** J. K. Murphy P. Macdonald, G. Tamlin, T. M. F. Roberts, A. D. M. Thomas—G. I. Small, M. Hodgson—L. Cohen, R. C. Cochrane, A. R. Jones, J. F. A. Maskell, F. I. Macadam (Capt.), J. R. Nicholson, D. Black, D. M. Cuthbert.

### HOCKEY CLUB

**2nd Round Hospitals' Cup.**

**v. LONDON HOSPITAL.**

Result : 3-1.

Bart.'s had a bye in the 1st round. In the second the club was drawn against the London for the third successive season. The game was played at Motspur Park under good conditions.

Bart.'s lost the toss and had to play up the slope. From the outset it was obvious that the game was going to be hard fought, but Bart.'s were unfortunate not to have scored in the first ten minutes. After some twelve minutes' play the ball was loose in the Bart.'s circle for only an instant, and a first-time hit put it into the right-hand side of the net.



At half time the score was London Hospital 1, Bart.'s 0. The second half was mainly in the London half of the pitch although the London were continuously dangerous and pressed hard. After a few minutes' play a quick shot by J. Batterham made the score even. A few minutes later J. Godden strained a groin muscle. The score remained unchanged until the end of time when it was decided to play a further ten minutes each way. John Mellows, his lower lumbar region strapped with plaster and doped with codeine, put Bart.'s one up in the next ten minutes and then put in another to make the score 3-1 to Bart.'s. That was the final score.

**Junior Cup.**

**v. MIDDLESEX HOSPITAL**

Result : 8-0.

This year United Hospitals have resurrected the Junior Cup. Bart.'s duly entered the 2nd XI. On Wednesday, February 1, they turned out in full strength perhaps the strongest side for some two years. As soon as the whistle blew it was plain to see that Bart.'s were the stronger side and it was not long before they were three up. Conditions were not particularly good underfoot, due to thaw following frost, but it was a fine day. At half time the score was 5-0.

In the second half of a vigorous game Bart.'s scored three more and the final whistle blew to a signal win to Bart.'s by 8 goals to nil. Henry Whitting at centre-forward scored no less than five. J. J. McL. Hill scored one and N. Petersen two. Peter Haigh in goal had perhaps the most idle time he has ever had between the sticks.

### CRICKET UMPIRE

In recent years the Cricket Club has been without the services of a regular umpire, which has caused some embarrassment from visiting teams. If there is anyone, particularly an Old Bart.'s man, who could undertake to umpire for us fairly regularly at weekends—with meals and transport, of course, provided—we should be very grateful. Would anyone so willing please contact P. B. Biddell, the Cricket Club Secretary ?

## BOOK REVIEWS

**A TEXTBOOK OF THE PRACTICE OF MEDICINE,** edited by Frederick W. Price. 8th Edition, 1950. Geoffrey Cumberlege, Oxford University Press, xlv + 2076, illus. 87. Price 45s.

With the march of progress it is not long before any scientific work must be revised and brought up to date. In the case of a book so comprehensive as this the task can be no easy one. It is now four years since the previous edition was published. The eighth edition contains many changes and several new articles. It is with pleasure that we note the names of three Bart.'s men among the new contributors. They are Prof. L. P. Garrod, writing on the antibiotics, Dr. E. F. Scowen, on the sulphonamides and Dr. R. Bodley Scott. The high standard of the work has been maintained throughout. The format remains the same and the size has been increased by 42 pages. The only criticism that can be made is against its somewhat unwieldy dimensions. The editor aims to cover the whole field of medicine in one volume. Were it not for this one might wish to see the expansion of some sections, particularly that on psychological medicine. A division of the book into two volumes in later editions would be a development well worth any corresponding increase in cost. This work is so familiar to medical men that further recommendation is unnecessary. It deserves a place in every student's personal library.

**COMMON SKIN DISEASES,** by A. C. Roxburgh. 9th Edition, 1950, The General Practice Series, Lewis, pp. xxxii + 505, 8 col. plates, illus. 215. Price 25s.

This excellent text-book is well-known to most Bart.'s students. As its title suggests it does not claim to be a complete treatise on skin diseases but it nevertheless covers everything that the general practitioner is likely to meet. Dermatology is an important branch of medicine and the time alloted for its study in the clinical course is far from being adequate. Although there is much that can only be learned from clinical material, a good text-book is essential to the student. Dr. Roxburgh's book is amply illustrated, clearly written and well arranged. It can be recommended for both reading and reference. The new edition contains several changes and the matter has been brought up to date.

**MEDICAL TREATMENT :** Principles and their application, edited by Geoffrey Evans. Butterworth, 1951, pp. xxvi + 1398 [66]. Price £5 5s. 0d.

The rapid growth of our knowledge of therapeutic agents renders it impossible to maintain books dealing with treatment up to date. Today a book may take at least two years between delivery of the manuscript and date of publication, so that no book on the subject can contain the very latest information on therapy.

This volume of 1400 pages by 53 contributors consists of an alphabetical arrangement of subjects, which are sub-divided under each heading. Commencing with Addiction, Antibiotics and Sulphonamides, we proceed through Blood diseases (by R. Bodley Scott); Blood transfusion (by H. F. Brewer); Cardiovascular diseases (by Paul Wood); Chest diseases (mainly by Robert Coope); Endocrine disorders (by A. W. Spence); Liver diseases (by E. R. Cullinan); Skin diseases (by R. M. B. MacKenna and Brian Russell); to end with X-ray and radium therapy. These sample subjects indicate something of the scope and arrangement of the book, and the names of the authors vouch for its high standard of accuracy as reflecting present-day trends in medical treatment.

Dr. Geoffrey Evans is to be congratulated on editing the contributions from these experts in

their respective fields, to produce what must become the standard work on medical treatment. We hope that its high price will not prevent regular revision, without which such books are ineffectual.

**THE PRACTICE OF NURSING,** by H. M. Gration and Dorothy L. Holland. Faber & Faber, 1950, pp. 456, Figs. 428. Price 18s.

In nursing, as in all other subjects taught to students, the syllabus enlarges year by year. More and more new material is added without any shedding of outmoded procedures. Having regard to our present professional examinations, the authors of this nursing book can hardly be blamed for including some of these. It comes from Guy's Hospital, and is of the standard that is expected of such a School. The style is readable and the illustrations and diagrams acceptable. The sections dealing with special subjects are all good.

The attitude of the nurse to her patient is well suggested throughout, except on page 343 where an exceedingly peculiar reason is given for using local treatment to women with a certain infectious disease.

W. E. H.

**HILTON'S REST AND PAIN,** edited by E. W. Walls and Elliot E. Philipp, 6th Edition, 1950. Bell, pp. xxxiv+503, Illus. 105. Price 25s.

The first edition of this classic appeared in 1863. There has been no new edition since 1892 and for ten years the book has been out of print. This production is, therefore, more than welcome. The merits of Hilton's great work are so well known that to praise it more is scarcely necessary. The author's doctrine of the value of rest in the treatment of disease has influenced medical thought ever since he first expressed it. His masterly insight into the significance of pain and his accurate diagnosis without the aid of X-rays are both remarkable. When he suggests the condition of prolapsed intervertebral disc he is seen to be well ahead of his time. His clear thinking and fine English are in themselves enough to make the work a delight to the reader.

The text is as in the fifth edition and is almost identical with the original. The small changes that there are date back to the earlier editions. The editors have in places added their own explanatory footnotes. A series of short essays in which certain points are enlarged in the light of modern knowledge have been appended to the lectures and appear at the end of each chapter. The appendices are most useful additions. Hilton's own writing remains uninterrupted. The original drawings remain in the text and the editors have added a few more to illustrate their essays. The new edition starts with an introductory biography of John Hilton and ends with notes on several of the famous persons mentioned by the author. The volume is attractively produced and a copy of it would be profitably included in the library of every student.

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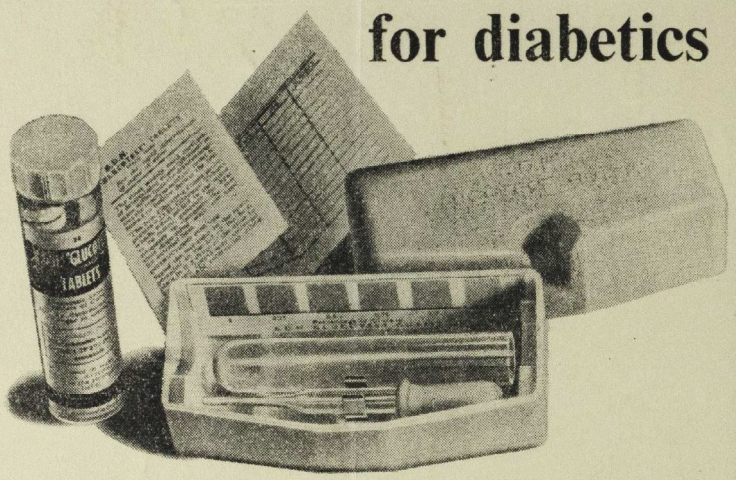

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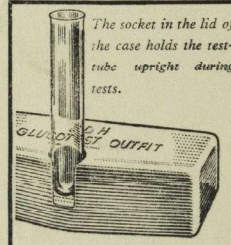

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