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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

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WASTED YEARS?

A VISITOR in our midst who had last seen the hospital three or four years ago might be aware of certain changes which had been unnoticed by us. He might observe that the moustaches are not what they were, that fourteen days' leave has become a mere two weeks' holiday, that the Regiment and its doings overseas are seldom spoken of; and he might conclude, correctly, that the ex-serviceman is half-way to becoming a doctor. Although there are ex-servicemen in all years of the course, the majority, including most of those who were in the services during the war, are now in the middle of their clinical training. The study of medicine has inevitably wrought certain changes upon the ex-serviceman, some of which he shares with his colleague fresh from school in their journey towards a common goal. But just as he has begun his course from a different point in his life, so he approaches his objective from a different angle, and his journey is beset with different problems.

He started with a fairly clear idea of what he desired from the future, with a realisation that all he had learnt at school had vanished as in a puff of smoke, and with a conviction that evenings were not made for study. In the earlier part of his course he was probably at a disadvantage: his memory was less acute than that of his colleagues from school; his mind less equal to the agility with which the atoms seemed to besport themselves in chemical equations; his hand had lost the ability for fine work which was as necessary to his early practical courses as it later becomes to his practice of medicine. The pre-clinical sciences were not viewed as subjects to be studied in their own right, but rather as stepping stones to medicine. "Training," with all the sense of urgent practical application that war had given it, is the word that most closely describes his attitude to this part of the course; "education" belonged to more spacious days.

There are not many careers in which service training in wartime can be turned directly to good account in peace. Aviation, engineering and a few other subjects of a more or less technical nature quickly fill the list, and the remaining ex-servicemen provide living proof that it may be easier to beat a sword into a ploughshare than to turn its bearer into a farmer. Though perhaps of no direct value in a medical career, years spent in the services can provide experience that is not entirely irrelevant to medicine. The ex-serviceman should have had the opportunity to mix on terms of equality with men of all occupations and to learn something of their ways of life. Such experience can be of the greatest help when he becomes a clinical student and, armed with an ill-digested mass of physiological fact and next to no knowledge of medicine, he has to gain an understanding—and even the confidence—of his patients.

Yet there is no doubt that some of the advantage he reaps is not his by right. Greater age may easily be confused with greater experience by the unwary, and the ex-serviceman is seldom present to hear the patient's remarks on discovering that the man who has just examined him was not the expected specialist from another department but merely one of the dressers.

It is not intended that these remarks should even touch upon all of the many aspects of this subject, nor is it intended to try to show that the ex-servicemen can get ready-made that understanding of his patients which only years of medical practice can give. But it is hoped that when he finds himself at Queen Square and clutches with the avidity of a

drowning man the form on which he sets forth his war-time service, he may reflect perhaps that they were not entirely wasted years.

BART'S IN 1851

ST. BARTHOLOMEW'S MEDICINE CHEST

Between 200*l.* and 300*l.* are spent every year for strong sound port wine for the sick poor in St. Bartholomew's Hospital. It is bought in pipes, and drawn off as needed. Nearly 2,500 pounds weight of castor oil, 200 gallons of spirits of wine, at 17s. a gallon; 12 tons of linseed meal, 1,000 pounds' weight of senna, and 27 cwt. of salts, are items in the annual bill for drugs. The grand total spent upon physic in a twelve-month is 2,600*l.* 5,000 yards of calico are wanted for rollers, for bandaging: to say nothing of the stouter and stiffer fabric used for plasters . . . In a year 29,700 leeches were bought . . . gathered in France and Poland, in Africa and Spain . . . A ton and a half of treacle is annually used to make some kind of syrup (and, together with five casks of hips) makes linctus for coughs . . . As winter comes on, the coughs increase, and the demand upon the linctus becomes heavier and heavier. This is expected and provided for, but one season it had been larger even than usual. The same children and the same women came again and again, most perseveringly, when, in consequence of some inquiries, it was found that one of the most urgent claimants for the favourite physic lived by selling little sweets and pies to children, in a back street near Smithfield, and that she used the favourite linctus to make fruit tarts of.

Reprinted from The Times *by courtesy of the Proprietors.*

CORRESPONDENCE

THE DAY OF THE LEECH

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

Dear Sir,

"The Times" of February 7 gave an extract from its columns of the corresponding day in 1851 entitled "St. Bartholomew's Medicine Chest." which presents a very interesting picture of the drugs and other materials in use at that time. We are told that "In a year 29,700 leeches were bought . . . gathered in France and Poland, in Africa and Spain . . . A ton and a half of treacle . . . " and so on.

This consumption of leeches is at the rate of 80 a day. As the average intake of blood by a leech is known, someone could calculate the amount of blood removed in this way and compare it with the amount of fluid now injected into the circulation in the same time. Can the pharmacologists tell us when leeches were first used in medicine, and whether the practice was ever beneficial, and whether the native leech was not used because of its smaller size and less impressive colouring. Perhaps the leech came into increasing use as a stage in the abandonment of the system of copious blood-letting.

This treatment is not a matter of very ancient history. My mother when a child had leeches applied to her tonsils. When I was a very inefficient dresser to Sir Alfred Pearce-Gould at the Middlesex, and was in attendance on him at one of his rounds, which were frequented by a very large number of students, he asked me which end of a leech was applied to the patient; I could only reply, "I should leave that to the leech, sir," and escaped safely, though any hint of frivolity was dangerous with Pearce-Gould, especially before an audience (he had a disconcerting way of taking one's hand out of one's pocket, if one were so unwise as to give him the opportunity. What would happen if a surgeon did that now?)

Yours etc.,
E. L. KENNAWAY.

St. Bartholomew's Hospital.
February 8, 1951.

AN INTRODUCTION TO CORTISONE AND A.C.T.H. THERAPY

By H. V. MORGAN

It has been said that when endocrinology becomes respectable it is called metabolism. The success of hormones in the treatment of rheumatic fever, status asthmaticus and acute gout has established the importance of endocrinology in the field of general medicine itself. The early over-enthusiasm of jubilant endocrinologists has sobered, however, as more extensive and critical trials are demonstrating the limitations, as well as the uses of these agents. The publicity given by the lay press, particularly in the United States of America, to Hench's discovery of the effectiveness of an adrenal cortical steroid in rheumatoid arthritis has led unfortunately to many false hopes among sufferers from chronic disease; hopes which the patient's physician too often has not discouraged. The public demand for therapy has, however, resulted in considerable financial outlay to stimulate research and produce the hormones in increasingly large quantities. As a small supply of these agents is now available in this Hospital, it seems appropriate to describe briefly their nature and possible use.

The Pituitary Hormones

The progressive refining of extracts of the anterior lobe of the pituitary gland has provided preparations which are more or less specific stimulators of the target organ whose name they bear, e.g. :—

Thyrotrophic Hormone.
Follicle stimulating Hormone.
Luteinizing Hormone.
Growth Hormone.
Adreno-cortico-trophic Hormone (A.C.T.H.).

A.C.T.H. ("the hormone of the anterior pituitary gland nourishing the adrenal cortex") has been refined to the extent that a small polypeptide containing only seven or eight amino-acids is capable of stimulating the adrenal cortex, thus reproducing on that organ the specific stimulating effect of the anterior lobe of the pituitary. Much work remains to be done, however, in identifying the amino-acids and their arrangement in the molecule before it will be possible to synthesize the hormone. In the meantime the hog pituitary is the richest and most widely employed source of A.C.T.H. The yield is unfortunately small, and large numbers of hogs' organs are required to produce enough hormones to treat even one patient.

The Adrenal Hormones

Stimulation of the anterior lobe of the pituitary results in an outpouring of A.C.T.H. which excites the cortex of the adrenal gland to liberate its hormones. An identical effect is produced by injection of A.C.T.H. extracted from a hog pituitary. The hormones of the cortex of the adrenal gland are generically termed corticoids, and are of three types. (Figure 2a.)

(1) **The Androgens.** — These adrenal androgens are relatively less virilizing than those of the testis, but metabolically more active in causing the body to store nitrogen. This is laid down as protein instead of being excreted as urea and ammonia—hence the name formerly applied to this group of the "N" (Nitrogen) hormone. This anabolic function of the adrenal androgens is important in relation to chronic illness, but in short-term metabolic experiments stimulation of the adrenal gland usually results in such an excess of Glucocorticoids that the anabolic effect of the androgens is masked. The adrenal androgens are excreted as 17-ketosteroids. The number 17 refers to the number of the carbon atom to which the ketone group is attached (Figure 1). In females the adrenal androgens are almost

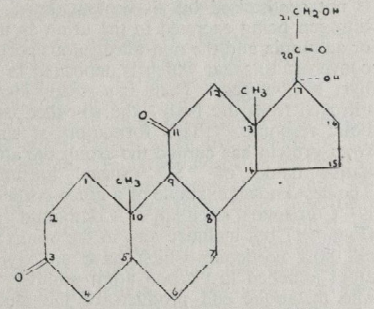

FIG. 1—Cortisone (17-hydroxy-11-dehydro-corticosterone. C atoms 4 and 5 are linked by a double bond).

the sole source of the 17-ketosteroids found in the urine ; in males the testis contributes

as much or more. The daily output of 17-ketosteroids in the urine is a measure, therefore, especially in women, of the androgenic activity of the adrenal cortex. A.C.T.H. stimulates the production of androgens by the adrenal cortex and therefore increases excretion of 17-ketosteroids in the urine.

(2) **The Mineralo-corticoids.**—The status of this group of steroids which in general cause excretion of potassium and retention of sodium by the kidney is far less certain. One member of this group is deoxycortone, a synthetic steroid, which has been employed successfully in the treatment of Addison's disease for many years. This steroid has been found only once in extracts of the adrenal gland, although compounds with a similar action have been identified. Deoxycortone exerts a powerful action in preserving life under stress, arresting the urinary loss of sodium in Addison's disease and protecting the organism against potassium intoxication. Selye has reported that large doses produce hypertension, arthritis and other changes in animals. It is without direct action on protein or carbohydrate metabolism.

The injection of A.C.T.H. often causes rapid retention of sodium chloride and water by the kidney, and it seems not unlikely that this is the result of increased production of mineralo-corticoid.

(3) **The Gluco-corticoids.**—These are so named from their power to affect sugar metabolism. Under their influence protein is not synthesised but is broken down, the nitrogen being excreted in the urine as urea or ammonia and the non-nitrogenous portion converted to sugar which is deposited in the liver as glycogen. There is a steady loss of nitrogen from the body—the so-called catabolic response. This formation of sugar from protein has earned the group the alternative name of "S" (Sugar) hormone. The best known example of a gluco-corticoid is Cortisone (Kendall's Compound E) (Figure 1), but included also in the group are all those corticoids which have an oxygen atom attached to Carbon atom number 11. The metabolic end products of the gluco-corticoids are excreted in the urine with a ketone group on the carbon atom number 20. Although not all the steroids with this molecular arrangement found in the urine are physiologically active, nevertheless the estimation of the 20-Ketosteroids ("chemical corticoids") provides a reasonable measure of gluco-corticoid production.

Gluco-corticoids tend to raise blood sugar, although they lower renal threshold for glucose. They are apt, therefore, to cause exacerbation of diabetes mellitus, although they have little demonstrable action on the sugar metabolism of the normal subject. Injection of gluco-corticoids also results in a fall in the eosinophil count of the body to a minimum about 4 hours after injection. Provided the initial reading is not too low this reaction of the eosinophils to Cortisone is useful in controlling therapy, since a fall of 50% in the eosinophil count denotes that the cortisone is producing a metabolic effect. This has an even more important application in A.C.T.H. administration. In Addison's disease the adrenal cortex is destroyed: there are, therefore, no cells to secrete cortisone in response to stimulation by A.C.T.H. An injection of A.C.T.H., therefore, does not cause the normal 50% fall in the eosinophil count. This observation, described by Thorn, provides a useful diagnostic test for adrenal cortical insufficiency. For A.C.T.H. to act, there must obviously be in the body adrenal tissue capable of being stimulated to produce gluco-corticoids. A fall in the eosinophil count of 50% after an injection of A.C.T.H. is a useful indication, therefore, that gluco-corticoids are being in fact produced by the patient's adrenal gland. It should be added, however, that in treatment a patient's disease may improve without a striking fall in the eosinophil count occurring and conversely such a fall does not necessarily imply that clinical improvement will follow. The explanation may be that the A.C.T.H. stimulates the production not only of cortisone, the most active steroid therapeutically, but also of Kendall's Compound F less potent therapeutically but having a greater depressant effect upon the eosinophils.

Deficiency of the adrenal gland as found in Addison's disease, illustrates the result of the inadequate production of these hormones.

(a) There is a deficiency of mineralo-corticoid shown by increased loss of sodium and chloride ions in the urine, which produces the diminished blood volume, hypotension and circulatory collapse.

(b) There is a deficiency of androgens which is detectable chemically in the very low output of 17-ketosteroids and clinically in the muscular weakness and loss of axillary hair.

(c) There is a deficiency of gluco-corticoids, responsible for the profound hypoglycaemia on starvation and increased sensitivity to insulin manifested by many of these patients. Patients with Addison's disease cannot excrete water normally, perhaps because there is excessive production of posterior pituitary antidiuretic hormone. Cortisone helps to combat this abnormality.

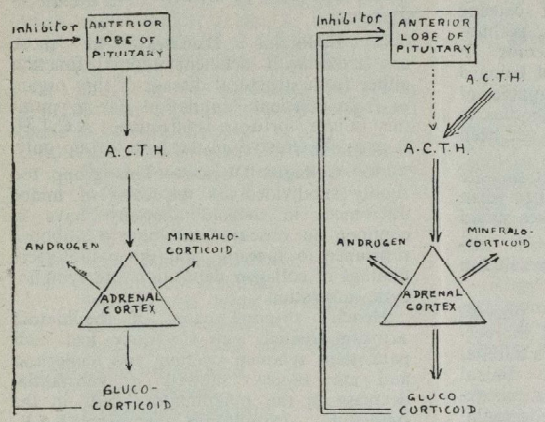

FIG. 2a—Normal pituitary-adrenal balance.

FIG. 2b—Effect of injection of A.C.T.H.

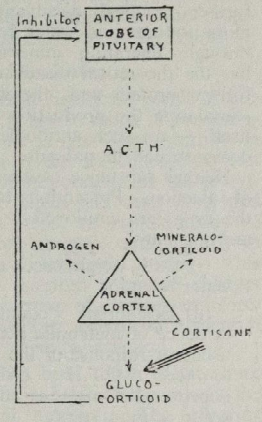

FIG. 2c—Effect of injection of cortisone.

Over-activity of the adrenal gland shows itself in two chief clinical groups.

(a) Those in which there is an excess of adrenal androgens resulting in increased muscular development, hirsutism and virilism. The adreno-genital syndrome and pseudohermaphroditism in females and certain types of sexual precocity of boys.

(b) Cushing's syndrome in which there is thought to be an excessive production of gluco-corticoids. The excessive breakdown of protein results in a liberation of glucose and sometimes of diabetes mellitus of insulin-resistant type. Part of the carbohydrate is converted to fat and deposited, it is said, chiefly in the region of the shoulders and neck—the so-called "buffalo-hump"; at any rate increase in weight is common. The loss of protein causes a failure of osteoid formation in the bones: the absence of this scaffolding into which calcium can be precipitated resulting in osteoporosis. A further consequence of protein deficiency is the presence of large purple striae due to loss of elastic tissue from the skin. Acne vulgaris, polycythaemia and hypertension may appear. Lastly loss of potassium in the urine may cause a hypopotassaemic alkalosis.

No clinical syndromes have yet been finally proved to be due to an excess of the mineralo-corticoids in man.

Cortisone and A.C.T.H. Therapy

Cortisone acetate is obtained by partial synthesis from bile acids. Its slow absorption enables it to be given in a single intramuscular injection once a day. In doses of 100 mg. it fails to produce significant toxic effects when given for periods of up to a month. In larger doses or for longer periods it may cause appearance of any or all of the symptoms and signs described under Cushing's disease. Its action in relieving the pain of a long-standing rheumatoid arthritis may not unnaturally arouse in the patient a feeling of exhilaration, but often this amounts to a pathological euphoria. Other mental changes may occur including sudden depression with suicidal tendencies.

A.C.T.H. is a white powder which is dissolved in normal saline and injected intra-

muscularly. The usual dose is 5 to 25 mg. which must be injected every 6 hours.

Cortisone and A.C.T.H. are therapeutically interchangeable except that A.C.T.H. cannot obviously be effective in conditions of adrenal deficiency. A.C.T.H. has the further practical disadvantage of causing more sodium and water retention, perhaps through liberating mineralo-corticoids. It has the theoretical disadvantage of being a foreign protein and, therefore, capable of stimulating the production of antibodies to itself — no such antibodies have yet been demonstrated in patients.

Neither substance causes pain at the site of injection. Precautions to be taken when the drugs are employed in the doses stated are not many.

(i) Daily weight check to detect salt and water retention.

(ii) Eosinophil count to provide evidence of metabolic activity of the cortisone or response of the patient's adrenal to the A.C.T.H. (Although clinical improvement may, as mentioned above, occur without a fall in the eosinophil count.)

(iii) Diet should be unrestricted, thus ensuring an adequate intake of potassium. Symptoms from potassium deficiency have developed only in those whose intake was reduced as part of a metabolic experiment.

A self regulating mechanism exists in the body whereby the products of the target organ (the cortisone) depress the secretion of the stimulator hormone (the A.C.T.H.). Injections of cortisone given over a period will depress the secretion of A.C.T.H. by the patient's own pituitary (Figure 2c), so that a period of temporary adrenal cortical deficiency of some severity may follow *cessation of therapy*. This is minimised by gradually reducing the dose of cortisone, thus diminishing the inhibitory effect upon the patient's pituitary gland and enabling some return of endogenous A.C.T.H. secretion before the end of treatment. Injections of A.C.T.H. stimulate the patient's adrenal cortex to produce large amounts of cortisone which in turn depress the patient's pituitary thus diminishing the secretion of endogenous A.C.T.H. (Figure 2b). Shortly after stopping therapy, there may, therefore, be a temporary period of partial adrenal cortical insufficiency ; less marked than after cortisone since the adrenal cortex has not been unstimulated and inactive, but actually overactive, during the period of treatment.

Indications for Therapy

A.C.T.H. and cortisone possess certain properties in the body which can be applied to the treatment of the following groups of diseases.

(a) **Endocrine Diseases** — In those associated with deficient adrenal function either from structural disease of that organ, or from deficient stimulation due to pituitary failure, cortisone is effective. A.C.T.H. is partially effective in the latter group only.

(b) **Collagen Diseases**—This group too rigidly subdivided on the basis of minor differences in morbid anatomy, have in common an obscure aetiology, a stubborn resistance to therapy, and the pathological findings of collagen deposition and lymphocytic infiltration.

Hench's original cases of rheumatoid arthritis treated with Cortisone lost their pain, their synovial swelling and tenderness and on biopsy showed a substantial decrease in the inflammatory cells in the synovium. In addition, the raised E.S.R. fell to normal. There is no evidence that mature fibrous tissue once formed can be reabsorbed, but the earlier fibroblastic stages of the progress toward fibrous tissue can be halted and indeed reversed. In addition cortisone inhibits the enzyme hyaluronidase so that the spreading factor is reduced.

The employment with benefit of A.C.T.H. in diseases which show progressive scarring, such as beryllosis and Dupuytren's contracture, has led to considerable anxiety about its employment in tuberculosis. Whether the fibrous reaction to a tuberculosis focus is consistently weakened remains to be decided.

(c) **Allergic Diseases**—Adrenalectomised animals are abnormally vulnerable to anaphylaxis and sensitive to histamine. Adrenalectomy in rats leads to a rise in the histamine content and a fall in the histaminase content of the tissues ; a change that is reversed by adrenal cortical extracts. The association of a high eosinophil count with allergic conditions made the trial of A.C.T.H. in asthma, urticaria and other conditions inevitable. It has been strikingly successful in modifying the local tissue response to the antigen-antibody reaction.

(d) **Haematological Diseases**—The bone marrow may be stimulated to liberate reticulocytes and increase the formation of red blood corpuscles, notably in rheumatoid arthritis and pernicious anaemia. Cortisone inhibits lymphocyte production and has been employed in lymphoid new growths.

(e) **Gout**—A.C.T.H. increases uric acid excretion in the urine. In acute gout it produces rapid clinical remission but relapse is apt to occur within 3 or 4 days of stopping the drug, unless colchicine is exhibited.

A short list of conditions in which A.C.T.H and cortisone therapy have been found to be most effective.

(a) Addison's Disease (Cortisone only).
Other causes of Adrenal Insufficiency (Cortisone only).
Parhypopituitarism.
Anorexia nervosa.

(b) Acute Rheumatic Fever.
Rheumatoid Arthritis.
Disseminated lupus erythematosis.
Periarteritis nodosa.
Acute iridocyclitis and Keratitis.

(c) Status asthmaticus.
Serum sickness.
Exfoliative dermatitis.
Loeffler's syndrome.
Urticaria.
Vasomotor rhinitis.

(d) Acquired acholuric jaundice.
Leukaemia.
Lymphoma.

(e) Acute Gout.

Many of these diseases relapse on stopping the treatment ; in others such as periarteritis nodosa the patient may go on to die of cardiac or renal failure with his arterial lesions healed. The temporary cessation of a chronic disease like rheumatoid arthritis must be used to encourage the patient to employ other corrective therapy. The dose of the drug must, furthermore, be slowly reduced, to avoid a dramatic relapse occurring after the last injection of the course.

Conclusion

Perhaps the most significant result of this new knowledge is not so much in the therapeutic advance as in the demonstration in convincing form of the old concept of host resistance. The importance of the individual reaction to stress has been developed by Selye into a theory to explain many of the diseases of obscure aetiology from hypertension to rheumatic fever. This emphasises the essential chemical changes occurring in this group of diseases and foreshadows a pathology based on structural change than on chemical reaction.

An attempt has been made to introduce the reader to the subject of the role of the adrenal cortex in therapy. The following recent reviews will provide a survey of the field, which is beyond the scope of this oversimplified and partly obsolete paper.

Hench, Phillip. *Lancet*, 1950, 2, 483.
Ingle, Dwight J. *Journal of Clinical Endocrinology*. 1950, 10, 1312.
Selye, Hans. *British Medical Journal*, 1950, 1., 1383.
Thorn, G. W., *et al. New England Journal of Medicine*, 1950, 242, 783, 824, 865.

TWELFTH DECENNIAL CLUB

The Eighth meeting of the Club will be held at the Naval and Military Club, Piccadilly, London, W.1, on Friday, April 20, at 7.15 for dinner at 8 p.m.

All St. Bartholomew's men who joined the Hospital in the academic years 1925—1935, inclusive, are entitled to attend. Will any one who would like to come and has not been circularised, please communicate with the Secretary, W. D. Coltart, 5 Wimpole Street, London, W.1.

THE RAHERE CLUB IN EAST ANGLIA

We should like to draw the attention of Bart.'s men living in Norfolk, Suffolk and Essex to the "Rahere Club" in these counties.

On November 4 last a dinner was held at The Grange, Broome. The meeting was a great success; 30 Bart.'s men attended, and the Chairman was Dr. George Day of Norwich. It was decided to hold a similar function this year at the same place.

The Club's Hon. Secretaries for this year are Dr. C. S. Hall-Smith (for Norfolk) and Dr. R. Hanbury Webber (for Suffolk and Essex).

VIEW DAY

View Day this year will be Wednesday May 9.

FOUR CASES OF RAT BITE

By L. S. CASTLEDEN

IT is a peculiar thing that the less common diseases seem to appear in "runs"; that several unusual cases may be observed in a comparatively short space of time, and that their like may not be seen again for many years. The cases reported below all occurred between 1946 and 1948.

Case I

A farm labourer, aged 60 years, was ferretting on a Saturday afternoon. He detected a rabbit by auscultation. As is commonly done, he lay down on the ground and plunged his arm into the hole to extract the rabbit. He was rewarded by being seized upon by a large rat which clung to the web of his right thumb. The rat was slain and the hand dressed and bathed with "Dettol."

He reported sick two days later with a mildly infected wound of the right thumb. Four days from the original injury it appeared to be healing well.

However, seven days after the bite he began to have rigors and pains in the back. He retired to bed and sent for assistance on the twelfth day after the original injury.

On examination, temperature was 102.4°F., pulse 90, respiration 20 per minute. The local lesion was clean and dry but surrounded by scattered pinkish nodules. The right epitrochlear and axillary lymphatic glands were tender and palpable. The spleen could not be felt. There was no jaundice or hepatic tenderness. There was great pain and tenderness of the right ankle and right sacro-iliac joints and these parts were palpably inflamed.

After some thought rat-bite fever was diagnosed, and it was decided to give him an intravenous injection of arsenic. .06 G "Mapharside" was administered. The fever fell to 99°F. within 48 hours and the injection was repeated. However, his back and sacro-iliac joints were very stiff and inflamed and it was necessary to transfer him to hospital.

Here the opinion of the consultant confirmed the diagnosis of rat-bite fever. The following investigations were done :—Blood film : no spirilla seen. W.R. and Kahn : reactions both weakly positive. White cell count : 15,500 per c.cm. (67% polymorphs).

He was given a six-day course of penicillin, 100,000 units 5-hourly. At the end of this he was much improved. The joints were treated with physiotherapy, and in due course he returned to work. There has been no recurrence.

Case II

A retired farm worker, aged 85 years, was devoted to his few chickens. There were rats in the nearby wood-pile and there he set an old-fashioned gin. In the morning there was a "gaffer" rat caught by one leg in the gin. Our patient was clumsy in removing the rat and sustained a bite on the back of his left hand.

Fourteen days later the wound, which had healed, broke down, and he took to his bed with a fever.

On examination, temperature was 100° F. The wound was of a curious dark appearance, and there was some enlargement of the axillary glands. Blood was taken for investigation. The nearest hospital being distant 24 hours by post it was not surprising that guinea-pig innoculation produced no evidence of spirochætosis or spirillosis.

"Mapharside" .06G produced a rapid resolution of the local condition, and 19 days after the bite the fever had subsided and the hand was healing. There were no joint signs or symptoms.

A little over a year later the patient died of uraemia and acute retention for which he had refused any but palliative treatment. There had been no recurrence of fever.

Case III

A farm labourer aged 63 years was helping at threshing time. There were rats and mice bolting in all directions as the stack bottom was cleared. The lads and dogs pursued them actively. The excitement reached its peak as a rat ran up our patient's sleeve, across his chest and down his trouser leg, where its descent was impeded by the old man's thigh boots. The patient wrung its neck through his trousers, and the rat in its death agonies inflicted a hearty bite.

The patient was attended by my chief some ten days after the injury. There was a well-marked fever and minimal signs of local infection. The wound was discoloured and there was inguinal adenitis. The patient had a well marked osteo-arthritis of the spine and hips. There was a marked worsening of the arthritis during his illness.

Rat-bite fever was diagnosed, and the condition rapidly responded to arsenical injections at home. There was no recurrence of fever, and the patient died three years later of a cerebral thrombosis.

Case IV

A young man aged 22 came home to his mother's farm at the week-end. A war on the rats in the hen house was declared. There was a beating with sticks by torchlight. In the course of the battle a rat leapt for liberty from a perch and inflicted several scratches on the temple and face of the patient.

A week later the patient developed a feeling of "flu" with backache and fever. It was worse after three days and he was seen on the eleventh day.

There had been a nosebleed the previous night. He was photophobic and complained of severe headache. On examination, temperature was 103°F, pulse 85 per min. There were definite signs of meningeal irritation. There were no other signs of hæmorrhage. The liver and spleen were not palpable. The urine contained no blood but was dark with bile. The scratches on the face were dry and healthy.

A diagnosis of Weil's disease was made, and next day jaundice was clinically apparent. Investigations done included : W.R. and Kahn : negative. Agglutination with Bact. typhosum and para-typhosum and Br. abortus nil.

He was definitely improving on the 13th day and made an uninterrupted recovery without specific treatment.

As a result of the foregoing four cases the local pest officers presented me with a number of fresh rat carcases. These were sent forthwith to a laboratory in London which was interested. However no spirilla or other organisms were found.

SOME NOTES ON OSTEOARTHRITIS

By G. D. KERSLEY

Etiology

OSTEO-ARTHRITIS is due to wear and tear and poor quality of the joints.

Wear and Tear may be the predominant factor in, for instance, arthritis of a hip that has been injured, or where a congenital dislocation has upset the normal mechanism, in a "valgus" knee, a knee used uneconomically because of bad walking caused by corns, a knee that carries undue weight or a thumb which has born the brunt of unusually hard work.

Poor Quality and poor circulation may cause a premature wearing out of many joints and may be hereditary or affected by the "endocrine orchestra." Heberden's nodes of the terminal joints of the fingers are often due to a hereditary factor in women or traumatic factors in either sex.

Clinical

The patient is often elderly but usually quite fit in himself, with normal sedimentation rate and no anæmia.

One or more joints may be affected, often a hip, knee or the base of the thumbs. The condition may or may not be painful and much of any pain may be due to a concomitant fibrositis.

Pathology

Central fibrillation and eburnation of cartilage with later throwing out of peripheral osteophytes are the predominant features.

X-rays show reduction of joint space, irregularity of joint line with some sclerosis, often peripheral osteophytes and sometimes areas of rarefaction in the cancellous tissue at the ends of the bones.

Treatment

(1) Reduction of trauma, e.g., avoiding excessive use and strains, protection of the joint, correction of any mechanical factors and possibly weight reduction (2) non weight bearing exercises (3) stimulation of the circulation by heat or contrast bathing (4) treatment of any fibrositis with massage, etc., and possibly also (5) intra-articular injections (6) Radio-therapy (7) Surgery.

WARDSMANSHIP

(With apologies to Stephen Potter)

Mr. Stephen Potter's book, "Lifemanship," leaves untouched that vast field of technical lifemanship so closely associated with our own work, namely that of "Wardsmanship." So we endeavour to enumerate below a few simple ploys and gambits in this particular tangled jungle of life.

The young student, fresh from the gentle hands of the Anatomy Department, is at once plunged into a whirlwind existence in a totally new environment. He meets new gods, at whose feet he must lie; he talks with a fundamentally new class of people—namely, patients—and he will soon find that one Unwardsmanlike Act can cause a rift between himself and a sister that three months of flawless dressing can never expunge.[1] It is a life fraught with danger to the young, inexperienced wardsman.

He starts afresh with a set of companions who know him for what he is; they are aware that his standard of Biochemistry may be higher or lower than theirs. That is past. They do not know his "Wardsmanship" prowess. Thus the first maxim is—start "Wardsmanship" at once. A few early simple ploys can gain an advantage that the most complex gambits will fail to do if played too late. He MUST start on the first day of the Introductory Course.

Clothesmanship

The wise Wardsman will now discard his green corduroys and his louder tweeds, and assume a more sober garb of some nondescript grey or blue suiting, preferably with small side pockets. These will enable him to stuff a stethoscope well inside, and yet leave enough of the instrument showing, so that there is no doubt as to its identity.[2] From his breast pocket will protrude an auroscope and a patella hammer, and nonchalantly hanging, a tape measure. (It is considered ostentatious to carry a sphygmomanometer.)

[1] Sister play will be considered under a separate heading, but it can be briefly stated here that this is a very advanced Wardsmanship, and only the daring and the foolish will venture more than a well-tried standard ploy against a sister of more than two days' experience.

[2] This ploy is also useful in Housemanship, but the dress assumed can be a little more "deshabillé."

Smithson-Grierson always carried a sheaf of papers on a blue board, as he contended that everyone else carried folders and portfolios, and that the board lent atmosphere. This ploy is certainly efficacious, but we advise delaying its use until first time dressing or clerking as it is then more effective, and the impression left upon patients and probationers is more convincing than upon fellow-Wardsmen.

Thus equipped, the Wardsman turns up twenty to forty minutes late for his first session with his group. He should endeavour to kick the door as he enters the pathroom, as this will attract more general attention, and may even arrest the flow of discourse. One may feel embarrassed for the new Wardsman who turns up five minutes late, but only admiration can be felt for the Wardsman who arrives half an hour late, gives a casual nod to the lecturer, selects a metal chair, clatters it to a suitable position in the fore, and sits complacently awaiting the words of wisdom. A casual few words of apology give added finish to the gambit. Even the most resistant of Registrars will be somewhat shaken. The final blow is struck by a very small but effective ploy used by P.O. Masterling. At the end of the first session someone usually asks the Registrar his name, so that he may be fully discussed and compared. P. O. Masterling casually unlimbered himself and said in a drawl: "Excuse me, but are you Professor X?" This timely compliment will at once differentiate him from the casual run of students, and a well-marked impression will have been made.

If asked a question during one of these sessions the Wardsman should repeat it slowly, savouring each word. With luck, either the questioner will have answered it himself, or else some bright, ostentatious spark will pipe up with the answer. Either way, if played correctly, the impression left is that of having given greater thought to the answer than the questioner gave to his question. A counterploy, as used so brilliantly by Miss Dulcie Demolting, is to answer a stupid question with an equally stupid adaptation of elementary biological principles.

When asked how to remove carbon dioxide from an oxygen tent Miss Demolting replied: "Put a geranium plant inside with the patient." The Registrars will seldom try again.[3]

Clinicianship

This is the real meat of Wardsmanship; it is the subtle use of ploys and gambits against a mixed group of persons, viz.: patients, nurses, sisters, students and sundry staff, all with their sub-divisions and gradings. This is basic play, and the Wardsman must be thoroughly well grounded in it if he is to succeed in future life in advanced Outpatientsmanship, and Examination Cunning.

We will now consider **Wardroundsmanship.**

On a ward the Wardsman will be allocated several patients of his own. It is as well to have a cursory knowledge of their ills, but he should make a point of knowing every detail of one patient other than his own. Then on ward rounds he will, if he is lucky, scrape past his own cases in a nondescript manner: but when the round approaches his secret study, a few interjections as the dresser reads the history, the correcting of Haemoglobin figures and blood urea readings, quoted from the dresser's shaken and failing memory and, finally, the trump card played[4]—the bringing out of the latest liver function test, which was only back from the laboratory a few moments previously and which was unknown to the houseman—will bring a chief's eyes to bear upon what is obviously a student with marked clinical ability.[5]

The Examination

Here the Wardsman is playing to a more limited public: the patient, who never stands a chance, anyway, and a nurse who is only waiting to go off duty to her lunch. Thus the Wardsman will try to capture as his chaperone at least a Belt, and will drag his examination out to a minimum of half an hour.

He will casually ask her to get a screen, while he gets the other. He then goes off, conveniently forgetting the screen, and returns with an auroscope, an ophthalmoscope, a torch, a spatula, a stethoscope, a patella hammer, a sphygmomanometer, a pin, a tape measure, a tuning-fork, a rectal tray and proctoscope, and cotton wool. If he can bring these on a trolley a Wardsmanship point is definitely won. When the examination is almost complete he should slip out with the air of returning with another instrument; the nurse will be left to clear up, and the Wardsman can be first in the lunch queue.

But beware of the experienced Belt, who promises to chaperone, places the screens, and then never turns up. Women can be very treacherous about these things.

Steriliser Play

Miss Demolting devised a simple ploy that served her well during her dressing time. To overcome the morning shortage of sterile instruments she would hover by the steriliser, and just as someone put a load of stuff into it, she would look pitiful, and say, "I was just going to take something out. Now I must wait again I suppose."

After two or three people had been thus caught, they would all wait until she had removed her stuff from the steriliser before venturing to approach it again. Thus she was able, even at a peak period, to select her instruments and utensils from a wide variety, and by then it was too late for a complaint by the rest.

Smithson-Grierson counter-ployed several times rather unkindly by waltzing hastily into the steriliser-room, and seizing her stuff, slinging it into the sink, and saying at the same time, "Why will people leave dirty crockery lying about."[6]

Theatre Play

Here the would-be Wardsman is up against stiff opposition. The Pink is already well established as the limelight figure, followed closely by the surgeon and chief assistant. The houseman is always hovering on the brink and is apt to be a serious obstruction to the Wardsman.

If the patient is his, he is advised to use

[3] A ploy of this nature can only be used once, and the Wardsman is advised to think up ahead a few standard counter-ploys for future use. Only the more experienced Wardsman can counter-ploy on the spur of the moment. Indeed, he would be foolish to leave himself open to such a hazard.

[4] It is good Wardsmanship always to study sister's desk before a ward round.

[5] No counter-ploy has yet been advised, although P. O. Masterling used to stand in front of the Wardsman and tread on his toes at each interruption. This necessitated a considerable reshuffle of personnel around the bed every few moments, and tended to annoy some of the chiefs.

[6] This can be dangerous, and he finally ceased counterploying after twice scalding himself on freshly sterilised bowls.

the late-arrival gambit, scrub up, and then find himself unable to open the drums as the foot pedals have stuck. He should kick the nearest drum until relief arrives. This can always be guaranteed to cause some personal attraction. On approaching the table the Wardsman should hiss his fellow-students away and take his place at the surgeon's side. A casual nod of acquaintanceship, a muttered "Doing something in the surgery," covers the late arrival.

He should endeavour at some time to touch something unsterile with his gloves, and then, just before the Pink sends him to change them, touch the surgeon's gloves as well. This necessitates wholesale scrubbing-up, and limelight is achieved.[1]

If the patient is not his, the Wardsman can gain a certain momentary notoriety by fainting, preferably full length, and knocking over the Pink's bowls of water. W. C. Hogshound would always mutter as he was carried out, amidst the resulting confusion, "Save the women first. Leave me. Get the children away." This clever twist to the gambit gave his name to it, and "Hogshound's Ploy" is now a classic theatre ploy, and is, indeed, one of the earliest to bear an originator's name.

Research is now going on at our centre at the Lesser Snelling Cottage Hospital, and in our next paper we hope to publish a monograph on "Sister Counter-ploy, Chiefmanship—or When to Laugh on Ward Rounds," and "Outpatientsmanship." Meanwhile we would like to leave this maxim with the budding Wardsman.

To every ploy there is a counter-ploy, and the clever Wardsman will always anticipate the counter-ploy with a counter-counter-ploy. If two clever Wardsmen come together, then the counter-counter-counter-ploying can reach the stature of a complex gambit.

One other thought—once you have started a gambit, see it through. Many Wardsmanship points have been lost by the fainthearted failing to play a complete gambit, because some slight variation was required for the immediate environment. Gambit variation is the essence of good Wardsmanship.

[1] Some surgeons become very abusive at the gambit, but the Wardsman will realise that the rough must be taken with the smooth, and that offensive remarks are best treated with a stony silence.

HARVEY AND FOSTER PRIZES

The Harvey Prize for 1951 was awarded equally to R. D. Clements and M. J. Witt. Prox. Acess. J. E. A. Wickham.

The Foster Prize for 1951 was awarded to M. G. Smith. Prox. Access. A. L. A. Reid. Certificates were awarded to R. D. Clements, R. C. Taylor, M. J. Witt, D. F. P. Wooding.

SO TO SPEAK . . . .

A bit fishy?

There is no real orthopnœa. The patient sleeps with two pillows and a lobster.
—A student in M.O.P.'s.

Referred pain

"You don't look well dear. What's the matter?"

"I've got an awful sore throat and I can hardly swallow. My doctor said that the tip of my uterus was inflamed."
Heard on a bus.

The long view.

"On inspection of the abdomen the substantia nigra was seen."
—From a student's gynaecological case.

APPOINTMENT

Sir Selwyn Selwyn-Clarke, who completed his tenure of office as Governor and Commander-in-Chief, Seychelles on February 23, has been appointed a Principal Medical Officer at the Ministry of Health with effect from March 1, 1951.

We take this opportunity of offering him our congratulations also on his K.B.E. in the New Year's Honours.

CAMPBELL DE MORGAN AND HIS SPOTS

By E. MERVYN ROSSER

CAMPBELL GREIG DE MORGAN, F.R.C.S., F.R.S., was a well-known surgeon at the Middlesex Hospital during the middle part of the nineteenth century. He was born at Clovelly in Devonshire in 1811 and died while still in practice in London in 1876. He was the youngest of three sons of an Indian Army colonel. Little is known of his early years. His father died when Campbell was a youth. He had two brothers, Augustus and George, the former becoming Professor of Mathematics at University College, London, where Campbell studied before he entered the Middlesex Hospital. He became M.R.C.S. in 1835 and F.R.C.S. on December 11, 1843, being one of the original 300 fellows. It was customary at this time for one man to lecture on several subjects and this lot fell to Campbell De Morgan. He took a leading part in the Middlesex Hospital Medical School from its foundation in 1835 being lecturer on Forensic Medicine, Anatomy, Physiology and Surgery. He continued his lectures in Surgery to within a few weeks of his death. His lectures on Cerebral Function created much interest, and he dealt with such subjects as "How a blow on the head might manufacture a thief or a liar from an honest man." He took charge of the Ophthalmic Department on its foundation in 1843. When the hospital was enlarged in 1848 he devoted much time to this work, especially to its proper ventilation, and the prevention of erysipelas, which had been very prevalent in the old Hospital. He became full surgeon to the Hospital in 1854 at the dismissal of Mr. Tuson, due to differences of opinion with his colleagues, which caused some bad feeling at the time. In the introductory address to the students in 1856 he stressed the necessity for clinical study, and the abolition of the then prevalent evil of cramming towards the end of the curriculum. He helped his friend Mr. Tomes, later Sir John Tomes, the eminent dental surgeon, in the foundation of the Dental Hospital of London in 1858, and was chairman of the Management Committee, and consulting surgeon, until his death.

He was elected a Fellow of the Royal Society ten years before his death, mainly as the result of a paper on "Observations on the structure and development of bone," which was prepared in conjunction with his colleague Mr. Tomes, and printed in the Philosophical Transactions in June 1852. He published another paper in the same periodical on "The structure and functions of the hairs in crustaceae" in April 1858. He also wrote the article on Erysipelas in Holmes's "System of Surgery" in 1860. He collected several examples of cavernous angiomata in voluntary muscles in 1864. A case in the seminem branosus of a girl aged 10 years, noticed at birth and removed because of an increase in size, is preserved in the Middlesex Hospital Museum. A cavernous naevus from a semitendinosus muscle is in the Bart.'s Museum.

He joined the Pathological Society of London in 1866 and contributed much original work on malignant tumours. He was well able to speak with authority on this subject, having the opportunity of studying malignant disease during a period of nearly 34 years in the special cancer wards of the Middlesex Hospital, which were founded as long ago as 1792 by Samuel Whitbread, and have now been replaced by the Myerstein Institute of Radiotherapy. He read a number of papers to the Pathological Society of London, which are printed in their *Transactions* on a wide variety of cases of surgical interest. However, his main contribution was in March, 1874, when he opened a discussion on cancer (7, p. 287 303). He gave a comprehensive address, and the majority of leading pathologists were present. He confined his remarks to the question "What are the relations of cancer to the organism, whether in its natural or morbid condition?" The discussion which followed extended over several meetings, and embodied the views of practically all who were competent to give them. Ten days later, Sir James Paget, who regretted that he was unable to be present at the previous meeting of the Society, opened the discussion, when he agreed with Campbell De Morgan "that they must hold both a local and a constitutional element as a necessary condition in nearly every case of cancer which comes under our observation." Sir James Paget also stated that he had traced an hereditary tendency in one of four cases. Sir James went on to emphasise the necessity "of a

full and complete consideration of the constitutional element in the origin of cancer," whereas Campbell De Morgan stressed the local origin of the disease, which accounted for his wide excision of cancerous growths at operation.

Three years previously, in 1871, he published a series of articles in the *Lancet* entitled "On the origin of cancer," where he discusses the question "Does the disease consist solely in a local change of structure or is it the local determination of a general morbid condition of the blood, or are the blood and the tissues equally interested in its formation?" The only statement he makes about the well-known spots which bear his name in this country, is in the second article in this series in the *Lancet* of July 8, 1871[8]. He was developing the theme that doubt should be cast upon the belief that a cancer poison in the blood is one of the factors in the production of cancer, which was then the generally accepted belief among pathologists. He talks of cancer frequently appearing in robust and healthy individuals as well as in cachectic ones, when he writes:

"There is another circumstance in connection with the recurrence of cancer after operation which to my mind is very significant. I have noticed, and it has been verified by the observation of many others, that concurrently with, or following on, the development of cancer, small outgrowths of warty, or vascular, or dermoid structure are frequent. Now one would imagine that if there were a cancer-poison in the blood, these or one of them would become the seat of the disease. But it is never the case, although a large outbreak of cancer may have taken place in other situations, which are the usual seats of the disease after operations, but the rare one independent of them. The frequent coexistence of cancer with other growths will be alluded to."

He then goes on to discuss the hypothesis of the double origin of cancer. The rest of the articles deal with inoculation of cancer, its dissemination, its reproduction, the cause of the return of cancer, a latent tendency to cancer, relation of cancer to tubercle, inheritance of cancer, and lastly treatment by caustics, pressure, excision and starvation.

Thus he did connect these spots (if indeed these senile angiomata are the ones he refers to) with cancer. These articles were published in the form of an 87-page tract in 1872, under the heading "The origin of cancer, considered with reference to the treatment of the disease." There is a copy in the Library of the Royal College of Surgeons presented by the author[4]. There is also a lithograph of him by G. R. Black dated 1876, and a photograph, in the Royal College collections.

Campbell De Morgan married a Miss Hobson after being engaged for many years. There were three children, two sons and one daughter, the latter dying when only a few months old. Mrs. De Morgan died shortly afterwards, somewhere about 1856, which proved to be a terrible blow for him, from which it is reported he never fully recovered. Campbell De Morgan was a man of dominant religious convicitions and sincere belief. His high standard of character brought him many friends and some enemies. He cared little for money, never pressed for fees, and when the circumstances warranted it, would make such a remark as "Wait until you are asked!" He had an apparent indifference to worldly success. As a surgeon, he was a painstaking, conscientious and a bold operator. He had a gift for drawing caricatures which was appreciated by his students.

He put private considerations secondary to the well-being of the Hospital. He was an accomplished musician. It was due to his exertions that a performance of Mendelssohn's "Elijah" at Exeter Hall resulted in £1,417 for the Middlesex Hospital. In the latter part of 1875 his colleagues suggested giving him a testimonial. When he heard of it he said "It humiliates me to think how small are my claims to such a distinction as they propose to confer upon me. I am sure that those who feel so kindly disposed will not consider it unkind if I urge that no further steps be taken."

When his friend, the well known sculptor John Graham Lough, who married a sister of Sir James Paget, was dying, he sat up with his friend until the early hours of the morning. On returning home he caught a chill. While receiving patients next morning he was seized with a severe and persistent rigor. Pneumonia developed, and he died five days later in his 65th year in 1876. He was buried beside his late wife in Kensal Green Cemetery.

There is a marble bust of Campbell De Morgan at the far end of the Middlesex Hospital Bland-Sutton Institute of Pathology Museum. This likeness was presented to the Hospital by the sculptor, J. G. Lough, "In token of deep affection and gratitude, July 1875," the year before their deaths.

The male line of the family ended with the death of Campbell William De Morgan, grand-nephew of the above, who died on

The Spots

They are bright reddish-purple in colour, round or oval in shape and vary in size from a minute speck to a few millimetres, and appear slightly raised from the skin surface. They commonly occur on the thorax, abdomen and back.

They rarely appear before middle life and are equally common in males and females. Most patients say that they cannot remember when they appeared, or that they have been there as long as they can remember, or that they have not noticed them before. According to Murison, Williamson and Southerland (3, p. 736) 5 per cent. of adolescents have them, and their incidence rises as age advances. At 30 years 20 per cent. of people possess them. At 50 years 50 per cent., and at 70 years 75 per cent. of people have acquired them. Although the spots increase both in number and size as age advances, their rate of growth decreases. The spots take about 20 years to grow 3 mm. in middle age, and grow at half this rate in old age. These workers found by an analysis of 1,300 cases that they were only slightly commoner with malignant disease, but not significantly so. They are only known as Campell De Morgan spots in Great Britain. In the International Literature the spot is usually known as angioma senile. Other synonyms are angioma eruptivon, angioma tuberosum, senile actasia, angioma nodulare cutis, perles sanguines, ruby spots and cancerodermes.

Pathogenesis

According to Boyd's Textbook of Pathology a hæmangioma is a new formation of blood vessels, whereas a telangiectasis is merely a dilatation of pre-existing vessels. Some authorities, however, consider the latter term to be a clinical one only.

Histologically a number of views have been put forward:—

1. That they are capillary hæmangiomata or localised new growths of the capillary endothelium.
2. That they are late developing nævi which is a view suggested by Dr. R. M. B. MacKenna.
3. That they are simple dilatations of normal capillaries or capillary telangiectasia.
4. F. Parkes Weber[7] says that they are simple "mutational" tumours of cutaneous capillaries, or minute capillary angiomata rather than telangiectasia.
5. Sir John Bland-Sutton[1] held the opinion that they are patches of pigment not nævi.
6. W. Sampson Handley, 1909, says that they begin as small nodules of connective tissue under the epidermis of atrophic skin. Wide blood channels develop as the spots enlarge, which raise the epidermis causing further atrophy.

Known as the Leser-Trélats symptom they are said to indicate internal cancer and it has been suggested that they indicate the position of the growth. Dr. A. T. Brand writing in the *B.M.J.* in 1902 on "Plaques De Morgan" strongly supported their connection with cancer and called them cancerodermes. He did not support his views with statistics. On the other hand W. Sampson Handley was of the opinion that diseases had no relation to the incidence of the spots. He also said that each has a narrow vascular pedicle. Gentle rotatory pressure with a glass slide can empty these dilated vessels, the colour disappearing and reappearing on release of pressure * He also stated that they are the product of advancing years, especially liable to appear in the waist region where the skin is subject to pressure and lateral displacement. L. Wertheim who also investigated these spots wrote that there was little evidence to support the theory that they indicate cancer. F. Parkes Weber says that they are of no importance, not even as identity marks. They may formerly have been of value as "witch marks"! Sir John Bland-Sutton, who made observations for 25 years on these spots, writes that they are as common in non-cancerous as in cancerous patients[4].

Campbell De Morgan's name is thus immortalised in the minds of British medical men, but the spots are probably of little significance, apart perhaps from an indication of advancing years.

Acknowledgements

Thanks are due to Mr. J. L. Thornton, Librarian, St. Bartholomew's Hospital for suggestions and corrections, Mr. W. J.

* However, the writer has been unable to accomplish this feat.

Bishop, Librarian of The Wellcome Historical Research Foundation, Mr. W. R. LeFanu Librarian of The Royal College of Surgeons, and Mr. D. H. C. Harland for commenting on the final manuscript.

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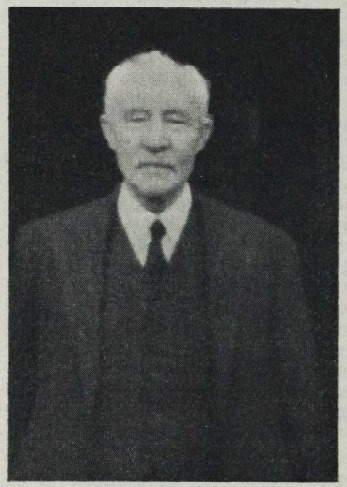
OBITUARY

G. E. GASK, C.M.G., D.S.O., F.R.C.S.

GEORGE ERNEST GASK, first Professor of Surgery at St. Bartholomew's Hospital, died at his home at Hambledon in the Chilterns on January 16, 1951. He had reached the age of 75 on August 1, 1950, and on that day three of his old pupils and assistants paid their last visit to his home to give him a specially bound copy of his collected papers on surgical history. This volume had been printed without Gask's knowledge for more than 500 subscribers, who wished to do him honour on his birthday. Gask's visitors found him in bed, cheerful and, as he put it, in excellent condition "from the neck upwards," but his heart was beginning to fail. He was still able to write a personal acknowledgement to each of the subscribers to his book, his pleasure in the gift being very great, but he was never able again to make any physical exertion.

Gask's early schooling was received at Dulwich College, but he left at 17, spending some months at Lausanne and Freiburg-i-Baden before entering the Bart.'s medical school in 1893. This interlude abroad was characteristic of Gask's life-long belief in the benefits of taking every opportunity to broaden experience and outlook by contacts with outside influences. He qualified in 1898, and became house surgeon to John Langton. In 1901 he obtained the Fellowship of the Royal College of Surgeons of England and after working for a few years as demonstrator he was appointed Warden of the Medical College. This was in 1906, a year before being elected to the staff of the Hospital at the age of 32. He lived for several years in the old Warden's House in the Hospital precincts, where Sir James Paget and other distinguished Bart.'s men had preceded him. He thus became Assistant Surgeon to D'Arcy Power, whose quickness in speech and action contrasted conspicuously with his own deliberation of



Professor Gask shortly before his 75th birthday.

thought and movement, though each appreciated the other's qualities so that they worked together in perfect harmony. Gask's attitude to life was that of the practised mountaineer, a pursuit which he followed with careful enthusiasm during his active years. The competent mountaineer plans his expeditions with thought and foresight, he is ready to withdraw if circumstances change so as to introduce unnecessary risks, he avoids all rash and hasty movements, and he keeps a watchful eye on the weather; his thoughts are directed as much to the safety and welfare of his companions as to his own. These were Gask's methods in all his dealings with men and affairs and, above all, in his surgery.

During the seven years that preceded the outbreak of the First World War Gask was steadily building up a practice as consultant and a reputation for sound work in general surgery. His good craftsmanship and humanity engaged the confidence of doctors and patients, and his assistants in later days were accustomed to losing (as they thought) a good deal of time while Gask questioned his patients about seemingly irrelevant details of their private lives. The establishment of human contacts, whether with his colleagues or the humblest of his patients, seemed to him to be of the first importance, for he loved his fellows and his interest in them was genuine, not a bedside trick.

Soon after the outbreak of war Gask entered the R.A.M.C., and served as a Captain attached to No. 1 General Hospital, as a Surgical Specialist with the rank of Major at a Casualty Clearing Station, and finally as Consulting Surgeon to the Fourth Army with the rank of Temporary Colonel, A.M.S. Already before the war he had given considerable attention to the problems of thoracic surgery, a field which had been surveyed by few surgeons before 1914. Gask naturally turned his attention, therefore, to the study of thoracic injuries and their treatment, and his work in this line attracted much attention and brought him many honours. He was four times mentioned in despatches, was awarded the D.S.O. in 1917, and was made C.M.G. in 1919. It seemed that Gask was thus marked out for a successful career as a London consultant in his middle years, but this was not his aim. In his slow and thorough way he had been "turning over in his mind" (a favourite phrase of his) for some time before the war the idea of the Professorial Unit as part of a teaching hospital. He ruminated on it and discussed it with his friends during leisure hours in France, and when the war was over he was ready to seize the opportunity offered to him of becoming Director of the first Professorial Unit at his own hospital. His team had been chosen in advance, and he showed his readiness to break with tradition by readily giving up all private practice and by inviting an Australian surgeon, T. P. Dunhill, to act as his part-time Assistant Director. The experiment was a bold one, especially, perhaps, in the reputedly conservative atmosphere of Bart.'s, but Gask's wise and careful leadership, combined occasionally with a quiet ruthlessness, proved equal to the task, and the establishment of the professorial system in medical education in Great Britain owed much to his initial success. Gask, without himself possessing any outstanding originality of mind, led his team gently but firmly along lines which he suggested, while giving them all the freedom they could want for their own development. His principle of broadening their outlook was continually at work by leading his associates on visits to other surgical clinics in all parts of Great Britain, and by inviting a distinguished surgeon from another school in England or America to take temporary charge of his unit each year. His assistants in this way came to know intimately the work done by men such as Sir Cuthbert Wallace, Lord Moynihan, and Dr. Harvey Cushing. His senior colleagues Gask piloted, as a body of Pilgrim Surgeons, to clinics all over Europe, acting himself as organiser and courier to everyone's admiration and satisfaction. During the fifteen years of his Directorship at Bart.'s, he performed an immense amount of service to the Hospital and College on innumerable committees—it was believed that he positively enjoyed them—and showed there his flair for imperceptibly directing his fellows along the ways he thought they should go. He also served on the Medical Research Council, and as a member, also for many years chairman, of the Editorial Committee of the *British Journal of Surgery*.

Gask's term as Professor of Surgery ended in 1935, when he reached the age of 60. He was then still a strong man both physically and mentally, and he retired to his home in the Chilterns ready to turn his mind to local duties such as Rural District Councillor and Justice of the Peace, and his hands to his favourite pursuit of gardening. Four years later, however, the outbreak of war in 1939, demanded his return to a very active life as Consulting Surgeon in Oxford. He was appointed to temporary duty at the Radcliffe Infirmary, and was made Lecturer on Surgery to the University. Soon his services were engaged more widely and he became Regional Adviser in Surgery in the E.M.S., a member of the Medical Advisory Council of the Nuffield Provincial Hospitals Trust,

and chairman of the Medical Advisory Committee of the Berks., Bucks., and Oxford Regional Hospitals Council. He was also one of the Surveyors of the Medical Services in those Counties. He was thus able to give another five years of strenuous service to his country after his supposed "retirement," and it was not until 1946, at the age of 70, that he was allowed to think again of resting from his labours; but even after that the introduction of the National Health Service naturally led to his taking an important part in the work of the Regional Board, until the signs of coronary atheroma forced a curtailment of his activity.

Gask's sturdy physique matched the strong and enduring qualities of his mind. His personality was massive and undemonstrative, but his feelings could be deeply stirred. He inspired affection and loyalty in his assistants, and his own loyalty to his colleagues and his hospital were unfailing.

Gask's writings were not prolific, but he was part-author of a text-book of surgery and of a monograph on *The Surgery of the Sympathetic Nervous System*. He delivered the Lettsomian Lectures on "The Surgery of the Lung and Pleura" at the Medical Society of London, of which he was President. He delivered the Vicary and Bradshaw Lectures at the Royal College of Surgeons, where he was twice a Hunterian Professor, and a member of Council from 1923 to 1939, serving as Vice-President for the usual term of two years. He was deeply interested in the history of medicine, and made a number of contributions to the subject, including the papers collected in the birthday volume published in 1950.

Gask was fortunate in his marriage in 1913 to Ada Alexandra, daughter of Lt. Col. Alexander Crombie, M.D., I.M.S., who survives him after thirty-eight years of happiness. Their son John was a student at Bart.'s, and after serving as Surgeon-Lieutenant in the R.N.V.R., is now in practice at Market Drayton.

George Gask's name will be recorded in the annals of this hospital as that of one of its most valued and loyal sons.

St. D.

CLINICAL CASE-BOOK

The two cases described below were treated with Cortisone in this Hospital. The drug was administered locally in Case I, i.e., subconjunctivally and then as eye-drops, and systemically, i.e., by intramuscular injection, in Case II.

Case I

Mrs. M., 49, housewife, suffering from bilateral iridocyclitis (inflammation of the Iris and Ciliary Body) and hypopyon (pus in the anterior chamber) of the left eye.

History of present condition

Patient had had a six years' history of bilateral Iridocyclitis which had been treated with some temporary success with systemic penicillin, the inflammation always recurring after an interval.

On examination (January 29, 1951)

L. hypopyon. Vision in that eye: perception of light only.

Treatment

Cortisone Acetate subconjunctivally, 0.4 ml. (6.25 mg.) once, then Guttæ Cortisone Acetate 15 times per diem.

Progress

January 31: Hypopyon absorbed.

February 7: Cornea clear, a few cells in the anterior chamber, posterior adhesions of iris. Patient discharged.

Case II

Mrs. N., 51, housewife suffering from recurrent Scleritis.

History of present condition

The patient had had an eight years' history of bilateral attacks of "prickling," "watering and redness" of the eyes, the L. more than the R., which lasted some two weeks, with sudden onset and remission, and normal vision in between. She had had three or four attacks each year and had been treated with courses of suphonamides and penicillin, and, in 1947, with streptomycin injections and aureomycin eye-drops. Then had no attack for three years, until in September, 1950, a typical attack developed and lasted until admission.

On examination (December, 1950, on admission)

Eyelids, conjunctivæ and scleræ injected, both lids oedematous, photophobia and watering of eyes. Cornea, Iris and remainder of eyes normal. T=98°F, P=78, R=24

p. min, ESR 23 mm., blood picture normal, W.R. negative. (No other significant symptoms.)

Treatment (January 2, 1951)

I.M.I. Cortone, 200 mg. in one day, then 100 mg. per diem for five days.

Progress

January 5: Marked improvement of eyes. A paronychia and tenosynovitis of R. thumb developed. Sulphonamides, then penicillin were given. Eye "inflammation" then recurred, and cleared up when the penicillin was stopped. The thumb became normal in a few days.

January 17: Patient discharged: eyes normal.

Comment

1. Factors in the production of scleritis may be tuberculosis, syphilis, herpes zoster, or an allergic reaction to a bacterial toxin. The length of history and present unscathed condition of the eyes in this case is evidence against a straightforward infection. In most cases the ætiology is obscure; in this patient all examinations to find a cause had negative results.

2. The following are among the effects of Cortisone systemically which may be noticed.

(i) *Retention of sodium and water.* This may proceed to ascites, effusions and heart failure. This patient was weighed daily, and sweating tests were carried out. In the latter test, sweat is collected in a rubber glove and analysed for sodium content. She was given a diet containing a normal quantity of salt.

(ii) *Depletion of body potassium.* This produces muscular weakness and characteristic E.C.G. changes. The patient showed no signs of these.

(iii) *High blood sugar and decreased response to insulin.* The patient had no glycosuria or symptom of Diabetes.

(iv) *Retardation of wound healing and inhibition of growth of granulation and fibrous tissues.* (Suggested by Carlisle, M.D., 1950 *B.M.J.* 2, 590.) It is possible that the occurrence of an acute paronychia and tenosynovitis in a patient who had never previously had a similar infection had some relation to a lowered ability to control an infection.

Conclusion

The eye is a particularly suitable organ in which to watch the effects of this new agent, as it is possible to treat eye inflammation by small subconjunctival doses and thus to avoid the general effects sometimes seen. Moreover, the day to day progress of the inflammation may be easily watched.

The subjunctival method of administration of Cortisone offers advantages over intramuscular injections in the treatment of eye inflammations.

I wish to thank Messrs. A. S. Philps, R. Scott and R. S. Corbett for encouragement and permission to publish these cases.

J. P. WATERHOUSE

EXAMINATION RESULTS

CONJOINT BOARD

Final Examination — **January, 1951**

Pathology

Cassells, M. J.	Haigh, P. G.	McKinna, C.	Picthall, G.
Chuck, V. R.	Hazelton, S. F.	Matthews, P. D.	Wallace, J. R. C.
Corbet, J. L. M.	Ledell, R. C. H.		

Medicine

Cassells, M. J.	Fildes, P. G.	Nielson, J. S.	Smith, D. P. Q.
Clarke-Williams, M. J.	Haigh, P. G.	Parrish, J. A.	Taylor, J.
Connell, P. H.	Hambling, M. H.	Phillips, G. D.	Trevan, A. C.
Courtenay, P. H. E.	Hart, C. J. R.	Sims, A. J.	Williams, D. K.
Farley, J. D.	Ibbotson, R. N.		

Surgery

Albright, S. W.	Carroll, D. S.	Drysdale-Anderson, R. J	Montagnon, J. L.
Apthorp, G. H.	Cassells, M. J.	Goff, E. G.	Shore, E. C.
Birch, G.	Coldrey, J. B.		

Midwifery

Cassells, M. J.	Farley, J. D.	Jones, K.	O'Sullivan, D.
Chuck, V. R.	Hardman, B. M. H.	Jones, R. F.	Shore, E. C.
Courtenay, P. H. E.	Hazelton, S. F.	Leigh, J. G. G.	Wilkinson, B. R.

The following Students have completed the examination for the Diploma M.R.C.S., L.R.C.P.:—

Cassells, M. J.	Coldrey, J. B.	Nielson, J. S.	Phillips, G. D.
Clarke-Williams, M. J.			

SPORT

RUGBY CLUB

Hospital Cup Match
v. ST. THOMAS', February 13.
Result : LOST 0-11.

This year the little god that watches over the draw for the Hospital Cup ordained that Bart.'s should meet St. Thomas', the holders of this coveted trophy in the first round, and not content with this he also selected the 13th as the date for match, and when the day came it hadn't stopped raining since the previous Sunday night. However, despite all this, the game turned out to be extremely exciting, and remarkably open.

St. Thomas' won by a goal, a penalty and a try to nil, and it must be admitted that with the exception of M. J. A. Davies at fly half, and A. M. Baker who played a truly magnificent game at full back, the Bart.'s outsiders were no match for St. Thomas' brilliant back division. Forward however, although outweighed in the set scrums and at a disadvantage as regards height in the lines-out, the Bart.'s pack played excellent football. In the loose all worked hard, but none harder than A. J. Third whilst in the fore of many very good foot rushes was C. W. H. Havard who throughout the afternoon led the team with great spirit. The defensive covering of the forwards was all well executed, and D. M. Cuthbert did a lot in this direction.

The game started well for Bart.'s and with the team playing intelligent football much of the first 30 minutes was spent in the Thomas' half. A clever jinking run by M. J. A. Davies carried him through the defence and a score appeared a possibility but he left his pass just a little too late. Both sides had opportunities for scoring by penalty goals but neither did.

Towards the end of the first half Thomas' attacked and from a rather loose kick they found touch right next to the corner flag on the Bart.'s line. From an infringement in the line-out a set scrum was given and it was from this that the St. Thomas' scrum-half came round the blind side and spirited the ball over the line with commendable dexterity for an almost inevitable try. This was not converted.

A few minutes later from a scrum in the Bart.'s 25, St. Thomas' heeled and the ball reached their fly-half Maekleburgh who, with a fantastically elusive run, crossed the Bart.'s line without a hand being laid on him. This try was converted and so at half-time Bart.'s were 8 points down.

Soon after the beginning of the second half St. Thomas' were awarded a penalty from which they scored and this ended the scoring. For the last half hour Thomas' opened up the game and attacked using their powerful line to its fullest advantage, and it was a combination of a poor finish on their part and the stout defence of A. M. Baker at full-back that prevented a higher score.

A fine run by M. G. Taylor once carried him through almost the entire Thomas' team whose attempted tackles he treated with a fine disregard but he just wasn't able to score. Again in the last 10 minutes Bart.'s came very close to the line but couldn't quite cross it, and so at no-side the score was 11-0 to St. Thomas' who now go on to meet Guy's in the second round of the Cup in which we wish them the best of luck.

Team : A. M. Baker, J. K. Murphy, M. G. Taylor, K. A. Clare, J. L. M. Corbet, M. J. A. Davies, A. J. Third, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.), D. W. Roche, M. V. J. Fitzgerald, G. W. Mears, D. M. Cuthbert.

v. KENILWORTH, February 3, at Home.
Result : DRAW 3-3.

The Hospital drew with Kenilworth on Saturday, February 3, by a try to a drop goal. The ground was heavy, and it was raining at the time of the kick-off. Despite these conditions, however, the ball was moved around the backs by both sides to begin with. Bart.'s opened the scoring half-way through the first half when G. Picthall on the right wing gathered a kick ahead and much to his and everyone elses surprise, found the left wing J. L. M. Corbet outside him—the latter plunging over near the right-hand corner. The kick at goal failed. Kenilworth pressed hard after this reverse, but the defence held out and Bart.'s led at the interval 3-0.

The first part of the second half developed into a forward battle, neither side taking risks with the greasy ball. Most of the attacking was done by Bart.'s, but in one of the few occasions when Kenilworth were in our half their fly half dropped a neat goal from the 25-yard line. This seemed to stir the whole Bart.'s side to greater efforts and the ball swung from one side of the field to the other, both wings narrowly missing scoring in the corners. However, the hospital had left this revival too late although with a shade more skill and luck, they might have recorded a win rather than a draw.

v. OLD CRANLEIGHANS, February 17, at Home
Result : WON 3-0.

St. Bart.'s beat the Old Cranleighans at Chislehurst this afternoon by a try to nil, in an exciting open game.

The home team won the toss and took the advantage of the wind and slope for the first half. They failed to make the best use of this advantage, for, although most of this half was played in the Old Cranleighans' 25, Bart.'s never managed to score. The forwards played well and gave the backs plenty of the ball, who on several occasions did everything but score. Mackay and Clare were combining well and the ball was getting out out to the centres and wings regularly. A combination of good defence from the Old Cranleighans and lack of penetration from the Bart.'s backs prevented any score.

In the second half Bart.'s attacked again and, thanks to the vigour and hard work of the Bart.'s forwards who were up against and outplaying a heavier and taller pack, the Hospital was once again in a scoring position. Then as a result of a quick heel from the loose the ball went out to Taylor who beat his man and passed to Murphy who, after a determined run, went over to score; this was not converted.

The rest of this half, except for one determined run by one of the Old Cranleighan centres, which led to touch 10 yards inside the Bart.'s 25, the home line never really looked in danger.

A good Bart.'s forward rush almost resulted in another score for the Hospital, but an opponent was able to make the touch down first. No-side came with Bart.'s still attacking but score still only one try to nil.

Team : A. M. Baker, J. K. Murphy, M. G. Taylor, J. M. Kneebone, P. Macdonald, K. A. Clare (Capt.), A. Mackay, L. Cohen, P. Knipe, F. I. Macadam, D. W. Roche, A. J. Third, M. V. J. Fitzgerald, G. W. Mears, D. M. Cuthbert.

"A" XV

Cup Match
v. ST. THOMAS' "A" XV, February 21, at Home.
Result : WON 5-0.

This match, played at Chislehurst as St. Thomas' ground was unfit promised to be a hard forward game. In this we were not disappointed, though the ball kept remarkably dry; had there been less wind there might have been more three-quarter play.

St. Thomas' kicked off downhill and their big pack appeared dangerous—there were several times when they heeled and their threes broke through our centre—only to be stopped by their knocking-on or by the hard tackling of G. Small at full-back. Our forwards formed a loose scrum rather quicker than they did and several times two or three of them broke through with the ball at their feet—L. Cohen and J. Maskell were well to the fore in this aspect of the game. In the set scrums we were rather outweighed but even so R. C. Cochran's feet could often be seen pulling hard on the ball when it was in their second row and, as a result, we had well over 50 per cent. of the ball. It was, however, rather distressing to see the ball sticking more often than it should in the second row after an otherwise quick heel—this allowed their scrum-half to get round and M. Hodgson did well to get the ball away as often as he did.

About 10 minutes before half-time we were awarded a penalty some seven yards inside their half and in the middle of the field. G. Small failed in his kick but proved conclusively that it pays to back up really hard, for the ball bounced off one of their men, and was carried over by him for a really fine try—which Caiger converted.

The second half was a to and fro battle with their fly-half always dangerous—principally because our tackling was not of the "first time" variety. In attack, however, the threes were more resolute but their passing in the wind—like St. Thomas's—was rather erratic and the wings, when they got the ball—were too often on their own with no man backing up to receive a pass back.

Bart.'s can be well pleased with the result—which is a revenge for the 1st XV—and the team are to be congratulated on their fine and hard playing.

CRICKET CLUB

SEASON 1951

Practice nets will be held at Chislehurst in the middle and end of April in preparation for the first fixtures at the end of April. Notices of times of nets will be placed on notice-boards in good time, and anyone wishing to play cricket this season is asked to turn up at these times. Any new Bart.'s men are particularly welcome. Fixture cards may be obtained from the officers for 1951 :

Captain: M. Braimbridge; Vice-Captain: H. B. Ross; Secretary: P. B. Biddell; Treasurer: B. N. Foy.

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 ?

ATHLETIC CLUB

THE 1950 SEASON

During the past year the Club, under the very capable leadership of P. D. Matthews, had a very successful season. Although we did not quite maintain the all-round standard of the previous two years, we were always able to give a good account of ourselves. The outstanding result of the season was our victory in the United Hospitals Championships at Motspur Park, on June 10, and we owe this success to the hard work put in by our trainer Mr. A. H. Drewer, and to the enthusiasm and keen team spirit shown by the members of the Club.

Several members represented the United Hospitals, and the Universtiy Teams during the season, and A. H. Macdonald is to be congratulated on obtaining a "Purple" for his performances for the University.

The following have been awarded Honours :—
D. L. Bee, A. H. Macdonald, J. A. Stainton-Ellis.

And Colours were awarded to :—
D. F. Craggs, J. Lambourn, G. Middleton, H. Poirier, D. M. Stainton-Ellis, B. R. Wheeler.

1950 saw the formation of a Ladies Section of the Club, and with seven keen members they made a very promising debut on the track. In their section of the United Hospitals Championships they gained first place in four events and second place in the fifth event, thus finishing up very worthy winners. We should like to congratulate Miss Meredith and Miss Bott, who represented the University Team at a meeting in Paris.

The Annual General Meeting was held in the Abernethian Committee Room on Friday, 2 March, 1951, when the following officers were elected for the 1951 season.

Captain: A. H. Macdonald; Vice-Captain: E. M. Rosser; Secretary: D. M. Stainton-Ellis; Treasurer: J. A. Stainton-Ellis.

THE 1951 SEASON

We have been Inter-Hospitals Champions for the past three years, and we are hoping that we shall record yet another victory this season; but without new members this task will be well nigh impossible. Therefore we should like to appeal to all students, both male and female, who are interested in athletics to join the Club and give us their support, in order that we may uphold Bart's fine athletic tradition.

The 68th Annual Sports Day will be held at Chislehurst on Saturday, May 26, 1951. Please make a note of the date and be sure to come and give us your support.

FENCING CLUB

Once again this year Bart.'s entered a team for the inter-collegiate foil competition (De Beaumont Trophy).

In the first round we were drawn against Chelsea Polytechnic and we expected to win fairly easily. However, it was not to be on this occasion, and we narrowly lost by 7 fights to 9. The finish was exciting as we were winning the final and crucial fight by 4 points to 1 with only one more point needed; credit must be given to Chelsea for retrieving the situation.

Once again lack of experience and determination on the part of our younger fencers was evident, but it was equally evident that our team now has the technical skill and ability to do far better in the future, and we look forward to meeting Guys. Scorers for Bart.'s :—

W. M. Beatley	...	4 wins	0 losses
G. Middleton	...	2 wins	2 losses
D. Eaton	...	1 win	3 losses
E. Henderson	...	0 wins	4 losses
Total	...	**7 wins**	**9 losses**

SWIMMING CLUB

v. ST. MARY'S HOSPITAL (Friendly)
Result : WON 6-1.

In this match the team was somewhat of an experimental nature, new players being tried in match conditions.

The defence of Cohen and Moyes together with Graham in goal played well together but the forwards played independently to a large extent.

Goal Scorers : Wilkinson 1, Cohen 2, Bliss 3.

v. L.S.E. 2nd (League Match)
Result : LOST 5-7.

L.S.E. fielded a strong team including some University 1st team players.

After a very poor start Bart.'s played together better in the second half after being 6-0 down at half-time (five goals being scored by one player).

Graham played well in goal saving many difficult shots.

Scorers : Horrocks 1, Corbet 1, Cohen 1, Bliss 2.

v. ST. MARY'S HOSPITAL 2nd
League Match
Result : WON 2-0 by default.
Friendly Match
Result : DRAW 5-5.

Due to their inability to field a suitable team Mary's turned out a team including 1st team players. In a somewhat hectic match in which many players—from both teams—were ordered out the standard of play was good.

Scorers : Low 1, Cohen 2, Bliss 2.

v. LONDON HOSPITAL (League Match)
Result : WON 9-1.

Bart.'s, as usual began by playing scrappily, resulting in the London scoring first. This goal steadied the Bart.'s team greatly and two minutes later Bliss equalised. Bart.'s then began to assert their supremacy in all parts of the game. Graham played extremely well in goal, stopping the few but difficult shots during the first half. After half-time with Bart.'s leading 5-1 and defending the shallow end the London team played more determined polo, and it was only due to outstanding play on the part of Cohen and Graham that London did not score more goals.

In attack Low played well and marked his opponent quickly whilst Bliss was always quick to utilise scoring chances.

Scorers : Low 2. Cohen 3. Bliss 4.

WOMEN'S HOCKEY CLUB

Saturday, January 13 v. Bedford College. Home. LOST 2-7.

Saturday January 20 v St. Mary's Hospital. Home. WON 4-1.

Saturday January 27 v. Atalanta Club. Home. DRAW 1-1.

Semi-finals, Hospital Cup

Wednesday, January 31 v. Royal Free Hospital Home. LOST 3-4.

This was a very close and enjoyable match. Bart.'s were away to a good start and scored the first goal within the first five minutes. The Royal Free soon drew even and after that the game was fairly distributed over both halves of the field giving a half-time score of 3-2 against us. In the second half the advantage seemed to be with Bart.'s and the score was soon three all.

Just before the end the Royal Free scored again after a determined rush down the field. Bart.'s tried hard to get another goal and almost succeeded off a centre pass from the left wing. However, the whistle went for time leaving the Royal Free the winners by one goal. The whole team played well and were unlucky to lose their chance of the Cup for another year.

Saturday, February 10 v. Chislehurst Beaver's Club. Away. LOST 3-6.

Unfortunately all other fixtures for Februray had to be cancelled because of rain.

FUEL-SAVING FEARS

"Look out or we'll be in the Fountain."
With apologies to the original creator.

BOOK REVIEWS

RECENT ADVANCES IN PHYSICAL MEDICINE, edited by Francis Bach. Churchill, 1950, pp. xv+490, figs. 93. Price 27s. 6d.

This rapidly growing branch of medical practice is of immediate interest to the consultant and to the keen general practitioner (when he has time to be keen). Francis Bach gives an answer to the question "what is Physical Medicine?" as it is generally accepted nowadays, but he does not altogether explain why it should be "physical medicine" and not "physical methods of treatment." The truth is that this subject is concerned with therapeutics and should not be confused with medicine on its diagnostic side. This is more true now that rheumatology is recognised as a speciality in medicine and no longer as part of physical medicine.

The present trend, and an excellent trend it is, is for Physical Medicine to progress along two important lines. The one—the development and use of bio-physical instruments in a precise and careful manner. The other is the organisation and co-ordination, particularly in the Hospital, or Group of Hospitals, of the work that is now termed rehabilitation.

The book follows these two important lines in its arrangement, although Section 3 is something of a red herring. The clinical information in this Section is too condensed to be of value and the technical methods described are apt to be reproductions of what has appeared, or subsequently appears in other Sections. The Sections on "Organisation of a Physical Medicine Department" and on "Rehabilitation and Resettlement" are of great interest, and provide a mass of information which cannot be obtained anywhere else in a single volume.

It is no criticism of its value to the qualified man to suggest that this book should be read by the advanced student with a selective eye. Unless he is a physicist he must not start with Chapter 1 or he will be depressed by his ignorance of the mysteries of the Quantum Theory as was this reviewer. He should read something of Electromyography from Chapters 2 and 5, and of Posture and Gait from Chapter 3. Chapters 8, 9 and 10 will teach him a good deal but not everything of the work of the Physiotherapist and he must not miss Chapters 27 and 30 if he is interested, as he should be by now, in Social Medicine. Chapter 25 will be of value for those who have their military service still to do.

W. D. Coltart

THE LIFE OF DR. JOHN RADCLIFFE, 1652—1714 : Benefactor of the University of Oxford, by Campbell R. Hone. Faber and Faber, 1950, pp. xiii + 149, 8 plates. Price 15s.

Dr. John Radcliffe is chiefly remembered for his bequests to Oxford University, his name being perpetuated in the Radcliffe Camera, the Radcliffe Observatory, the Radcliffe Infirmary and the Radcliffe Travelling Scholarships. It is not so generally known that he was a Governor of this Hospital, having been elected in 1690, and that his Trustees contributed a large sum of money towards rebuilding in 1755, £500 in 1822 towards enlarging the lecture theatre erected for John Abernethy, and that Radcliffe left an annual bequest of £500 "towards mending their diet," and £100 "for buying of Linnen," which sums are still received.

This new biography by Bishop Hone corrects the date generally given as that of Radcliffe's birth (1650) to 1652 or 1653, and contains information from documents discovered in the Radcliffe Science Library in 1948. It is a scholarly study, and contains interesting sidelights on Radcliffe's period, but the references given at the ends of the chapters are incomplete, as is also the index.

Previous biographers of John Radcliffe have leaned heavily upon the Life by William Pittis, first published in 1715, the trustworthiness of which has frequently been questioned. Bishop Hone has re-examined the evidence, to produce a readable biography of a remarkable character. The publishers have contributed by clothing the resultant volume in attractive garb.

J. L. T.

ESSAYS IN THE HISTORY OF MEDICINE, by George Gask. Butterworth, 1950, pp. viii + 209. Price 30s.

"This book is intended to mark the occasion of Professor George Ernest Gask's seventy-fifth birthday and to give practical expression to the affection and respect felt by so many of his students, colleagues and friends, and their appreciation of his great contributions to the practice of surgery, to medical education and to the organisation of the Health Services."

Since it was published, in 1950, Professor Gask has died, so that this is his last published work. It contains a selection of his historical writings from various sources, and throughout one is impressed by their objectivity. All too often historical essays ramble on and seem to have no particular purpose. In Profesor Gask's work one feels that the author has a thesis to present, a point to make, and invariably he makes it. The essays on Early Medical Schools illustrate this to perfection. The next six sections, Vicary's Predecessors (Vicary lecture 1930); The Medical Staff of King Edward III; The Medical Services of King Henry V Campaign of the Somme in 1415; A Contribution to the History of the Care of the Sick and Wounded during Marlborough's March to the Danube in 1704, and at the Battle of Blenheim: John Hunter in the Campaign in Portugal, 1762-3, contain masterly interpretations and assessments of various historic documents, with very interesting conclusions. They form a real contribution to medical history. The Lettsomian Lectures on the history and practice of chest surgery are reprinted as section VII and show very well how the pioneers, and amongst them we must include Professor Gask, have brought chest surgery to its present position. Section VIII, Changing Surgery, traces the development of specialism, surgical teams and professorial units, and the effect which these have had on surgical practice. It concludes with a note on the future. Mr. J. L. Thornton has compiled a bibliography of Professor Gask's writings which is appended.

The material, then, is excellent, and the fact that it has all been published before detracts not at all from its value. There are, however, one or two criticisms which may be directed at its presentation. The original publication was distributed to over five hundred subscribers and was bound in blue. To each of the subscribers was sent a "book plate" consisting of the introductory quotation above, and a list of subscribers was printed in the book itself. The edition available to non-subscribers is bound in red and has neither of these items. The result is that it contains no mention of the appreciation which the publication is intended to express. This has now been, to some extent, remedied by the provision of a book jacket giving brief explanatory details. Also, the three photographs of Professor Gask are without caption. Those of us who subscribed do not need captions, but what of the rest of the medical profession?

WHEELER AND JACK'S HANDBOOK OF MEDICINE, revised by Robert Coope. 11th Edition, 1950, Livingstone, pp. xvi + 648, figs. 62. Price 20s.

Dr. Coope suggests that "the student should use this book primarily as a help in his days of clinical clerking . . . for a preliminary sketching-in of a background to his experience." In this capacity the book should prove a really valuable help. The whole book has been revised and brought up to date, much being rewritten and each chapter is concise and accurate. The section on chest disease is excellent, kidney disease is classified according to Ellis, the neurology section is aided by figures taken from Walshe, Holmes. and Rowbotham. The author points out the book is not intended for the extensive study of any disease and that the student will need "to read much more, either in larger text-books or in monographs"; but the reliability of the book and the capacity of its author to condense the various aspects of disease down to their essentials should also make it of value to students revising for their final examinations.

PRACTICAL PROCEDURES IN CLINICAL MEDICINE, by R. I. S. Bayliss. J. & A. Churchill, 1950, pp. viii + 445. Price 25s.

The House Physician embarking on his first appointment does so with visions of haematemeses, coronary thromboses and diabetic comas occurring simultaneously and on all sides, with not the remotest idea of how to convert his theoretically acquired knowledge of the requisite treatment into practical medicine. It is to allay these nightmares that this book has been written. No general book of Medicine has the space to cover detailed methods of treatment, and this book, describing as it does in meticulous detail all the manoeuvres required of a House Physician, serves an extremely useful purpose. It is not merely in the clarity of its descriptions of techniques that this book is so outstanding. Each procedure is preceded by paragraphs on the physiology and principles of the manoeuvre with a list of the apparatus required, and followed by its difficulties and the interpretation of its results. The diagrams are few but clear. This book is, in fact, essential for every House Physician newly qualified, and useful for anyone engaged in medical treatment, embracing as it does subjects as varied as the bromsulphthalein test and 17-keto-steroids.

MEDICAL JURISPRUDENCE AND TOXICOLOGY, by John Glaister, 9th Edition, 1950, Livingstone, pp. xi + 755. Illus. 234. Price 35s.

Books on Forensic Medicine have a certain reputation to uphold in the character of their illustrations, and the luridness of those selected by John Glaister leave little to the imagination. This is an excellent book, well-printed on good paper. It is particularly well laid out with clear headings that make reading easy, though the continual appearances of that mysterious official, the Procurator Fiscal, may be a little disturbing to Sassenach readers. In the section on Toxicology, the introduction is good. In spite of the fact, however, that it is published in 1950, no mention is made in the section on treatment of arsenical poisoning of B.A.L., an omission that caused your reviewer some highly uncomfortable moments in a recent examination.

A POCKET OBSTETRICS, by Arthur Bell, 2nd Edition, 1950, Churchill, pp. viii + 156. Price 7s. 6d.

Students are naturally drawn to books that are concise and present the essential facts in readily assimilable form. This is one of the better of the pocket editions. Its paragraphs are well arranged and headings adequate. Particularly useful are tables of facts in the differential diagnoses of A.P.H. and toxaemias of pregnancy.

AIDS TO BOTANY, by H. J. Bonham. 3rd Edition, 1950. Ballière Tindall & Cox, pp. viii + 224, figs. 57. Price 6s. 6d.

This new edition aims at providing sufficient information for the Higher Certificate and 1st M.B. Each botanical form (including viruses and bacteria) is discussed in evolutionary sequence. Plant structure is described, and illustrated with diagrams particularly clear for this series of books. The chapters on plant physiology, ecology and genetics are brief but adequate.

The opportunity has been taken to include paragraphs on viruses, hormones and trace elements. This is not a book to be read for pleasure or indeed for learning: its task is graver and more limited. It is exactly what the author hopes it to be—a means of rapid and inclusive revision when preparing for an examination.

A SYNOPSIS OF FEVERS AND THEIR TREATMENT. 9th Edition, 1950, published by Virol Ltd., pp. 192. Price 2s. 6d.

This synopsis has now run to nine editions. It has been completely rewritten since the advent of the antibiotics. It manages to keep its feet on the ground, giving practical information as to diagnosis and treatment of patients in their own homes, and laboratory tests are adequately discussed. Though this book is not by any means exhaustive, it is well worth the price. As the ready index and the hard-wearing cloth cover would suggest, this is just the book to keep in the bottom of one's little black bag.

SISTER THEATRE, by G. Vaizey. Harrap, 1950, pp. 271. Price 10s. 6d.

We are told that Mr. Vaizey spent considerable time in a hospital studying "atmosphere" before writing this book. It is immediately apparent to the reader that it was not at Bart.'s that he studied. Nevertheless, although not the atmosphere to which we are used, in parts it does ring true; though in other parts atmosphere has been sacrificed to the somewhat shaky plot. Like most novels it has its moments (there is a delightful story about a professional wailer in the morgue). The fact that a reprint is called for is some indication of its popularity, mainly, I suspect, with the non-medical reader.

TEXT-BOOK OF GYNÆCOLOGY, by J. H. Peel. 3rd Edition, 1950, Heinemann, pp. xvi + 477, Illus. 219. Price 24s.

There are those who prefer a text-book to be long-winded and verbose, considering that it is possible to remember only a quarter of what one reads, and that the more padding consequently there is the better. Others would rather learn by headings and dogmatic conciseness. Peel's Gynæcology is for the second type of student. The lay-out is clear, diagrams are good, but microphotographs, as is so often the case, are no more than adequate. Uterine neoplasms are particularly well presented—with perhaps not enough emphasis on the early diagnosis of carcinoma of the cervix—and a very useful chapter is that of gynæcological symptoms, each considered temporary. Chapters on endocrine and radiation therapy are good symposia. In fact this is an extremely useful book for the student of gynæcology, particularly if he is new to the subject.

AIDS TO MEDICAL TREATMENT, by T. H. Crozier. 2nd Edition, 1950. Ballière, Tindall & Cox, pp. viii + 439. Price 7s. 6d.

The student is confronted at some time during his course—usually uncomfortably close to his finals—with a terrifying lack of knowledge of the subject of Therapeutics. This book—perhaps the best of the "Aids" series is expressly designed for this purpose. It covers the up-to-date treatment of all medical diseases in a methodical and concise fashion. Although it wastes no words, it is yet easy to read and will be a godsend to the hard-pressed student with little enough time to spare from Rugger.

CLINICAL EXAMINATION OF PATIENTS, by Forbes & Mann. Edward Arnold, 1950, pp. x + 323. Price 18s.

Perhaps no field on medicine is so thoroughly—and possibly so unnecessarily—covered by the literature as is that of the initial impact of clinical methods on the student. It is a somewhat trying period admittedly but has not the terror ascribed to it by a multitude of authors. This book is no better and no worse than most. The chapters on the examination of the nervous system are perhaps the best with good diagrams of the various pathways and their lesions. The sections on the radiography of the different systems are also excellent. Whether such a book, which—however good it is—is discarded early in a student career, is worth 18s. even in these days of inflated prices is a matter not easy to decide.

BROMPTON HOSPITAL REPORTS, vol. XVIII, of the Brompton Hospital, pp. vii + 221, Illus. Price 12s. 6d.

This volume contains reprints of articles which have appeared elsewhere in the medical press, and authoritatively covers a wide range of topics concerned with disease of the chest. Some are of a rather highly specialised nature and will appeal to those interested in the rare or uncommon, but there are several of more general interest to the medical student. In particular we would like to recommend all who can spare a few minutes to read the admirable article on bronchial carcinoma which opens the book and which apportions so fairly the credit for the occasional successful treatment of this condition. The production is excellent and there are many plates and skiagrams.

APPOINTMENTS

The undermentioned appointments to the Junior Medical Staff have been made.

Registrar to the Children's Department
Dr. J. G. Millichap (from March 1, 1951).

Junior Registrar to Mr. Naunton Morgan
Mr. Gordon Bourne (from April 1, 1951).

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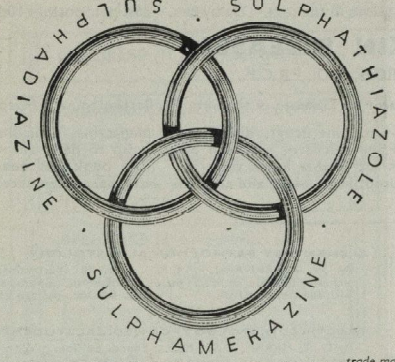

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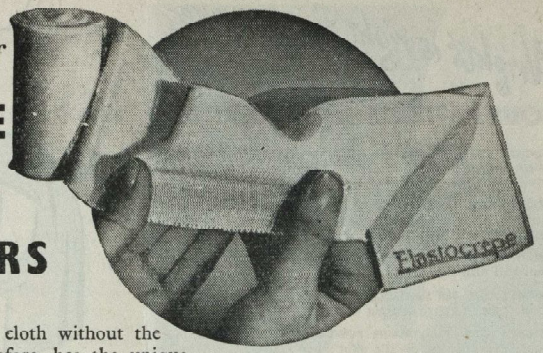

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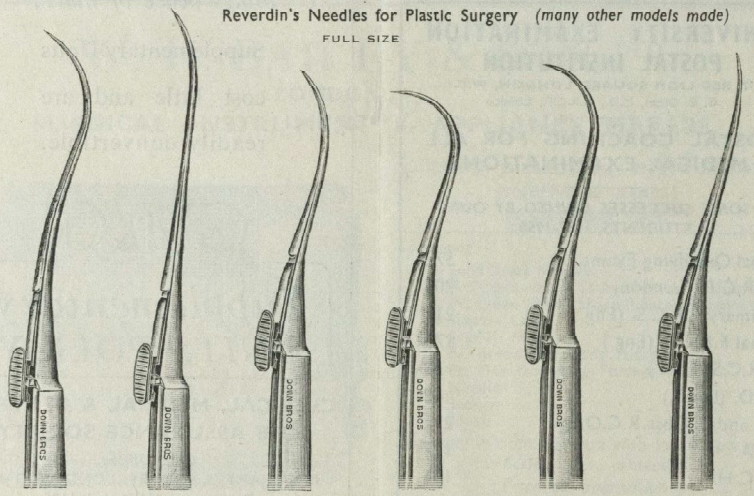

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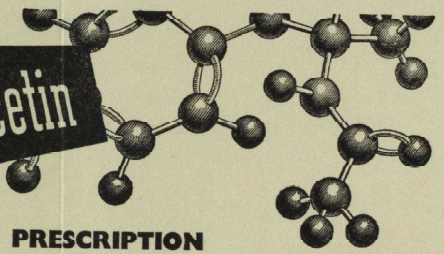

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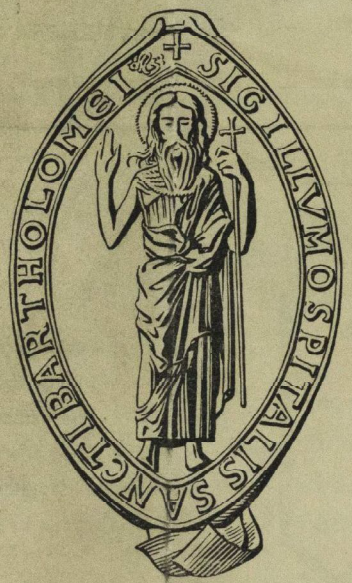

MAY 1951

VOL. LV No. 5

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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

May, 1951

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol. LV MAY, 1951 No. 5

PAGEANTRY AND MEDICINE

A love of pageantry and a respect for tradition are not qualities which a man will always admit to with readiness. Yet a grain of the former is found in most of us, and it is well known that the latter dies hard. Many of the old customs of this hospital have long been abandoned, and although they would be out of place in the modern world, they still delight the historian as, in his mind's eye, he places them in a familiar background. The Great Hall is now the scene of examinations and not of feasts. The Square no longer resounds to hooves and metal-rimmed wheels as a member of the Staff arrives, complete with top hat housing a stethoscope. Nor is it the assembly-point for all ward rounds, though it is no whit the poorer for the solitary firm which still keeps this ancient custom alive.

It is a commonplace that the outward ceremony connected with past customs often survives when the purpose it once served is forgotten. A familiar example is View Day. Its form survives, but its origin and purpose are forgotten. The earliest known reference to View Day in the hospital records is an entry on April 3rd, 1557, when, we are told, "This day it is ordered that on Tuesday next shall be the day of view of all lands lying within London and belonging to this house to peruse the state of them and there are appointed to be viewers Mr. Withers, President, Mr. Howett, Mr. Halle, Alderman, and others . . . and to meet here by 7 of the clock in the morning."

Later references are similar and do not give a clear idea of the origin of the View, but suggest that it served a practical purpose, and was not merely the perpetuation of an annual ceremony to mark some great event in the hospital's history. The latter is an attractive theory, which would suggest a very early origin, perhaps coincident with the founding of the hospital. There seems, however, to be little evidence to support it.

The ceremony of the View has remained almost unchanged for at least two centuries. Then, as now, Treasurer, Governors, Matron and Steward tour the hospital in procession, preceded by the head beadle bearing his staff of office. In each ward they are awaited by the physician or surgeon in charge, his assistant, and by the nursing staff. They hear the names of the patients, the condition from which each is suffering and the probable duration of his stay in hospital. The patients and staff are invited to make any complaints to the Governors, and the procession moves on.

The great majority of visitors to the hospital on View Day see little of this ceremony. For them it provides the opportunity to see the hospital of modern times at its very best. On this day the Square is brushed a little more assiduously than usual, the water in the Fountain is a little less verdant, the solitary goldfish seems to glow with a proud opalescence, and within the buildings the floors are even more highly polished than on other days.

The details of View Day are known to most Bart.'s men, but have been repeated here for those who have recently joined the hospital. These include students at Charterhouse Square, for whom the barrier separating them from the hospital, though in theory non-existent, seems in practice almost impassable. For them View Day provides an opportunity to put the clock forward, rather than back, and to see something of what awaits them when they reach "the other side."

A FRAGMENT

It is a wonder
(Says the observer Wu)
That the House of Healing,
Offering hope and health
To the living,
Offers nothing
To the dying.
Observe the Chief Healers,
How they arrive
In shining chariots
With many horses;
With what ovation
Do they enter
The rooms of sickness
Coming upon one
Quietly lying
In the shadow of the scythe;
The emptying sand
In the glass of the Reaper
Almost done.
How they stand
For a moment;
The encouraging nod;
The word of hope—
The hollow word—
Then passing on
To another, saying
" It is understood."

There once was a time
(Says the observer Wu)
When the healer's weapons
Were as straw
Before the scythe
On the disputed ground
At the borders of living.
But in the same days
Courage and strength
To endure the harvest
Of the Reaper
Were dispensed,
At no cost,
From the deep well
Of philosophy
And faith.
It is curious
How the old
Must be exchanged
For the new;
How much loss
Accompanies gain;
That there is no building
On old foundations.
It is a wonder.

E. A. J. ALMENT

RAHERE SOCIETY (WALES)

The Annual Dinner of the above Society was held at the Park Hotel, Cardiff, on Saturday, March 10th, 1951, when there were about 60 old Bart.'s men present.

The President, Mr. Melbourne Thomas, proposed the toast of Bart.'s, coupled with that of " Our honoured guests " to which Dr. Cullinan and Mr. C. Naunton Morgan responded.

The toast of the other guests was proposed by Dr. Cyril Joyce and responded to by Professor Gough of the Welsh National School of Medicine.

On behalf of the Society, the Treasurer, Dr. F. W. Campbell, handed over a cheque for ten guineas for the purpose of establishing the first Annual Rahere Society (Wales) prize—the terms and conditions of the award to be determined by the Dean of Bart.'s.

In accordance with the usual custom, Dr. Cullinan and Mr. C. Naunton Morgan were made honorary members of the Society.

Dr. P. O. Davies, Swansea, and Mr. Rice Edwards, Newport, were elected President and Vice-President respectively for the coming year.

Will any Bart.'s men, associated with Wales, who have not yet been contacted, please communicate with the Honorary Secretary :—

G. Emrys Harries,
The Residence,
City Isolation Hospital,
Cardiff.

THE JOURNAL

Contributions to the *Journal* should reach the Editor by the 1st of the month for inclusion in the issue of the following month.

Pre-clinical students are warmly invited to contribute.

THE MANAGEMENT OF THE BURNED PATIENT

By D. MACG. JACKSON*

I HAVE chosen this heading under which to discuss the treatment of burns because there is no one treatment which will produce the best results in all burned patients. A burn is an open wound, and as with other open wounds there are ideal treatments which can sometimes be practised, and less satisfactory ones which are indicated under other circumstances. In a short article it is necessary to make some generalisations, but I hope that the final impression left with the reader will be that every burn is a problem in diagnosis which should be followed by the appropriate treatment for that person.

Even in a large industrial city such as Birmingham, two-thirds of the burned patients, sufficiently seriously injured to be admitted, receive their injuries in the home. Over half of these are children under 5 years of age, and among the adults burned and scalded there are twice as many women as men. Moreover, a quarter of the adults burned at home are injured in an epileptic fit, so that it is no exaggeration to say that women and children and the physically handicapped are exposed to the greatest danger from burning. Over 90 per cent. of the *fatal* accidents from burning and scalding occur in the home, involving elderly women much more often than men.

Of the industrial burns the great majority, as would be expected, are men (92 per cent.), and one-third in Birmingham receive their injuries from molten metal.

The three chief enemies which every extensively burned patient has to meet and overcome if he is to live and avoid deformity are shock, sepsis, and contractures. Shock is still the commonest cause of death in burns; infection, especially in the form of bronchopneumonia, is still the second commonest cause of death, and scar contractures are responsible for the major part of post-burns disability and deformity. Each one of these complications can be prevented largely with correct and energetic treatment, and each one is easier to prevent than to cure. The problems raised by these three aspects of burns treatment will now be considered.

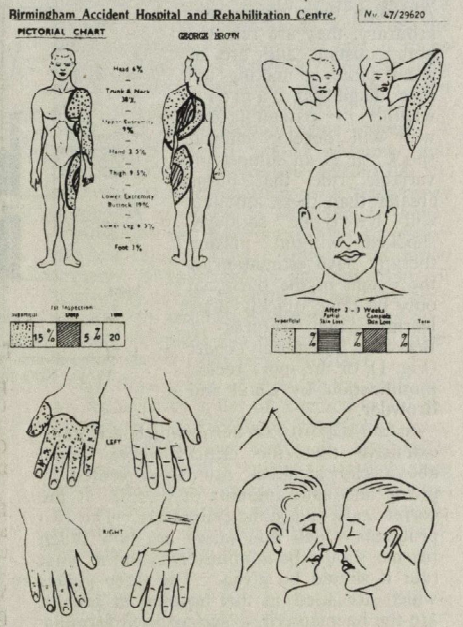

FIG. 1.—A Pictorial Chart based on Berkow's estimation: Head 6%, trunk and neck 38%, upper extremity 9%, hand 2.5%, thigh 9.5%, lower extremity, buttock 19%, lower leg 6.5%, foot 3%. To use the chart for children, the age of the child should be subtracted from 12, and the result added to 6% for the head and subtracted from 38% for the legs.

I. The Prevention and Treatment of Shock

There are three degrees of shock which may be seen in extensive burns :

1. Latent shock, which recovers with oral fluids only.

2. Reversible shock, which recovers with adequate correction of haemo-concentration by intravenous plasma or dextran, and sometimes blood.

3. Irreversible shock, which fails to

* Surgeon to Medical Research Council Burns Unit, Birmingham Accident Hospital.

recover with correction of the haemoconcentration, even if large amounts of blood are used also to make up any deficiency of blood volume.

In practice, only children with burns greater than 10 per cent. of the body surface, and adults with burns greater than 15 per cent. of the body surface, require plasma for the treatment of shock. These figures are estimated without including superficial erythema burning because this is not accompanied by appreciable plasma loss. Burns smaller than these areas can be resuscitated adequately with oral fluids only, provided these are sufficient. Although these figures are arbitrary, they are remarkably constant and are of great value in making the first diagnosis, namely, whether the patient is one who will develop clinical shock; it is an almost invariable rule that burns greater than these amounts will become seriously shocked without plasma therapy. An estimation of the extent of the burn can only be done quickly after learning the features of Berkow's pictorial chart (Fig. 1), or the more recent modification by Lund and Browder.

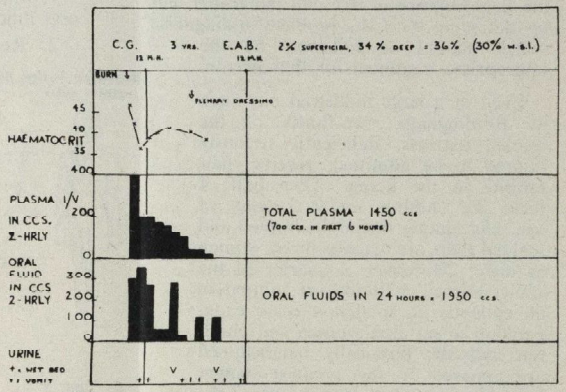

Fig. 2.—A shock chart showing correction of the haematocrit with plasma therapy; the normal haematocrit at 3 years is 36%. Note that half the plasma was given in the first 6 hours.

In the majority of burns which are more extensive than the critical figures given above, clinical shock can be prevented by giving adequate amounts of plasma, at the correct rate and sufficiently early. The two problems which this raises are how much plasma should be administered, and at what rate it should be given. The three guides which are used in this hospital at present are the haematocrit, a surface area formula, and several clinical signs. None of these should be used alone, but all three in conjunction.

(a) **The haematocrit.** If sufficient plasma is given to restore the haematocrit to normal as soon as possible and then to keep it there, most cases require an amount which is proportional to the area burned. A few, however, require a greater amount than this, sometimes much greater, to control the haemoconcentration and keep the patient well clinically; it is in these cases that repeated haematocrit estimations have an advantage over a surface area formula. The haematocrit is a good guide because it is sensitive and changes early: its weakness lies in not knowing the normal value for a given patient admitted in shock, for although average haematocrit values are known for age and sex, an anaemic or plethoric patient will have a low or raised normal haematocrit. In spite of this a numerical measure of the degree of plasma loss, even if only rough, is invaluable. The haematocrit estimation has the advantage of being easy to do in the clinical room attached to the ward, even in artificial light and without much practice. In the absence of a centrifuge, haemoglobin estimations are the next best guide: blood pressure readings for this purpose are useless.

Fig. 2 shows the shock chart of a girl of three whose clothes caught alight from an inadequately guarded electric fire, and who received 36 per cent. burns of her trunk, arms and legs. It shows how the haemoconcentration was corrected with plasma and controlled until the stage of exudation had passed.

(b) **The surface area formula.** During the last two years 31 extensive burns in patients over 10 years of age have been treated in this Burns Unit, with 12 deaths during the shock period of the first four days. All these cases had their haemoconcentration corrected, most of them at an early stage, but some of them still died. These shock cases have been plotted in Fig. 3, the percentage area burned against litres of plasma, blood and dextran given to each case. The thick black line represents the minimum transfusion amounts given to patients who survived: the maximum amounts given were about 3 litres more than the minimum, and the optimum amount that should have been given presumably lies somewhere between these two. The value of a surface area formula lies in the help it gives in determining on admission the total plasma which will probably be required, and its rate of administration. We believe that the plasma requirements for an adult during the first 24 hours after burning are in the region of 1½ litres of plasma for every 10 per cent. of the body surface burned, excluding superficial erythema, and this is the surface area formula which we are using at present. In addition to this, half a litre of blood should be given to a 30 per cent. burn, and a further half litre for every 10 per cent. above

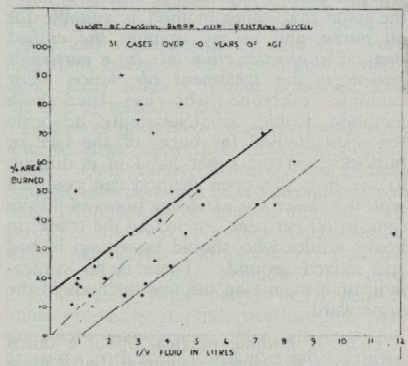

Fig. 3.—A chart of the amount of plasma, blood and dextran received by 31 cases over 10 years of age, showing which cases survived the shock period of the first four days. (The interrupted line indicates a previous formula of one litre per 10% burned.)

Key: + Shock deaths.
• Survived shock.

this figure, to make up for the red cell destruction.

In past experience, also, the most satisfactory cases appear to have been given half their plasma requirement in the first six hours following injury, and the other half in the next 18 hours, with a small amount also given in the second 24 hours in some cases; the surface area formula enables one to estimate on admission how much plasma is needed in the first six hours. In our experience, however, the most rapid method of correcting haemoconcentration is to use the estimated normal blood volume for the particular patient and the haematocrit to calculate the plasma loss, and then to make up this loss in the first hour.

(c) **Clinical signs.** Whichever method is used principally, the haematocrit or surface area formula, it is essential that the amount and rate of plasma administration should be checked by careful observations on the patient's clinical condition. This is impossible by occasional visits to the patient's bedside; it is necessary to live with the shocked patient if the serious case is to be saved. The most valuable physical signs indicating that insufficient plasma has been given are a cold nose and extremities, thirst, and an inadequate urine output. A catheter should be passed routinely and released hourly; between 30 ccs. and 200 ccs. an hour may be regarded as a satisfactory output for an adult, as suggested by Cope. Apathy and restlessness are also suggestive but less reliable signs. Although the blood pressure is valueless as an indication for instituting shock therapy, it may be most valuable in seriously shocked patients as a sign of incipient peripheral collapse after the haematocrit has been stabilised.

The third group of cases, those which fail to recover in spite of correction of the haematocrit and copious transfusion have been described as being in irreversible shock, but there is no way of diagnosing irreversible shock except by a fatal outcome after adequate, or more than adequate, transfusion. In other words it is a post-mortem diagnosis.

To sum up:—

1. Shock is still the commonest cause of death in burns.
2. No cases should be regarded as hopeless. Sixty per cent. burns have survived, and with greater understanding and efficiency there is no reason why 70 per cent. or 80 per cent. should not survive tomorrow. A burn of one-third of the body surface in a child should almost never be fatal.
3. No patient should die with the haemoconcentration uncorrected: and if it is

corrected at an early stage very few patients under 60 years of age will die.

4. The unanswered problem of shock at the present time is the mechanism and cure for shock which is irreversible to any degree of transfusion.

II. The Prevention and Control of Infection

"A burn is an infected wound produced by heat"—so wrote Moorhead in 1927. Investigations carried out in the Burns Unit at this hospital have shown, however, that only 10 per cent. of freshly burned cases admitted to the ward were contaminated with pathogenic organisms on admission. The surface of a new burn therefore is usually uncontaminated, and its treatment should be that of a clean wound.

There are obvious difficulties in keeping an open wound uncontaminated, but the importance of doing so can be measured in terms of mortality, and graft failure due to infection.

(a) The causes of death in the 19 fatal cases in 1949 were as follows:

1. Shock, after correction of the haemoconcentration	10
2. Broncho-pneumonia	6
3. Gas gangrene in an 80 per cent. burn (through a drip incision)	1
4. Uraemia and cardiac failure ...	1
5. Cardiac arrest during induction of anaesthesia	1
	19

Two of the broncho-pneumonia cases were found at post-mortem examination to be infections with *Ps. pyocyanea*, presumably contracted from the burns which were heavily contaminated with this organism; in two others there was evidence of septicaemia due to *Ps. pyocyanea*, and in three cases the broncho-pneumonia was accompanied by clinically infected burns. Including the case of gas gangrene, seven out of 19 deaths, or 37 per cent., were due to infection.

(b) As well as increasing mortality, the take of grafts is hindered by wound contamination. The cause of graft failure is most commonly haemorrhage, and next most commonly faulty fixation, but wound contamination is a real and important factor. A 100 per cent. take of grafts has been obtained in the presence of contamination with all organisms, but some, especially haemolytic streptococci, and possibly some staphylococci, seem to be particularly harmful in this way.

Precautions taken to prevent contamination of a burn should begin at the place of injury. The correct first aid treatment for a serious thermal injury is immediate cover with a sterile or freshly laundered cloth, and then transfer to hospital as soon as possible.

The decision to treat the case by the "open" or "closed" methods must then be made, and this choice is one of the controversial problems of the present time. The open method consists of drying the surface of the burn as quickly as possible by exposure, and immobilising it to keep it exposed and prevent cracking of the scab. The closed method is based on the fact that recent burns are virtually uncontaminated, and that they can be kept so by cover with a bacteria-proof dressing. Both methods are satisfactory when carried out efficiently, and both methods are appropriate to particular types of case. I believe it is unwise to force the issue that either method is suitable for all burns, and in my opinion *the easiest method to practice efficiently for a particular patient* is the treatment of choice. For example, everyone who has tried both methods would wholeheartedly advocate the open method for burns of the face or buttocks; on the other hand, it is difficult to see how the open method can compare with the closed for extensive burns of 40 per cent. to 60 per cent., encircling the trunk, in heavy adults who should be sat up in bed and moved around. There is no contra-indication to mixing the two methods in the same ward.

There is nothing magical about a burns dressing in the closed treatment, but it must fulfil certain criteria: it should be an adequate protection against contamination, it should not have any harmful effect on the burn or the patient, and it should be comfortable and secure. In our practice the burn is covered with Lanette wax cream containing penicillin 1,000 units/gm.; this has been shown to be prophylactic against haemolytic streptococci. Gauze is then applied over the cream, and covered with abundant dry cotton wool, a crepe bandage and possibly plaster of Paris. This dressing will remain an efficient barrier against cross-infection as long as the wool remains dry,

and therefore the dressings are done as infrequently as possible. Such a dressing is usually left in place until 16 days after the injury, and then the burn is inspected to see if full thickness skin loss is present requiring grafting. One might add that local polymyxin has been shown to be prophylactic against *Ps. pyocyanea*, although this is not yet generally available; also, systemic aureomycin is excreted in burn exudate, and has considerable value in preventing contamination with staphylococci.

The dressings of all patients in the ward are carried out in an air-conditioned Dressing Station using no-touch, aseptic technique. By changing the air in the Dressing Station twice every five minutes it is kept sufficiently free of organisms to prevent serious risk of cross-infection from one dressing to the next, and under this regime very little cross-infection can be attributed to the time when the burns are exposed for dressing.

A further important step in the prevention of infection is the early grafting of burns. Whenever possible full thickness skin loss burns are excised and grafted on the day of injury, and this removal of dead tissue and replacement by skin is a very important factor in the prevention of infection. Only when a wound is healed does the risk of infection cease.

In spite of preventive measures, contamination of large burns not infrequently takes place. Only rarely, however, are clinical signs of infection such as a surrounding red flare, lymphangitis or adenitis present. To get rid of infection or surface contamination with haemolytic streptococci, systemic chemotherapy with penicillin is used (500,000 units twice daily), or, if penicillinase producing staphylococci are also present, with aureomycin; also, alternate day dressings with local chemotherapy are instituted (using penicillin cream 10,000 u/g. instead of 1,000 u/g.). Fortunately, it is only an infrequent occurrence under this regime for infection or contamination of burns to result in extensive graft failure, so that even in the presence of contamination the burns are grafted without delay, making full use of chemotherapy.

III. The Prevention of Contractures by Grafting

The basic principle of present-day traumatic surgery is the excision and closure of recent wounds before they become infected, or even contaminated.

The benefits of primary excision and immediate grafting in burns are less infection, less fibrosis, and less joint stiffness; and to these may be added a saving of time and money by the patient, his employer, and the hospital service. But this form of treatment raises another problem, namely, the early diagnosis of full thickness skin loss in recent burns.

In some cases there is no doubt that a burn is not only full thickness skin loss but deep into the fat; others are obviously superficial; but the majority are difficult to diagnose early. The early appearance is particularly deceptive, for burns which are white and coagulated on the surface may simply be shallow partial skin loss burns, produced by sufficient heat intensity to coagulate the surface.

In 1940 the general teaching was that visible dermal circulation was a sign of viability, but dermis which possesses a circulation immediately after burning may lose it subsequently due to capillary stasis, and be obviously necrotic in 24 hours; in fact, it is not infrequently full thickness skin loss. This is also the fallacy in the fluorescine test, which is valueless in the diagnosis of full thickness skin loss. Similarly the application of stains to the surface of the burn only shows up the state of the superficial collagen, and gives no information about the critical layer, the level of the bases of the hair follicles and sweat ducts.

More recently Bull and Lennard-Jones have shown the correlation between analgesia and the depth of burning, and this has now been used as the basis of a diagnostic test for several years. In this test sensitivity to pin-prick indicates partial skin loss only and prevents the over-zealous from excising dead white burns which are not full thickness skin loss. Analgesia, although present in full thickness skin loss, is also present with deep partial skin loss, so that it is a physical sign which must be correlated with the history and the site of the burn. This test is a valuable diagnostic aid, but only those who are frequently treating recent burns are likely to appreciate its usefulness. If primary excision and grafting is not advisable, delayed grafting will be necessary. Dressed with penicillin cream the slough of dead dermis is seldom unseparated by three weeks, and it is generally possible to diagnose full thickness skin loss at the sixteenth

to eighteenth day. At this stage further delay to prepare the granulation tissue for grafting is wasted time, and subjects the patient to a further one or two weeks of wasting and risk of infection. If the granulation tissue has too many tags of unseparated slough to take a graft directly, it can almost always be removed by blunt dissection leaving an ideal surface for grafting. This separation takes place at the junction of the fat and granulation tissue. Here a warning must be given: it is essential to have a blood transfusion running before the operation if an area of more than 5 per cent. of granulations is to be prepared and grafted.

The types of graft need barely be mentioned: a burn, three weeks after the injury, is just an open wound, and as such it is subject to all the principles of plastic surgery. A split skin graft cut with a Blair knife is the routine graft for granulating areas, and also for extensor surfaces when the base is subcutaneous tissue. A dermatome graft or Wolfe graft has a place following primary excisions when thicker skin is necessary for better texture or to minimise contraction, and flaps are indicated when tendon, nerve and bone are exposed. Far more important than the type of skin graft is punctuality in grafting. The optimum time for delayed grafting is as soon as full thickness skin loss is diagnosed, and not later than three weeks. The more extensive the burn, the more important it is to graft early.

To the extensively burned patient, skin cover spells life: the problem is how to keep the patient alive till delayed grafting is possible, and how to find enough skin. The most important measures to this end are the administration of adequate blood and food. A haemoglobin estimation should be carried out at least every third day, and always kept above 80 per cent., and preferably at 100 to 120 per cent. A high calorie and high protein diet is often difficult to give, especially after two days of fluid diet and sometimes vomiting during the shock stage; in these circumstances tube feeding by an indwelling nasal catheter and a continuous drip may enable at least twice the normal working caloric and protein intake to be given: it will also restore the appetite, and then normal meals will be taken in addition, and even second helpings asked for! The problem of obtaining complete skin cover for an area of 30 per cent. or more of full thickness skin loss can only be met by applying homografts. Although these are only temporary, they give three weeks' respite in which to proceed with securing permanent cover by autografts, and if this time is well planned and used it can be life-saving.

In conclusion, I would summarise the problems in the treatment of the burned patient in the order in which they are usually met.

1. The problem of the necessity for plasma therapy to *prevent* clinical shock.
2. The diagnosis of the depth of the lesion and its suitability for primary excision and grafting.
3. A decision on whether the open or closed methods of treatment would be the easier to practice efficiently in the particular patient.
4. The place of elevation, splinting and physiotherapy (including immobilisation, breathing and leg exercises, and ambulation).
5. The type of skin cover which will be required, and the method and timetable for obtaining it.
6. An evaluation of the areas in an extensive burn which require skin cover most urgently (e.g., the hands, face and neck, and flexor surfaces of joints).
7. The problem of maintaining an adequate food intake and haemoglobin percentage.

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DEATH

We announce with regret the death, on March 17, 1951, of Dr. J. A. Nixon, Emeritus Professor of Medicine in the University of Bristol. Dr. Nixon was at one time editor of this *Journal*.

SOME NOTES ON SPONDYLITIS

By G. D. KERSLEY

SPONDYLITIS is arthritis of the spine. It may be of two main types—osteoarthritic and ankylosing.

Osteoarthritic Spondylitis

Osteoarthritic Spondylitis is of the same pathology as osteoarthritis elsewhere. For example, in the low back, it may follow shortening of the leg, a stiff hip or an old disc lesion. The *treatment* is as for osteoarthritis of the peripheral joints.

Ankylosing Spondylitis

Ankylosing Spondylitis is a disease mainly of young men and resembles in many respects rheumatoid arthritis in that the patient is himself ill, loses weight and has a raised sedimentation rate.

The onset may be heralded by (a) low back pain (b) sciatica or (c) a transitory involvement of peripheral joints, usually the knee or ankle.

Some cases rapidly become quiescent (form fruste), but many progress to a poker back stage, when pain may become slight provided deformity has been prevented. In some cases the condition spreads to the hips, and in some nerve root pain is a prominent symptom.

The condition usually starts in the sacro-iliac joints and is shown on X-ray by a woolliness of these joints progressing to obliteration, a generalised osteoporosis, and a "tram line" or "bamboo" appearance of the spine in advanced cases, due to calcification of the supporting ligaments.

Treatment.—(a) Treatment for the general health; (b) Prevention of deformity—possibly a plaster bed and later a brace; (c) breathing, postural and gentle mobilising exercises; (d) Radiotherapy.

ST. BARTHOLOMEW'S MEDICINE CHEST

1850 — 1950

By B. EDWARDS*

BEFORE attempting a rough comparison between St. Bartholomew's Medicine Chest of 1850 and that of today it is interesting to consider the general trend of present-day requirements.

Until 20 or 30 years ago practically all the Materia Medica in use could be and indeed were dispensed on the spot, and were presented in the time-honoured forms of draughts, mixtures, pills, lotions, plasters and so on. It is only recently that the great advances in Pharmacology, Microbiology and Chemistry have provided us with the highly specific and complex substances, the names of which, though less euphonious, are now becoming more familiar than the old botanical names.

In one field, however—that of laxatives and purgatives—the chemical manufacturer has not yet superseded nature. The physician still relies very largely on the pharmaceutical preparations of such vegetable drugs as aloes, cascara, rhubarb and senna. Indeed two drugs of this class in use today were known in ancient times. Senna was known to the Egyptians, and Isaac Judaeus (850—900 A.D.) mentioned it in his writings. Both the leaves and the pods were prescribed by Arabian physicians, and throughout the Middle Ages it seems to have had a considerable vogue in Medicine. Castor oil is mentioned by both Herodotus and Hippocrates, and later it was familiar to the Romans who gave it the name of "ricinus" on account of the similarity of the seeds to the insect now known in this country as the "tick."

It should not be overlooked that many of the new medicines are based on remedies which have been employed empirically for several centuries. The fact that modern medicine affirms their value is striking evidence as to their efficacy; such is the case with aloes, belladonna, castor oil, catechu, cinchona, digitalis, ipecachuana, nux vomica, opium and senna, to mention just a few.

The trend of modern medicine is more and more towards the prevention of disease, leaving therapy to take over where these measures have failed; a case in point is the

* Acting Pharmacist to this Hospital.

use of B.C.G. vaccine for the prevention of T.B. "Progressive Treatment" has also necessitated the use of substances of greatly increased cost; this trend is particularly noticeable in the newer antibiotics. The development of anti-histamines, vitamins, hormones, antibiotics and Biological products makes the physician of today more and more dependant on the discoveries which have been made in the laboratories by chemists, and then clinically approved.

The following is a list of those items in use in 1850 which were mentioned in "St. Bartholomew's Medicine Chest" (see last month's issue of the *Journal*, together with comparable figures of a century later.

	1850	1950
Port wine	£200—£300	£1 10s.
Brandy	Nil	£80
Castor oil	2,500 lbs.	75 lbs.
Spirits of wine	200 gallons (at 17/- per gallon)	35 gallons (at 150/- per gallon, after deduction of duty)
Linseed meal	12 tons	Nil
Senna	1,000 lbs.	Ext. senna 66 lbs. Conf. senna 46 lbs.
Salts	27 cwt.	Sod. sulph. 3 cwt. Mag. sulph. 4 cwt.
Calico for bandaging	5,000 yds. (approx. 50 gross bandages)	20 gross calico bandages 480 gross W.O.W. bandages (both are a cotton cloth of plain weave)
Leeches	29,700	12
Treacle	1½ tons	140 lbs.
Hips	5 casks	642,000 Vit C. tablets
Grand total for Physic per annum	(approx. 4 lbs. ascorbic acid) £2,600	(approx. 76 lbs. ascorbic acid) £42,532

SO TO SPEAK . . .

That sinking feeling

"A few weeks ago he had the sensation of walking on air. This did not last long."

—*Psychiatric report.*

Cerebral retrospection

"He has a worry whether he has an ulcer at the back of his mind."

—*Student in M.O.P.'s.*

Machinery murmer

Clerk: "In the axilla there is a noise I can only describe as like a steam-driven electric generator."

Voice from class: "A.C. or D.C.?"

—*M.O.P.'s.*

A knotty promblem

"The patient has been under treatment by Dr. K., but otherwise has been fit."

—*Student in M.O.P.'s.*

ANNUAL SPORTS DAY

The 68th Annual Sports Day will be held at Chislehurst on Saturday, May 26, at 2.30 p.m. After the distribution of the prizes a Dance will be held in the pavilion, commencing at 7.15 p.m.

FURTHER RATS

By L. S. CASTLEDEN

THE following two cases occurred in the same week in the autumn of 1950 and make a sequel to my article in the April *Journal*.

Case I

This worker in a chaff factory, aged 58 years, had a mitral stenosis and auricular fibrillation. He lay dying of cardiac failure in what Chaucer would describe as a "narwe cottage." It was thatched, of lath and plaster; with an earth and brick floor. The patient's mother-in-law used to come into the sick-room. When the patient was visited his wife was never at the bedside, but used to scuttle away with a cloth hiding her face. The reason for this conduct was discovered one day when she was seen from over the hedge as she hung up some washing; her nose was not there—some ulcerative condition had eroded it and left only a cavity in her face. (The long distance differential spot diagnosis was either lupus or rodent ulcer with the former the more likely.)

The patient died. He was seen late one night, moribund, and died at 2.0 a.m. next morning. After laying out the corpse the family retired upstairs to bed.

At 7.0 a.m. a very worried telephone call was received. The son was at the other end. "Oo! Doctor, me dad's nose is gone!" He added that an eyeball had also gone and that as far as he knew no one had been into the room since they went to bed in the early hours.

It seemed almost too great a coincidence that two noses in the same family should be removed. It was perhaps possible that the mother-in-law had crept down and hacked the organ off in a peculiar tit-for-tat mood.

The coroner, when asked what should be done, suggested that he was not interested in what happened post mortem. Provided the injuries were not caused before death it did not matter to him what the relatives did to the body.

This enquiry having been made, the body was carefully inspected. The nose was severely mauled. The left globe was missing. A trail of blood led over the sheet and under the bed to a large rat hole. A lens showed definite parallel incisor tooth-marks. It was also obvious that the injury was post-mortem. So it was not such an involved affair after all.

Case II

A few days later a telephone call was received from a different village. The voice of a young woman was quaking with agitation as she said that she thought that someone had "done in" her father-in-law.

The old gentleman was aged 78. He lived alone in a cottage which had formerly been the village shop. He was almost blind with arteriosclerotic retinitis and his arteries were of the pipe-stem variety. But, in spite of medical advice he had lived alone. His dog shared the cottage. He kept a few chickens and milked a goat—the pathetic remnants of a smallholding.

The policeman was collected and given a lift out to the scene of the "crime."

At first sight it was very convincing. The old man lay on his face. There was a fair-sized pool of blood which came from injuries of his head. Clenched in his right hand was a coal hammer. Underneath him was a bucket with a few pieces of coal in it. His dog had evidently slept on the body as there were white hairs on his coat. The door was swinging in the wind.

The body was rigid and it seemed that he had been dead some twenty-four hours. There was an ear mauled and an area of cheek missing. The lens was used, and the same rodent marks could be seen at the edges of the wounds.

At a full post mortem the cause of death was found to be cerebral haemorrhage. It was decided that the bleeding came from a cut in the scalp and that the rat injuries were post mortem.

. . . . . .

Lest it should be thought that our rat-ridden practice is a particularly cold comfort one, it should be said that every day provides variety of a greater or lesser degree. We read a lot in the *Journal* of special subjects, but there is no doubt that general practice provides the greatest interest both in humanity and medicine. Any G.P. could cap these stories with better ones. It is a pity that some students may feel that they go into general practice as a last resort. For those who enjoy all aspects of life and their fellow men it is the best job of all.

A GENERATION OF SURGERY AT BART'S

By REGINALD M. VICK, O.B.E.

IT has, more than once, been my privilege to write about the past in surgery. And I realise that, in doing so once again, one must of necessity be repeating certain facts. But repetition is not always boring and there must be many who have never read and many more who have forgotten anything that I may have written.

My experience of surgery at Bart.'s and elsewhere dates back to 1906, and although that is a long time, my memories are nearly as vivid as they ever were.

At that time one could say with truth that the antiseptic age was just passing and the aseptic era was opening. Many of the surgeons of those days were only beginning to understand what asepsis meant and hardly realised the enormous benefits of that regime. The triumphs achieved by the adoption of strict asepsis were even more dramatic than those attained by the use of penicillin and similar products in the years so far ahead.

But let us, first of all, consider the surroundings in which we had to work in those far-off days.

Picture a patient coming to Bart.'s in 1906. He would, if he came as an outpatient, be received in the old Surgery then situated in the North-East Corner of what later became the Lucas Block.

If one could enter those portals, I wonder what would strike one most. Would it be the smell of suffering humanity? Certainly, humanity was not so well washed then as it is today. Would it be the crowding? Truly the crowds were great. For, in those days, many of the Hospitals, which now take outpatients in and around London, did not exist, and the poor of London swarmed into the voluntary Hospitals. Or would it be the poverty of the patients? For there were far more poor and neglected people and many more wretched and verminous children.

So much for the material with which one had to deal.

Another thing that would strike us would, certainly, be the primitive treatment available for most of the diseases of those days. It would surprise us to see Casualty physicians dealing out little cards to patients, which they exchanged for medicine at the Dispensary without ever being examined at all. And it would horrify some of the surgical enthusiasts of to-day to see the Surgery dressers making fomentations in the "middle room." Here were the sterilisers boiling all the time, to which the young gentlemen came to wring out the lint in towels and carry it back to their patients. And I would remind you that fomentations were the main dressing used.

The patients were treated in boxes by the various surgical firms. These boxes consisted only of rather heavy screens. At the end of the morning, the boxes were cleared and each one became an outpatient theatre for the firm concerned.

There was of course no minor operation theatre. Sepsis was rampant and, in fact, most of the wounds were infected to a greater or lesser degree. Women with abscesses of the breast were operated upon as outpatients and went home bristling with tubes. Many of them took weeks to heal and some developed amyloid disease. The frequent visits of these patients not only added to the crowding but increased the risk of infection in other patients.

The first appointment held by students was that of Surgery dresser. Here—in a state of sublime ignorance—he found himself saddled with considerable responsibility. Many patients went through most of their treatment without proper supervision by the house surgeons, who were far too busy. This was fun for the dressers but bad for the patients.

The special departments such as they were—occupied little rooms around the surgery in the afternoon.

Soon after this date, the surgery as we know it today was opened and the whole of this unsatisfactory regime was swept away for ever. Yet I am glad that I did work in those surroundings because they had to be seen to be believed.

Should a patient be admitted into Hospital, he would find himself in a very comfortable ward heated by large coal fires. According to present-day standards, these wards left much to be desired. The "bed space" was inadequate but they were nice and warm. The Sister's room looked out into the ward, so the work there was constantly under her supervision.

All the dressings were done by the ward dressers. They had also to prepare the patients for operation. Often this preparation was an arduous procedure and ended with the application of an antiseptic dressing—sometimes of 1 in 20 Carbolic.

The house surgeons were directly responsible to their Chiefs, for chief assistants and registrars, as we know them today, did not exist.

And what of the surgeons themselves? Hero worship will never die. Looking back through the years, I am convinced that many of them were really great men, and they were working under difficulties which would dismay the surgeons of to-day.

Anaesthetics were pathetically inadequate. The ward sister was in charge of the dressings and swabs in the theatre and the instruments and ligatures were looked after by the dresser of the case. This was called "doing strings." This again was excellent practice for the dresser but a constant source of anxiety to the house surgeon and to the surgeon, if he had time to glance round and see the strange things happening behind his back.

Operating teams had not been thought of and some of the operations of today could not, possibly, have been done.

It is amazing what these surgeons of the past did get away with. My own chief—Sir D'Arcy Power—one of the most patient and yet one of the most rapid of operators—was a pioneer in the field of gastric surgery. He used to do gastro-jejunostomies at full speed and without clamps. Many of these operations were singularly successful, in spite of all the gastro-enterologists may say about them to-day.

It was not unusual to see strange lapses from the rules of asepsis. I remember seeing a surgeon remove his glasses during an operation, dip them in a lotion bowl, dry them on his gown, put them on and go on with the operation. And nothing happened; the wound healed perfectly. I once saw a physician come into the theatre to see one of his patients operated upon and put his stethoscope amongst the surgical instruments. Even in those days his action caused a gasp of horror from the onlookers.

Many of the operations were on the grand scale. Removal of the upper jaw for malignant disease—even after ligature of the external carotid—was a terrifying procedure. Aneurysms provided the biggest thrills. It is said that one surgeon at Bart.'s attempting to deal with an aneurysm of the innominate artery and being faced with uncontrollable haemorrhage put on an enormous ligature—and, at the post mortem was found to have tied everything in the neck except the vertebrae.

Wiring an aneurysm of the abdominal aorta was one of Sir D'Arcy Power's favourite operations. He did it with an apparatus invented by one of his own house surgeons—Colt. The trocar and canula was driven right into the lumen of the aneurysm through the back. The trocar was withdrawn—blood spurted across the theatre, and then umbrellas of wire were inserted.

The surgeons of those days began to lose their fear of the peritoneum but they still hesitated to open the chest or the head for fear of infection. Operations upon joints were done but they were always a great anxiety. I have known a knee joint suppurate after suture of the patella with the resultant loss of the patient's leg. But, in spite of all these trials and troubles—surgery advanced as anaesthesia improved.

Bart.'s has always been fortunate in its pathologists. In 1906, the department was housed in two rooms near the museum. But it had a giant amongst pathologists at its head. Sir Frederick Andrewes was not only a giant but he was one of the most approachable of men. When the present pathological laboratory was opened, he was joined by Dr. Mervyn Gordon, still happily with us, who did so much to elucidate the mysteries of the Streptococci. And, later, from that laboratory came Dr. Canti, who carried out such wonderful work on tissue culture and produced his marvellous films illustrating the growth of bone and the methods of spread of cancer.

I suppose that one of the most epoch-making discoveries of those days was made by Welch, when he first demonstrated the Anaerobes—and thus elucidated the cause of many an infection hitherto not understood.

And then, in 1914, the first world war burst upon us. The organisation of all the Hospitals was upset. Most of the Bart.'s staff joined the Army and went away. The remainder opened a general Hospital for soldiers at Wandsworth and one block at Bart.'s itself became military.

We all experienced the horrors of war, most of us for the first time. From the point of view of surgeons, the greatest horror was wound infection; practically every war wound suppurated. Carrell's tubes and Dakin's solution were adopted with abounding enthusiasm—later modified. Secondary suture of wounds came to stay. Towards the

end of this war, surgeons had been moved up into the Casualty Clearing Stations and were excising wounds and doing primary suture. But not long afterwards, peace was declared.

It is doubtful whether this first world war did much to advance the science and art of surgery, though it was not for want of trying. In every Army fighting in the war, surgeons were making gallant efforts to limit the disastrous effects of wound infection, but only too often ordinary infections by pus-producing organisms, streptococcal infections and worst of all, invasion of wounds by the anaerobes, defeated them. Amputations were the order of the day and "died of wounds" was constantly appearing in the obituary columns of the papers. The immediate surgical treatment of abdominal wounds reduced the mortality remarkably. Chest surgery advanced.

I think that surgeons, who had been doing war surgery, came back with improved technical skill and with more courage to tackle greater surgical problems.

Once more the world settled down to what was called peace. Anaesthesia continued to improve. And, partly as the result of this, surgeons were able to adopt a more studied, quieter and gentler technique. And this—perhaps, more than anything else—reduced the incidence of wound infection.

One of the greatest advances between the wars was in chest surgery. Nevertheless, although aseptic technique improved and theatre organisation became better and better, infection still played a great part in preventing surgeons from undertaking operations which they carry out unhesitatingly now.

Another factor which played a very large part in the practice of surgery between the wars was the improvement in X-rays. It could be said with truth that X-rays advanced so much that very soon surgeons nearly always knew what was the matter with their patients before they operated upon them. Cholecystograms, Ba Meals and Ba Enemata, pyelograms — intravenous and retrograde—to mention only a few—enabled a surgeon to diagnose the condition of his patient with a certainty hitherto unknown. And so the operation of "exploratomy" (laporotomy), disappeared from the list.

One of the greatest problems facing surgeons has always been the treatment of malignant disease. Drastic surgery at an early stage was and still is the only certain method of cure.

I can well remember the thrill of excitement when the effects of radium in the treatment of cancer were first demonstrated. This method was practised with thoroughness, and striking results were obtained in some cases, but gradually it began to be realised that it was not in most cases a cure. In some branches of surgery radium still does its job. But taking it by and large in general surgery, the results have been disappointing, though in combination with drastic surgery it has its place.

The same remarks apply to Deep X-ray Therapy. At first, some of the results appeared to be remarkable. But again there was and still is disappointment.

And the cure of cancer has still to be discovered.

And then, almost before we realised what was happening, the second world war started, and once more the whole organisation of the Hospitals was upset. The memory of that time is so much in all our minds that it is hardly necessary to dilate upon it. But of course, there is now a generation of students who can be described as belonging to the post-penicillin period. In other words, there are young men who did not know anything about surgery before the astounding discovery of penicillin and the other antibiotics.

It is interesting to record that, at the beginning of the recent war, penicillin was so difficult to obtain that it could only be used in cases in which it could be proved bacteriologically that the infecting organism was penicillin sensitive.

The effect of the use of penicillin in the treatment of war wounds was quite incredible. In the 1914-18 war, if a soldier was suffering from a compound comminuted fracture of his femur his wound always suppurated and he lost either his leg or his life. In the 1939-45 war he had his wound excised, his leg put in plaster and his penicillin—and he lost neither his leg nor his life. And the same applied to wounds in every part of the body. It has been proved statistically that penicillin saved millions of lives and it is equally true that it saved many more limbs.

And so we pass without more ado, into the penicillin era. Antibiotics are being discovered so rapidly that it is almost impossible to keep pace with them, and it would appear that very soon the spectre of infection in surgery will be laid for ever. If once that happens there would appear to be no limits to what surgery can do.

Vast operations in the abdomen for the resection of malignant disease of the colon or rectum, technically successful often ended, in days gone by, in death as the result of a seeping infection from an anastomosis—this should happen no more. The same applies to bold surgery in the thorax and the head.

It would be as well for the surgeons of to-day to thank God every night of their lives—if not in the mornings as well—for His abounding mercy in having assisted suffering humanity by the discovery of the antibiotics. And, if they don't happen to believe that such discoveries are in any way due to the intervention of the Almighty, let them just be grateful.

And so we have passed from the pre-aseptic age of surgery into the post-penicillin period—from the time when infection ruined most operations to the period when the risk of it is rapidly disappearing. It has been most interesting to live and work throughout the years when all these things have happened. If I were asked what has stood out in my mind throughout all this time I would say it has been the tireless devotion of surgeons and pathologists in their fight against disease and infection. Bitter disappointments have been their lot again and again. But they have never faltered in their endeavours. And now the pathologists have given the answer and the surgeons can work, if not entirely without the fear of infection, at any rate with that fear so much diminished that it has almost ceased to exist.

All strength to their arm.

BLACK AND YELLOW MUD — A FANTASY

By GAMMA

I was away for the weekend, and after dinner a small number of people were sitting round the fire. The discussion turned on ghosts and supernatural manifestations. After a few stories which seemed to me quite unconvincing, a man I knew slightly turned to me and said, "You had a very queer experience once, didn't you?" I was taken aback, as the incident happened many years ago and only four people knew about it. However, after a little pressure, I consented to tell the story.

I was a house surgeon at the time, and having had a septic finger needed a holiday very badly, as the work, with its night duties, had been very heavy. I went down to Salcombe in Devon to stay with a Cambridge friend in lodgings with his family, whom I knew well. We did a good deal of sailing, and after a few days I was already beginning to feel much better. We had gone up with the spring tide nearly to Kingsbridge, with a good wind, and commented as usual on the black mud of the estuary.

When I went to bed that night I was very pleasantly tired and fell asleep at once, and some time in the night had a peculiarly vivid dream. I dreamt that I, with a small number of soldiers, was on a wide estuary in which the mud was bright yellow, and that we had been told to find a ford to a large island. In order to do this we had to wade and we had all stripped, but had kept on our boots as one man had cut his foot rather badly on a piece of old iron, and no one else wanted to do this. After a little difficulty a ford was found, and we reached the island and prospected with the idea of setting up a small fort there. Suddenly there was an outbreak of firing, and one man was wounded. Our officer decided to send us back to the bank, and all got back safely carrying the kit, except the officer, one man and myself. Then the other man was wounded in the chest. I was half-way across when I heard him cry out, and turned back at once to find him quite incapable of moving. With difficulty I took him on my shoulder, and the officer carried the rifles and kit. He held me by the arm and steadied me as I went through the fast-running water, which reached up to the waist. Our men fired at our assailants and there were many bullets passing over our heads, but we, fortunately, got safely into a small depression. It had all been very exciting, and just as I felt safe I heard a loud explosion. At that stage I woke up sweating profusely and realised that I had been having a very bad nightmare, but I was delighted to find that after all I had not been in any danger.

After chewing over the dream for a little while I fell asleep again and slept well till I was called. When I woke I remembered my dream with some amusement, and then wondered why I felt so physically tired, because our sail the previous day had not been hard work. At that stage I realised that I had not got my pyjamas on, and saw them lying in a heap on the floor. Much astonished I turned back the bedclothes, and found I was covered with yellow mud up to the waist and the sheets were all damp and dirty. On sitting up, I saw that a pair of boots were on the floor. They were sodden with water and yellow mud, and had never belonged to me. The boots and the yellow mud reminded me again of my vivid dream, but I could not account for it in any way. If the mud had been black I could perhaps have been sleep-walking and fallen into the estuary. I used to walk in my sleep as a boy but had not done so for many years. But the yellow mud and the strange boots could not be explained. Much disturbed I got up, washed, and told my friends about it. They had been wakened by a loud noise coming from my room, but hearing nothing more concluded that I had fallen out of bed, as they knew I did this occasionally, and had not disturbed me.

Although we discussed it at great length we never arrived at any solution. I came back from my holiday much better in every way, and I did not tell anyone about the curious incident, and have rarely thought about it of late years. I should have said that after 1914 I knew that the boots, which I still have, were army boots.

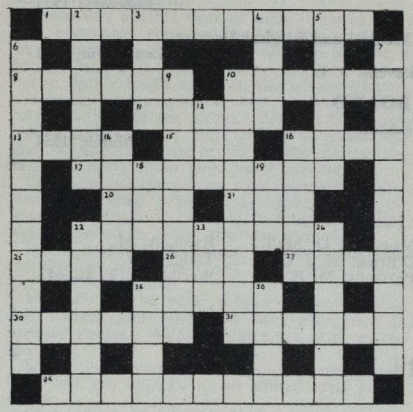
After I had finished speaking there was a long silence and then an old man with piercing black eyes and grey hair, who had been looking at me very attentively, as indeed everyone had, leant forward and said, "When did this happen?" Well, I was a house surgeon in 1910, so that it happened 40 years ago. "What time of the year?" I cannot say the exact date, but some time in the first ten days of September. "Well," said the old man, "exactly 40 years ago to this very day, September 5th, I was in China on the Yellow River, and trying to find a ford to an island when the events which have just been described took place. The soldier who came back to help me, carried the wounded man back with my assistance, and just as we got under the shelter of the bank a shell burst near us, knocking myself and a few men down. When I got up I counted the men to see if anyone was missing. The man who had helped me was not there. His rifle and uniform were lying there, but he and his boots had vanished completely. His name was Amyas Geffrye."

AMYAS GEFFRYE.

SCHOLARSHIPS AND PRIZES — 1951

Kirkes Scholarship and Gold Medal (Clinical Medicine)	**H. I. Lockett**
Brackenbury Scholarship in Medicine	**R. G. Huntsman**
Prox. Access.	A. E. Dormer
Burrows Prize (Pathology)	Not awarded
Skynner Prize (Children's Diseases)	**A. E. Dormer**
Brackenbury Scholarship in Surgery	**M. Braimbridge**
Prox. Access.	H. J. Wyatt
Walsham Prize (Surgical Pathology)	**H. J. Wyatt**
Willett Medal (Operative Surgery)	**H. J. Wyatt**
Matthews Duncan Prize (Obstetric Medicine) (Medal not awarded)	**V. Sarma**
Roxburgh Prize (Dermatology)	**R. E. Frears**
Wix Prize (Biographical Essay)	**A. N. Griffith**
Treasurer's Prize (Practical Anatomy)	**T. A. Boxall**
Certificates	D. H. Black
	N. L. Browse
	B. A. Jepson
	P. Sharer
Hon. Certificate	A. Lytton
Senior Scholarship in Anatomy, Physiology and Biochemistry	**Y. N. P. Forget**
	M. G. Smith aeq.
	J. E. A. Wickham
Herbert Paterson Medal in Biochemistry	**Y. N. P. Forget**
Prox. Access.	J. E. A. Wickham

CROSSWORD



Clues Across

1. Has it a cosmopolitan cell population? (2 words, 5, 6).
8. Those of the earth as they say have no lumen (6).
10. What the sea-cook did which made the A.B. rise? (6).
11. This disaster was gravely ominous (5).
13. Thus was the Victorian sentry between love and duty (4).
15. Her make-up is similar to that of 12 down.
16. Obnoxious undoubtedly but with an ending quite human (4).
17. In old terminology "made an anatomy of" (9).
20. My environs are of high degree but not altogether brilliant (3).
21. He ought to know (3).
22. A reasonable deduction (not from your income) (9).
25. On which it is not in keeping to stay put indefinitely (4).
26. A lot to a Roman perhaps but of no significance to a Frenchman (3).
27. The king lost his head but got it back in the end and remains noble (4).
28. Those with their backs to the wall might fittingly struggle at the last one (5).
30. Nothing before ten to the Eastern gentlemen a century later (it's not palatable anyway) (6).
31. Who shows signs of nervous irritation (6).
32. Child or peer (anag.) (11).

Clues Down

2. Obviously the right direction for a patient (6).
3. Measures resulting in equal divisions between two points (4).
4. Like a nail in a French door? (4).
5. There's only one small bear in these nations apparently (6).
6. Case where the surgeon consults the police? (11).
7. Proverbially a student of this might claim the entire province of beauty (11).
9. Such affections might well engender the narrow view of life (9).
10. No patient welcomes introduction to this Northern aspect of the hospital (9).
12. Does this politician know whether he's coming or going, or does it matter? (3).
14. The result of the ancient Roman letting off steam? (5).
16. Data concerning the type an airman might say (5).
18. You are entitled to return in 10 across (3).
19 & 22. Both associated with pots but 22 also with dead shots! (3 and 6).
23. Permit me to invert and decapitate William popular though he be (3).
24. Told the tale (as one who has been through the mill?) (6).
28. Would you find a record of its movements in the patient's notes? (4).
29. The Irish find a suitable beneficiary (4).

L.J.C-W. & F.A.B.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD

2nd M.B. Examination

Hilary Term, 1951

Forensic Medicine and Public Health

Brookes, L. D.	Carlisle, I. O.	Haysey, G.	Sweet-Escott, M. W.
Brooks, J. M. H.	Eaton, D. H.		

Special and Clinical Pathology

Brookes, L. D.	Eaton, D. H.	Macartney, B. W. M.	Sweet-Escott, M. W.
Carlisle, I. O.	Haysey, G.		

UNIVERSITY OF LONDON

Examination for the Academic Postgraduate Diploma in Medical Radiology (Diagnosis)

February, 1951

Part I

Friedman, J.	Geere, J. J.	Hurwitz, M.

UNIVERSITY OF CAMBRIDGE

Examination for M.Chir. Degree

February, 1951

Loosemore, T. G. E. Lunn, G. M.

Examination in Pharmacology for Medical and Surgical Degrees

Lent Term, 1951

Blow, R. J. Fitzgerald, M. V. J. Stevens, J. L.

CONJOINT BOARD

First Examination

March, 1951

Anatomy

Kellett, P. Reynolds, A. B.

Physiology

Dormand, G. S. Kellett, P.

Pharmacology

Biddell, P. B.	Fitt, W. P.	Moore, J. D. McB.	Ryan, A. M.
Brown, H. E.	Jones, H. S.	O'Brien, M. J. C.	Todd, I. N.
Cuthbert, D. M.	Maskell, J. F. A.	Pearsons, D. E.	Warburton, T. H. M.
Deane, W. H. H.	Mercer, M. H.		

SPORT

RUGBY CLUB

v. EXETER, March 10, at Exeter.

Result: Lost 0—14.

St. Bart.'s kicked off here this afternoon on a heavy ground but in conditions otherwise excellent for open football. The first half was most exciting, and Bart.'s did more of the attacking. The defence of both sides was excellent, and neither side really looked like scoring. At half-time there was no score.

In the second half Exeter showed themselves to be the better side. They gained more of the ball and did more with it. The Exeter centres were held by the strong tackling of the Bart.'s centres, but on the wing Exeter proved to be superior. By well-placed cross kicks they exhausted the Bart.'s pack, and before long the Exeter wing scored by the corner flag. For most of the second half Exeter were superior, and scored a further two tries and a goal. For the last ten minutes, however, Bart.'s attacked with great determination, but failed to cross the Exeter line, the final score being 0—14 to Exeter.

It was, however, an excellent game, and indeed football at its best.

L. Cohen, T. M. F. Roberts, M. G. Taylor, J. K. Murphy, A. D. M. Thomas, K. A. Clare, A. Mackay, P. T. Macadam, P. Knipe, A. J. Third, C. W. H. Havard (Capt.), D. W. Roche, J. Tallack, D. Black, G. W. Mears.

v. WOOLWICH GARRISON, March 21, at Woolwich.

Result: Won 19—0.

St. Bart.'s beat Woolwich Garrison at Woolwich by two goals, two tries and a penalty to nil. It was hardly a classic game as the forwards were far too individualistic and the handling behind the scrum of what was a confusingly light ball left much to be desired.

The scoring was opened by Roberts, and soon followed by Clare and Murphy. The last try was converted by Baker.

In the second half the game became snappy, though Bart.'s were having by far the better of the scrap! A further try was scored by Mears. This Baker converted into a goal, and a few moments later added a further 3 points to his bag by a successful penalty kick.

The Bart.'s pack had most of the ball from set scrums, loose scrums and line-outs, and Clare, Caiger and Murphy did a lot of useful kicking ahead. It was poor finish that prevented a greater score in the Hospital's favour.

v. SARACENS, March 17.

Result: Lost 0—3.

St. Bart.'s lost to the Saracens by a penalty to nil on the Saracens' ground this morning.

The game could hardly have been played under more appalling conditions, the ground was a mass of sodden mud, large areas of which were completely under water. To the spectator it must have appeared more like the Eton wall game being played in a ploughed field which during the week was used for water polo.

Bart.'s kicked off down the slope, and did their best to open the game up. But soon, as the ground became even worse, the game degenerated into a forward battle. At half-time there was no score, and so covered with mud were both sets of forwards that it was difficult to tell to which side they belonged.

Early in the second half the Saracens were awarded and converted a penalty—a good kick from near the touch line—and this proved to be the only score. After this Bart.'s attacked and came near to scoring on a couple of occasions, but for the most part it was a series of line-outs in the muddiest part of the field on the Saracens' 25.

Junior Cup, 2nd Round

v. GUY'S HOSPITAL, March 7.

Result: Lost 3—8.

Guy's, the holders, and subsequently the winners, beat Bart.'s in the second round of the Junior Cup. Guy's deserved to win, their backs getting more of the ball and looking more resourceful when they had it. The forwards were fairly evenly matched.

There was a great deal of loose forward play with occasional good rushes by both sides, but the forward play was too individual to become a decisive factor on either side.

The Bart.'s backs were, on the whole, playing a defensive game, and the ball was coming out very slowly from the scrum. Even in the Guy's half the backs were still tending to stand too shallow, and so on the occasions they did get the ball they never could look really dangerous.

Guy's opened the scoring with a penalty. Later their right wing, a powerful runner, cut in towards the centre of the field making an opening which resulted in a try; this was converted.

In the second half, Caiger, the Bart.'s fly-half, cut through from the Guy's 25 to score a nice try. The kick failed.

Maskell led the pack with much enthusiasm, and Tallack and Nicholson were prominent in forward rushes. Williams did great work in the line-outs.

Small, the captain, played a sound game at full back and was unlucky to be injured early in the game.

G. Small; A. D. M. Thomas, T. M. F. Roberts, G. W. Tamlyn, P. McDonald; V. G. Caiger, M. Hodgson; A. R. Jones, R. C. Cochrane, J. F. A. Maskell, W. D. Williams, W. B. Castle, J. Tallack, D. Black, J. R. Nicholson.

ASSOCIATION FOOTBALL CLUB

It is true that the side has only won seven of the twenty-five games so far played, as against eleven lost—the other seven being drawn—but they say it is attacking football and goals which make the game attractive. Certainly on the latter score, the team has set up a record quite unrivalled by any of your Arsenals, Blackpools or Newcastle Uniteds; for their matches have produced an average of 6.4 goals each, the lowest score being two and the highest twelve. Indeed, the side has never failed to score at least one goal in a match.

It must be admitted that Skipper Duffy's boys have often been disappointing, largely through having to rely on a reserve strength which thrives more on enthusiasm than skill, and certainly never through any lack of vocal exhortation from the Captain himself. But the team have played splendid football on a number of occasions, especially in the cup games, in two games with Goldsmith's College and in games with Queen's College (who have reached the final of the Inter-College Cup at Cambridge), with Northampton Engineering College and the Old Cholmleians. Those stalwart members of the Resident Staff, Messrs. Cairns and Gilks, so reluctant to turn out and yet so enthusiastic on the field, have always played well. Duffy and Wright (what will the side do if and when the latter qualifies?) have been consistently excellent, while Cox, Farrish and Sharer have had splendid seasons. Grassby and Hughes have shown great skill both in their football and in their comments, the latter being at his best on the day the side met a combination of one and a half hours' journey, a continuous rainstorm, a quagmire for a pitch, a cold bath, no tea and a 10—2 defeat by the Corinthian Casuals. Lastly, tribute should be paid to that stalwart body of reserves, who, seldom selected in the first place, have always been willing to turn out, usually at very short notice, to make up a team.

Cup Semi-Final

v. ST. MARY'S HOSPITAL, February 28, at Chislehurst. Result: Lost 3-5.

For the third year in succession, the side has been narrowly defeated in the Semi-Final. It was clear before the game started that with players of international repute—Kelleher and Sullivan—in the opposing forward line, the defence would not be short of exercise. The whole side, however, played fast vigorous football and, two Bart.'s goals in 25 minutes made it seem that the Mary's side might be put out of its stride. Wright and Mangan then each nearly put us three up, when just before half time, Mary's did finish off a movement in the approved or disapproved style. It must be admitted that all through the game, Mary's forwards were making opportunities for themselves to score, only to fritter away chances far easier than those which Bart.'s accepted. Cox, in goal, had a great deal to do with this, and used his skill and ample length in playing one of his best games. Two Mary's goals within a minute midway through the second half, the first a magnificent one by Bennett—the net just managed to contain the ball—put Bart.'s behind, and although we equalised and all but took the lead, an overworked defence made two slips in the closing stages which proved decisive.

A header by Wright from Mangan's corner (a goal to dream about) and good shots by Grassby and Duffy (the former ending up in the net himself) were responsible for the Bart.'s goals. Cairns at centre-half was outstanding and saw to it that Sullivan had a very quiet game. But oh! that man Kelleher . . .

A crowd of nearly 40 much enjoyed the afternoon, not least the President of the Club, Mr. Alan Hunt, who found opportunity to use some of the expressions he learnt on his recent trip to U.S.A., when watching baseball.

St. Mary's beat Guy's in the Cup Final by 4 goals to nil.

ATHLETIC CLUB

At the Annual General Meeting held on March 2 Mr H B Stallard resigned his post as President of the Club. For the past 13 years he has shown a great interest in the activities of the Club and has been present at most of our meetings and matches; he has followed us into the Home Counties on numerous occasions, laboriously following the Secretary's directions, or even more laboriously finding his own way when no directions were sent to him.

He gave invaluable assistance behind the scenes, and was always ready with advice and encouragement, and was a constant source of inspiration to us all. We shall miss him, but we hope that he will still be connected with the Club for many years to come.

We should like to extend a very hearty welcome to Mr. J. P. Hosford, who is to be our President this year. He has supported us for many years in the capacity of a Vice-President, and we are very grateful for his continued assistance to the Club.

United Hospitals Championships

The United Hospitals Championships will be held at Motspur Park on Saturday, June 9, and we hope that you will all come and give us vocal support.

GOLF CLUB

v. St. Thomas's Hospital

On February 7th, in a fourball match against St. Thomas's, Bart.'s were somewhat eclipsed by the standard of play shown by their opponents. However, Elliott and Sleight managed to keep on even terms most of the time with Webb and Shuttleworth and finished only one down.

Results

C. J. R. Elliott and B. Deering lost to H. Webb and K. Shuttleworth 1 down; J. S. Dodge and J. Bowman lost to W. S. Pease and A. Archer 3 and 2: A. B. Lodge and P. Sleight lost to J. W. Davies and A. R. Kittermaster 7 and 6.

Evening News Competition

Winners of the *Evening News* qualifying round were C. J. R. Elliott and P. Sleight, who returned scores of Net 72 and Net 79 respectively. We wish them every success for the first round.

Honours

The following were awarded their Honours for 1950:—

L. R. Gracey.
R. V. Fiddian.
D. H. Rushton.

RIFLE CLUB

The Rifle Club have just finished a successful smallbore season during which three teams have been run.

In the Intercollegiate League, Division I. the "A" team have scored 5 wins in 7 matches, and in Division II the "B" team have been equally successful with 4 wins out of 5 matches.

We have not fared quite so well in the Inter-Hospital League, having had 2 wins, 1 tie and 1 loss in the 4 matches, whose results are at hand, but we hope to have done better in the later matches, results of which are not yet confirmed.

In friendly matches, however, we have only 1 tie to record against 2 lost matches. Results :—

Intercollegiate League—Division I

"A" Team		
v. Northampton Eng. College "A"	W	573—565
v. Queen Mary College "A" ...	W	581—568
v. Guy's Hospital "A"	W	588—578
v. St. Mary's Hospital "A" ...	W	567—563
v. Imperial College "A"	W	577—574
v. University College "A"	L	575—580
v. King's College "A"	L	575—582

Intercollegiate League—Division II

"B" Team		
v. King's College "B"	W	564—546
v. Queen Mary College "B" ...	W	560—530
v. Imperial College "B"	L	573—574
v. University College "B"	W	567 564
v. King's College "B"	W	565—560

Inter-Hospital League

"A" Team		
v. St. Mary's Hospital	L	477—483
v. Guy's Hospital	Tie	480—480
v. London Hospital	W	481—472
v. St. George's Hospital	W	478—464

Friendly Matches

"A" Team v. City London Police I.	569—	581
" " v. City London Police Tie	1535—	1535
"C" Team v. Westminster H. "A" L	448	455

Individually we have been equally successful, and have provided the captains of both University "A" and "B" teams. B. D. Lascelles has captained the University "A" team which won the Inter-University Championship, and J. E. Cradock-Watson has also shot for them. M. C. Hall has captained the "B" team and members included T. B. Catnach, S. M. Lacey, F. P. Thoresby and C. M. Vickery.

The H. J. Waring Cup based on a Handicap system was won by M. B. McKerrow, with 100.461 points, followed by J. S. Bunting and J. M. Fairley with 100.333 points.

In the field of averages, B. D. Lascelles once more heads the list with an average of 97.125, closely followed by J. E. Cradock-Watson with 97.059 and C. M. Vickery with 96.600.

Finally we should like to congratulate the staff on their victory in the Annual Staff v. Students match for the first time on record. This they won by 576—573 after a very close match.

We now look forward to fullbore shooting once more—See you at Bisley !

BOOK REVIEWS

TEXT-BOOK OF ORTHOPÆDIC MEDICINE, vol. II, by James Cyriax. 1950. Cassell, pp. xv+328, 110 plates, 10 figs. Price 18s. 6d.

This book should be of interest to all those who treat disabilities of muscle tendons or joints.

It is an extremely clear and interesting exposition of the author's own methods—though it is, perhaps of necessity—narrow in its scope and outlook.

The manipulation and massage of specific muscles and tendons are very clearly described and well illustrated; and the great importance of accurate localisation and treatment explained most convincingly.

The final chapter by Miss Bartholomew on the modified Bisgaard technique for treating varicose ulcers describes in detail the very valuable regime which has proved its worth in so many hospitals since it was first introduced to this country in 1947.

L. W.

MEDICAL AND NURSING DICTIONARY AND ENCYLOPEDIA, by Evelyn Pearce. Faber & Faber, 10th Edition, 1951, pp. 723. Price 18s.

This author has a high reputation amongst the nursing profession: in this book she has succeeded in giving a general view of treatment and nursing care. It is in alphabetical form and the subjects are many and various from boils to Banti and from sassafras to scriverers palsy. Miss Nightingale is

preceded by night sweats, and ringworm followed by risus sardonicus. There are some curious entries such as lawn-tennis-arm and some really earthy Saxon terms such as "posseting" (from the late Middle English poshote) "stupe" and "hives." In general, however, good this book is for the nursing profession, it can only have a limited use for students or qualified doctors.

OLD AGE, by T. H. Howell. 2nd Edition, 1950. Lewis, pp. vii + 108, Illus. 9. Price 10s. 6d.

This second edition of Dr. Howell's valuable little book has been almost entirely rewritten. The material includes most of the lectures which he gives to students of this Hospital, and they and others will like to have this permanent record. The sub-title of the book, "Some practical points in geriatrics and gerontology," describes it very well. It is essentially practical and deals with the findings in and management of old age and its diseases. One feels that the format does not justify the price, particularly as this is a second edition; the contents tend to compensate somewhat for this.

OPHTHALMIC OPERATIONS, by Seymour Philps. Baillière, Tindall & Cox, 1950, pp. x + 397, illus. 510. Price 50s.

The author describes the techniques which he practices and does not confuse the reader with half a dozen ways of performing any given operation. The result is a concise, dogmatic book in which almost the whole field of ophthalmology is covered in some 400 pages. The illustrations, mostly actual photographs, are excellent and are a great feature of the book. The text makes easy and in places, very entertaining reading. The sections on major ophthalmic operations are authoritative and clear, those on several of the more minor procedures, such as the removal of the globe or lacrimal sac could be expanded with advantage, as the tyro in ophthalmology referring to the book for guidance, may find them less straightforward than the descriptions suggest. There is an extremely good section on the care and sterilisation of instruments with many good photographs of less familiar types required for more recently introduced operations.

J. H. D.

A HANDBOOK ON DISEASES OF CHILDREN, by Bruce Williamson. 6th Edition, 1951, Livingstone, pp. xi + 440. Price 17s. 6d.

In this book the author attempts and largely succeeds in the seemingly impossible task of covering the whole paediatric field in 450 small pages of clear type. Abbreviation has been achieved by a stern exclusion of non-essential matter and by an equally ruthless avoidance of verbosity. The style throughout is lucid and readable. The approach to the subject is eminently practical, and although the space given to many conditions is small it is usually sufficient to indicate accurately the main features of the disease and its treatment.

The text has been thoroughly revised for this edition, and recent advances, including modern antibiotics such as aureomycin, chloromycetin and acrosporin are incorporated.

There are few branches of medicine where opinion is so divided on so many topics as in paediatrics, especially in the field of infant welfare and dietetics. It is obviously beyond the scope of a book of this size to discuss the merits of rival schools of thought, and so the reader must remember that all the views expressed are not necessarily accepted everywhere. This is not to condemn the book as unorthodox. No practising paediatrician is fully orthodox.

The lay-out, illustrations and production of the book are of an exceptionally high standard.

AIDS TO SURGICAL ANATOMY, by J. S. Baxter. 3rd Edition, 1950, Baillière, Tindall & Cox, pp. viii + 204, illus. 30. Price 5s.

Anatomy is a difficult enough subject to memorise with dissections fresh in one's mind. After a lapse of some years, it is correspondingly less easy to rescue the remnants from one's fading memory for the benefit of Final Examinations. Some book, giving essentials with no academically interesting but clinically useless information is of great assistance. Such a book is this. It is very condensed and necessarily dry reading but fulfils its purpose. The space allocated to diagrams is of course limited, but no advantage has been taken of the available room and the standard is poor, both in subject and draughtmanship. Otherwise this is a useful "aid."

AIDS TO MATERIA MEDICA, by G. H. Newns. 4th Edition, 1950, Baillière, Tindall & Cox, pp. viii + 204. Price 5s.

This "Aid" combined with "Aids to Medical Treatment" will supply sufficient information in a compact but palatable form for any student to pass his Pharmacology and Therapeutics examinations. The modes of action of many drugs could have usefully been expanded without prejudice to the general conciseness of the book. Morphine's action occupies half a page only, digitalis three quarters. But it may be repeated—the information is sufficient. There is a useful appendix of the systems of the body with lists of the drugs acting specifically on them, and another with lists in ascending order of dosage.

PREVENTIVE MEDICINE AND PUBLIC HEALTH, by Fred Grundy. Leagrave Press, 1951, pp. 299. Price 18s.

It is curious that all books upon Public Health seem inevitably to be dull. Each in turn deals with the Administrative Services, Statistics, Death Certificates and Sewage Disposal; the ritual varies little from one book to another. The same diagrams, the same pictures appear in every edition as ubiquitously as that acromegalic with the seedy bow-tie who illustrates every section on endocrinology. Dr. Grundy's book does much to put all this right. This book is not dull ,though it would be an exaggeration to say "this is a book I just couldn't put down"; it is a book to be enjoyed, and not to be skipped through the night before the "Finals." Dr. Grundy has the co-operation of the Leagrave Press, who have provided the book with good paper, a substantial binding and an attractive lay out, all at a very reasonable price. In addition to the main text, there is an excellent section on the History of Public Health, and apt quotations head each chapter such as: "The ultimate goal of the Medical Officer of Health is to make himself unnecessary."

RECENT PAPERS BY BART'S MEN

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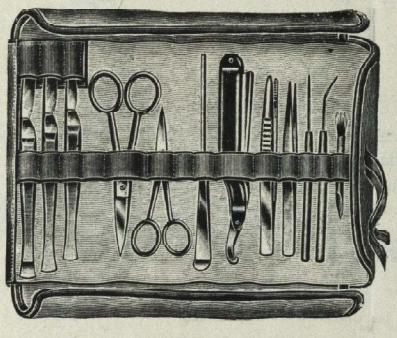

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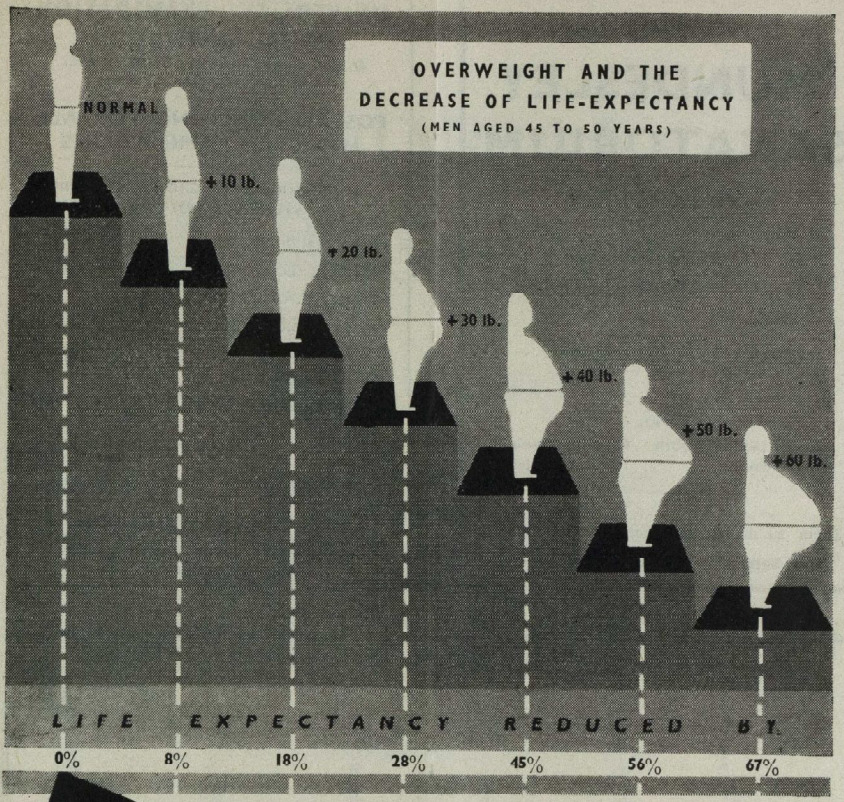

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JUNE 1951

VOL. LV No. 6

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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June, 1951

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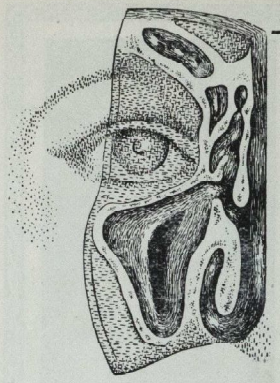

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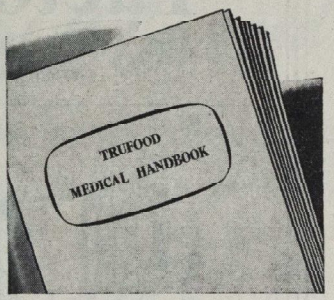

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LV JUNE, 1951 No. 6

PLAIN WORDS

Medical education in all its aspects has recently become a favourite and fashionable target for criticism. As a target it has many attractions: it is, for instance, so vast that even the tiro can hardly miss; it is constantly changing, and so to the satisfaction of the butts are added some of the thrills of the chase.

A century ago Cardinal Newman said of education that it taught the student "to see things as they are, to go right to the point, to disentangle a skein of thought, to detect what is sophistical and to discard what is irrelevant." For the modern scientific student at least, there must be added a further objective, the acquisition of that increasing mass of specialised knowledge essential to his particular vocation. These are the two divisions, the cultural and the vocational, into which his education must fall, and whereas at one time it was feasible to acquire each separately, the former by many years of non-vocational learning, the latter by a few years of technical study, they have now largely to be treated as parts of a single process. For the doctor, whose province lies in that no man's land between science and art, Newman's maxim has usually to be fulfilled by the scientific training which necessarily occupies so much of his time. It is idle to look back with regret on the days when every doctor was a scholar in the humanities, and contrast them with these more degenerate times when he is "becoming a technician." It is more profitable to consider how the ends, once so well served by the older education, may now be served by the new.

Science can, if it does not become the sole subject for study at too early an age, provide many of the accepted essentials of education. One notable exception is training in the use of words. Words are no less important to the practitioner of today than of a century ago, but their study is no longer a part of his education. Sir Arthur Quiller-Couch once observed that "for Men of Science the neat clean carving of words is a very necessary accomplishment . . . Words are, in fine, the only currency in which we can exchange thought even with ourselves." By the "neat clean carving of words" the acute observations of the Hippocratic writers were so recorded that they are still a part of medicine today; and because of the difficulty of its language. Arabian medicine has become little more than a legend.

One might cite as examples from more modern times and humbler sources, the case-notes of nineteenth century physicians, often models of accurate observation clearly expressed, or even the entry in the minute book of the Abernethian Society in which is related Sir James Paget's description of *Trichina spiralis* in 1835. There are indeed many examples to show that, even fifty years ago, the arsenal of the student and practitioner, though lacking many of the refinements of science, at least contained a mastery of words which few can claim today.

However much the fluency of the doctor in standard English may have declined, he has not been left speechless. There has sprung up a rich growth of medical jargon containing many new and strange words. Only the purist will criticise these words as such. Many are certainly ungainly or ugly, and some own to a mongrel birth from both Greek and Latin, but they have developed side by side with the science they define and have a necessary place in its description. But the very ease of their use brings danger; for one has only to attend a ward round to see how glibly they slip from the tongue; and to realise how much easier it is to talk about

his condition than to tell the patient what is wrong with him. It is no wonder that he, confusing the terms he hears, goes home to nurse his "gastric stomach"; but are we necessarily nearer the root of things, who know he has "gastritis"?

Those who plan the medical course have long been aware that narrow specialization can defeat the ends of education, but there has been little agreement on a remedy, apart from a widespread feeling that specialized scientific training should not begin too early. This is a sentiment that should command general approval, but we are here concerned with training in the use of words. Language can obviously be the object of spare-time study for those interested. This was the view of the writer of a pre-clinical text-book who, with a modesty that was a match for his wisdom, prefaced his book with an admonition that the student must continue to read good English and especially poetry "that he may retain the flavour of a lovely language while studying from his text-books." But the use of words may also take a greater part in the medical course itself. It is in the pre-clinical years that some reform is most urgently needed. For one can hardly regard as an ideal education a course which the student may successfully complete without ever attempting to describe either the facts which he learns or the ideas which link them, save under examination conditions.

In 1948 a little book was published by the Stationery Office. Its title was "Plain Words" and it sought to cut some of the dead wood from the language of officialdom. It awakened an interest in its subject far beyond the circle for which it had been intended. Business executives began to look to their English as well as to their sales figures; even University Faculties were a little uneasy; the medical world, however, went its way unruffled. But perhaps even in medicine plain words would do much to promote precise observation and clear thought within the profession, and to provide a closer link with those outside it.

DIAGNOSTIC DITTY

EAT, DRINK . . . . AND BE MERRY?

The patient who presents with gout
Is often rich and rather stout,
And eats unto his heart's content
In restaurants on the continent.
Each meal he has when out to dine
He washes down with good red wine,
And blissfully eats away the years
Collecting tophi on his ears.

F. W.

A RUMOUR

We understand there is no truth in the rumour that, pending the hoped for re opening of the "Vicarage," a barrel of beer is to be installed in the Refectory which will then be known as the "Rectory."

THE JOURNAL

Contributions for the *Journal* should reach the Editor by the 1st of the month for inclusion in the issue of the following month.

ARTERIAL BLOCK IN THE LEG

By C. J. LONGLAND, M.V.O.

THERE is not very much to be found in the standard text-books about the effects of arterial obstruction until disease has become so advanced that frank gangrene is present. It seems worthwhile therefore to attempt to set down some of the experiences which the Vascular Clinic provides, where gangrene is rare and the lesser degrees of arterial disease are common. In the Clinic patients are examined by clinical methods without the use of special tests, the oscillometer excepted; a large proportion of them have blocks in the limb arteries, nearly all in the leg, the arm being much less commonly affected. Certain of these patients are admitted to the wards for special investigations but we shall deal here with the clinical aspects alone, that is with the complaints of pain on exercise, pain at rest, ulceration, and the signs that go with them.

The Symptoms of Arterial Blockage

Exercise Pain (Intermittent Claudication).—From the patient's point of view intermittent claudication, meaning intermittent limping, is not the best description of his symptoms; what he is most aware of is pain, and this comes on in muscle after a certain well defined amount of exercise. It varies from a tightening or stiffening sensation in its mildest forms to an intolerable deep ache or cramp; "cramp" is quite often the word the patient uses to describe it, though in fact the muscle does not go into the violent spasm of true cramp. Sometimes it is so severe that it is said to feel as though the part were being squeezed in a vice. Together with the muscle pain there are often sensations of tingling, numbness or deadness in the foot. When the patient has walked a certain distance the pain begins; as he continues it increases and he may limp to try to diminish it, but the limp is not the important feature of the syndrome. Sometimes the pain may not become severe and he may be able to go on walking without further increase in the pain, particularly if he slackens speed. As a rule the pain intensity continues to mount and it becomes imperative to stop; the pain then diminishes rapidly, within seconds, and, vanishing, except perhaps for a mild soreness within a minute or so, allows him to go on. After going about the same distance the cycle repeats itself and so he progresses by regular stages of perhaps a few hundred yards interrupted by halts. It is a striking thing to be told how rapidly this pain disappears, severe as it may be, merely as a result of ceasing to walk, without the necessity of sitting down or otherwise taking the weight off the limb, though the patient will do so if he can. The pain does not come on however long he may stand still. It will be noted that the masculine pronoun has been used; most of the patients with this symptom are men, though women are by no means immune.

When pain of this kind occurs in muscle with such clear cut relationships to activity, and most particularly to cessation of activity, one can be sure that one is dealing with a deficiency in the blood supply to the muscles concerned. The calf is the commonest site of such pain; it may also come on in the foot, when foot strain may be suspected, or in the anterior muscles of the leg, or in the thigh or buttock. In its milder forms "rheumatism" may be diagnosed, but once the relationship to exercise is clarified the diagnosis is certain.

The physiological basis of the pain is well known to all who have exercised a hand with a tourniquet occluding the arteries of the arm till pain in the arm occurs; release of the tourniquet brings prompt relief. In the patient the arterial stream is only partly cut off but a deficit still develops between the demands of the exercising muscle and the supply of blood, and this is the crux of the matter. The deficit is quickly made good when exercise ceases, for the blood supply is still more than ample for the needs of the limb at rest, and the pain-producing substances are removed. The severity of the symptoms is determined by the amount of the deficit and this varies with the rate of exercising. If the deficit can be reduced sufficiently either by increasing the blood supply or by lessening the rate of working of the muscle pain will not occur.

A striking feature about patients with uncomplicated exercise pain is that they appear perfectly fit people: they walk about the room without trace of a limp unlike those having other painful musculo-skeletal

lesions, and indeed they are functionally normal until they have walked the requisite distance to bring on the pain, which may be anything from 20 to 2,000 yards. They are mostly over 40, generally over 50 years of age; they may have prematurely greying hair or an early arcus senilis, both of which sometimes accompany arterio-sclerosis. The combination of good health and apparently sound limbs with an incapacitating cramp after a short walk not infrequently cause the patient to express himself very forcibly about his symptoms.

Rest Pain and Ulceration.—The patient with these graver and more advanced evidences of arterial disease presents a different picture from the foregoing. There may be an antecedent history of exercise pain, but now he has a different and persistent aching and burning pain unassociated with exercise, most troublesome at night, very difficult to relieve and interfering with sleep; he soon shows signs of this in his general bearing.

Such pain is felt first in a toe or the forefoot and may spread proximally. Its presence is ominous because it is due to the blood supply being so diminished that it cannot maintain the tissues in a proper state of nutrition even though they are at rest. With a slight further reduction tissue necrosis begins. Often this has already happened by the time of the patient's first visit, for the blood supply in a foot to which the current has been largely cut off is not evenly distributed, and at some point, usually the tip of a toe, it may have ceased altogether.

The Signs

A foot with ischaemic rest pain looks abnormal. It will show some of several signs when the patient is examined lying down in a warm room (70° F.). It may be suffused or pale, and the blood may be red or cyanotic. It may be warm or cold. These signs reflect various states of the skin circulation. At the point where the blood supply is least, coldness and often cyanosis are to be found and they are the most malign of the signs enumerated. Wasting and atrophy of the skin and nails are evidence of long-standing disease; oedema may be due to concomitant venous thrombosis but is often due to the posture which the patient adopts to ease his pain, namely hanging the leg over the side of the bed.

As we have seen, in many patients presenting themselves with rest pain actual tissue necrosis has already begun. A small black patch a few millimetres across lying beneath an intact epidermis is recoverable and may disappear without further harm; but when the full thickness of the skin turns black and becomes hard true necrosis has begun and pain becomes intense, often needing morphine for its relief. The dead tissues may in time be cast off leaving a painful indolent ulcer. If a whole toe or larger piece of tissue dies the clinical term "gangrene," meaning death of tissue in bulk, may properly be used. It should be noted that the necrotic changes occur in the toes or forefoot, unless pressure as from a tight bandage has occurred elsewhere causing necrosis of poorly nourished tissues beneath it; ulcers occurring more proximally are generally not due to arterial disease.

Postural Colour Change.—It is very easy to demonstrate that the arterial blood supply to a foot is grossly restricted. The patient lies on a couch and the limb is elevated for a minute or two as nearly vertically as possible. The toes first and then the foot will be seen to blanch. Pain will be made worse as the blood drains out of the foot; this is added evidence of the ischaemic origin of the pain, but the leg must be promptly lowered again for the patient's comfort. If the foot then lies beside its normal fellow it presents a striking contrast by reason of its pallor; if the arterial inflow is only a trickle the limb will take some time to refill with blood; by observing how long the collapsed superficial veins take to refill one gains some idea of the rate of blood flow into the foot.

Such blanching on elevation is a sign of lowered blood pressure in the arteries of the foot; the the lower the pressure becomes the less need the foot be raised to blanch it. The pressure is reduced by blockage of a main artery. Blanching may be demonstrable in a patient without symptoms in the foot, for it is not till the blood pressure becomes very low that rest pain and ulceration occur.

The Arterial Lesion

The Site of the Block.—The foregoing signs and symptoms are clear evidence of arterial disorder, if gross anaemia is absent, and give precise information about its severity as it affects function. However, a proper understanding of such cases requires information

as to which arteries are blocked. This is obtained first and foremost by feeling the arterial pulses and determining at what level between the heart and the foot they cease or weaken. It is convenient to begin with the foot and to feel for the dorsalis pedis and posterior tibial pulses at the ankle, followed by the popliteal behind the knee and the femoral at the groin, comparing each pulse with its fellow in the opposite limb. The detection of the popliteal pulse requires some practice, for in any but thin people the artery is covered by a thick pad of fat lying under strong fascia. By pressing with increasing firmness in the middle of the popliteal fossa behind the relaxed knee the pulsations of the artery will gradually become apparent. Its presence or absence is an important physical sign because the upper end of a block may thus be localised below or above the knee. If the pulses cannot be found in the limb the external iliac and aortic pulses must be felt through the abdominal wall; if the pulses are absent from both legs the lesion may be in the aorta.

In this way one obtains an approximate idea of the level of the upper end of the block; sometimes it can be determined accurately by feeling along the course of the femoral artery or the popliteal artery and finding a point where pulsation stops. Many blocks are a few inches in length with open vessels beyond, though they may be anything from what is really a narrow stricture to obliteration of a whole vessel. The lower end of a block cannot be located by feeling for pulses; such precise information is provided only by arteriograhy, but this is of little practical importance except in the occasional younger person with otherwise healthy arteries, in which some form of operative removal of the block may be contemplated. It is important to be on the watch for such people.

The Collateral Circulation.—Blood is carried past a block by many small collateral arteries; the stream which they pour into the open distal vessels is non-pulsatile, and it is for this reason that the lower end of a block cannot be made out by feeling for pulses. The collateral vessels however, can often be felt pulsating beneath the skin round the knee when the popliteal artery is blocked, for the collateral vessels themselves do pulsate; when blocks occur in the thigh or calf they are deeply placed and cannot be felt. The collateral vessels grow in size and number for many months after the main vessel becomes obstructed, but they are not capable of such development in the old as in the young. The stimulus to their dilation and growth is an increased bloodflow through them; this increase in flow is bound to take place when flow through the main vessel ceases so that they immediately begin to develop. How exactly this stimulus works is not known. The adequacy of the collateral circulation can be judged by the severity of the ischaemic symptoms and signs beyond a main vessel block, because all the available blood is necessarily passing through these new vessels.

Certain patterns of signs and symptoms are commonly found. Thus, usually, in a patient with exercise pain in the calf the popliteal pulse will be absent; if exercise pain is felt in the thigh or buttock the pulse will have disappeared high in the thigh or above the groin; if symptoms are confined to the foot there is arterial obliteration somewhere below the knee, and if to a toe disease may be confined to foot arteries, when the pulses at the ankle will be present. There may be blocks above and below the knee and then the state of the tissues beyond the second block may be precarious indeed. These are the usual patterns, but curious and fascinating deviations from them are encountered and special investigations may be needed to elucidate them.

The Nature of the Lesion.—The pathological processes responsible for arterial obstruction, itself a thrombotic process, are several. Arterio-sclerosis accounts for the great majority; cases in 5th decade are not unusual though most occur later. Changes may be evident in other accessible arteries like the brachial and radial, and X-rays may show calcification of arterial walls in the legs and pelvis, for this is a widespread degenerative process. Embolism from clot adhering to the site of a myocardial infarct in older people, or from a dilated and fibrillating left auricle consequent on mitral stenosis in somewhat younger ones may block the leg arteries with dramatic suddenness. Thromboangiitis obliterans, a rare disease fortunately, attacks predominantly the limb vessels, and almost without exception those of young men; it may ultimately involve all four limbs. When such a block is associated with past or present superficial phlebitis the diagnosis is almost certain. Diabetes must be added to the list of important causes, for it

is well known to hasten arterio-sclerotic changes. Injury of a severe kind is responsible for a few cases.

Treatment

General Management.—Acute ischaemia is always an emergency. Sudden ischaemia with pain and a cold numb foot in a previously symptomless limb is generally due to embolism. Hours count, for consecutive clotting is occurring beyond the embolus and the paramount need is to stop it and if possible clear out the embolus and clot so that the artery may not be permanently blocked. This requires admission to hospital where heparin can be given and embolectomy can be done if necessary. Thrombosis secondary to local disease of the arterial wall occasionally occurs suddenly and produces acute signs; such a case, too, needs heparin urgently.

However, thrombosis occurring in an artery which is the seat of arterio-sclerosis or other disease generally narrows and finally blocks the artery in more gradual fashion, and the patient does not go to the doctor for a week or more after symptoms appear. Then clotting has already finished and the block is fully established. It must be recognized that an arterial block once formed is nearly always permanent, for little natural recanalisation occurs and operative removal is generally impossible. Treatment therefore resolves itself primarily into getting the best out of the collateral vessels; it is often wise to explain the nature of his malady to the patient so that he understands this and realizes that the development of collaterals will go on for many months, and that everything which hinders their growth must be eschewed.

The Basic Regime.—In a moderately severe case of recent origin with, for instance, a short claudication distance and a cold foot, treatment should be begun by putting the patient to bed. The stimulus to collateral dilation is present and it may be increased by keeping the patient very warm; this induces peripheral vasodilatation which increases the demand of the limb for blood; sound sleep assists this vasodilatation. Tobacco is forbidden; alcohol is useful; postural exercises for the limb and non-weight-bearing exercises for the rest of the body are valuable. At the end of a month considerable progress will have been made. By this time the collateral vessels may well have largely accommodated themselves to the blood flows demanded by the limb while the patient is in bed, and he should now begin to get about, walking in stages to the limit set by the onset of pain, so increasing the flow of blood through the limb. It is important that he continues to pay attention to the instructions previously given and that he avoids standing, sitting instead with the foot on a stool, for when standing erect vaso-constrictor impulses go to the lower limb. He must also watch his weight, for the lack of a full amount of exercise will tend to cause him to gain. By the end of six months or a year progress will cease and further increase in the collateral circulation is unlikely.

Modifications of this regime may be necessary. If ischaemia is so severe that insufficient blood is available for the foot at rest, as evidenced by rest pain or necrosis, the foot is exposed to the room air to cool it and so reduce its metabolic needs, the rest of the body being kept as warm as possible as described before. The head end of the bed is also raised nine inches on blocks; this eases ischaemic pain and keeps more blood in the foot. In such cases it is more than usually important that the blood arriving in the limb should be of good quality and that anaemia, if present, should be treated. On the other hand symptoms may be too slight to warrant a prolonged rest in bed when the interference with the circulation is slight; in such a case the patient is treated as in the ambulant stage.

Special Methods of Treatment

(1) *Drugs.* On the whole chemical vaso-dilating drugs are disappointing when arterial block is present; unless given intra-arterially into the limb concerned they produce widespread vaso-dilatation and may thereby cause a deleterious fall in blood pressure.

(2) *Sympathectomy.* Sympathectomy confines the vaso-dilatation to the limb in trouble; it is not a dangerous or very trying operation but it requires general anaesthesia. Its use should be considered in severe cases when medical management alone is not proving sufficient and in young people who cannot afford long periods off work, and in whom a good response is more likely than in the elderly; it may enable them to get back to work more quickly than would otherwise be the case.

There remain to be considered those

patients whose symptoms have remained more or less stationary for some months and who may be supposed to have reached the limit of their collateral response. In many, though not all, of these about 50 years of age or less sympathectomy will produce a further improvement in collateral blood flow; it will not as a rule be very large, but if a small addition is likely to be helpful the operation should be undertaken. Thus a man whose pain is only just bad enough to make him stop when he walks, and who can if necessary continue to walk despite the pain, has only a small deficit of blood to make up; he may be able to walk without stopping in comfort after operation.

(3) *Diminishing the work of muscles.* When nothing more can be done to improve blood-flow into the limb the only way to lessen the severity of exercise pain is to diminish the activity of the muscles in which the pain arises. Slowing the pace, the use of a stick and raising the heel of the shoe to shorten the calf muscles may help. Pain arising in the calf from the gastrocnemius-soleus group may be abolished by tenotomy of the Tendo Achilles; the gain in comfort is achieved at slight cost to the gait which looses its spring. Pain in the front of the thigh arising in the quadriceps may be eased by providing the patient with a back splint for the knee which fixes the joint so that he walks stiff-kneed. Both these procedures may be carried out on the same limb with a great gain in walking distance.

By pursuing treatment on the lines indicated above, based as far as possible on the known physiology of the peripheral circulation, it is possible to achieve a useful and sometimes startling amount of improvement in many cases. Unfortunately, however, the majority of patients must accept some disability and adapt themselves to it, and given time and encouragement this is commonly achieved.

SOME NOTES ON FIBROSITIS

By G. D. KERSLEY

UNDER the heading of fibrositis or non-articular rheumatism are usually included all cases of pain and tenderness of the mesodermal tissues of the body for which no other cause can be found. Although no definite pathology or morbid histology has been proven, this convenient "waste paper basket" of diagnosis, all other causes of pain having been carefully considered and eliminated, appears to contain a fairly well defined clinical entity.

Anatomically fibrositis may be classified as (1) muscular, probably arising from the connective tissue between muscle fibres, as in lumbago and stiff neck (2) periarticular in the capsule, bursae and ligaments around joints and often misdiagnosed as arthritis (3) perineural as in some cases of sciatica and brachial neuritis and (4) subcuticular panniculitis.

Fibrositic Pain

'Fibrositic' pain may be organic or psychosomatic, but in many cases there is a combination of both elements in the same patient. *Psychosomatic* pain is not the complaint of a malingerer, but the *subconscious* use or exaggeration of a symptom in order to avoid a dilemma or to make life easier. The diagnosis is not only negative—but positive, the result of consideration of the patient's mental "make up" and background, suggestibility, method of description and exaggeration, length of duration and inconstancy of symptoms, and failure of even temporary relief from analgesics and other treatment. *Organic pain* in fibrositis may emanate from certain trigger spots where there is usually some deep tenderness, but which may be anterior and proximal to the main site of pain. For example, pain and even some tenderness in the cardiac area may originate from a smaller area of deep tenderness near the vertebral column in the same segment or a segment higher than the one to which the pain has been referred. Two types of lesion have been suggested as possible trigger points: (1) localised muscle spasm, the result of irritation, either from accumulation of metabolites, or by neural stimulation from organic changes in the same segment—for example a disc lesion—and (2) strangulation and oedema of fatty lobules caught up in layers of fascia.

Etiologically a hereditary tendency, sensitisation and any form of stress or strain appear to be factors in causation of the fibrositic syndrome.

Clinical Description

Typically the patient is not sick, though pain may be severe. There is no loss of weight or anaemia and the sedimentation rate is only slightly, if at all, raised. The symptoms are usually intermittent, an acute attack as a rule not lasting more than a few weeks. Attacks are often associated with strain, exposure or changes in the weather. Tenderness, but little or no swelling is present.

Treatment

I. *Acute phase.*—(a) analgesics ; (b) superficial heat and counter irritation, antiphlogistine, a hot bottle, mustard poultice, Lin A B C. (aconite, belladonna and chloroform), painting or application of iodine, cantharides, etc. : (c) injection with novocaine of any trigger area.

II. *Subacute phase.*—(a) elimination of infection ; (b) reduction of strain and any cause of spasm—avoid draughts, unwonted and strenuous exercise,—adjustment of sitting posture in the car or at the desk; (c) regular mobilising exercises every morning; (d) injection of trigger points ; (e) deep massage and deep heat (infra red, short wave and diathermy); (f) re-education of circulation with contrast douches.

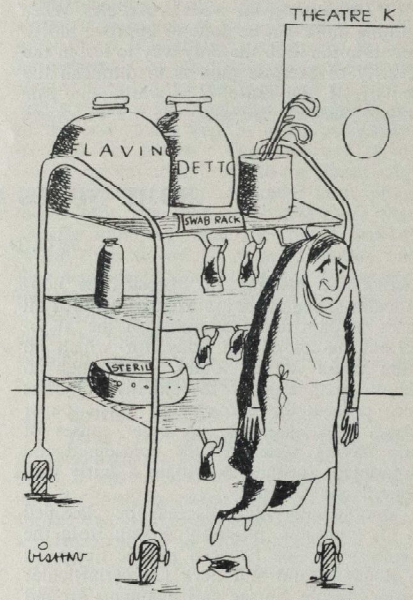
In the case of 'neuritic' pain especial care is needed. Rest and superficial heat alone are ordered in the early stage and later massage and movements require very careful graduation and are applied to the source of the pain only and not to the area of reference.

In periarticular fibrositis graduated manipulation, preferably in a hot pool, is most valuable; only where trauma initiated the syndrome and certain particular movements are painful and limited is manipulation under pentothal advisable as first choice.

In generalised panniculitis, usually associated with obesity, general spray massage followed by contrast douches is especially useful.

ANTIBIOTICS AND CHEMOTHERAPY

As the result of an exchange arrangement with the Washington Institute of Medicine we receive a copy of the new American monthly publication *Antibiotics and Chemotherapy*. This copy is available to readers in the Library.



The Dresser

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD

The Annual General Meeting of the St. Bartholomew's Hospital Women's Guild will be held in the Great Hall on June 29, 1951, at 3 p.m. An invitation to this meeting is extended to the wives of all members of the Medical and Surgical staffs. Those who wish to attend are asked to apply for an invitation card to the Honorary Secretary :—
Mrs. M. M. Oswald, 29, Campden Hill Road, W.8.

A GENERATION OF GENERAL PRACTICE

By NOEL E. WATERFIELD, O.B.E.

My first twenty years, after having filled various house appointments at Bart.'s, were spent in the Medical Service of the Sudan Government, but by means of doing locums in the yearly periods of three months' leave, I managed to keep in touch with general practice in this country.

Since 1925 when I retired, I have been in general practice; for the first five years in a country town in England with a good general hospital, and then in a semi-rural practice in Surrey, also with a good general hospital staffed by the practitioners in the area.

What are the changes that have occurred during this period of forty-five years, both with regard to the practitioners themselves and the conditions of practice? Does general practice still offer an opportunity for a useful, interesting, and lucrative career? I hope from the survey I shall give you, that those who are still doubtful, will feel that the answer is in the affirmative.

I think that, at any rate before the beginning of the "Panel" system, nearly everyone taking up medicine as a profession, did so because he felt that it was his vocation and the only thing he really wanted to do, and a large number were prepared to undergo considerable hardships to achieve their end. At Bart.'s there were comparatively few Oxford or Cambridge men. These I think were rather a set apart, as they were obviously better off financially than the London and College students, and for the most part came from the larger public schools, which was not the case with most of the London students. I think too, more of them went in for specialist posts, particularly medicine, and few if any of them went into the services. The point of these remarks is that the general practitioners of that period were drawn from a class who were for the most part financially badly off. They had to work hard to get through their exams. up to time, and from the outset had, with full knowledge of the struggle involved, entered on a life in which as C. B. Lockwood used continually to remind us, "the rewards are not to be measured in gold." At this time, competition to get on the junior Staff was very keen, and I suppose about one in eight was successful. The salary for Junior H.P. and H.S. was £30 for six months without any keep or lodging, and for the seniors, lodging and keep with no salary, so that in addition to the five years of studentship, there was an additional one in which the student had to keep himself. Having got through his exams. and usually having done a year in hospital appointments, most of those intending to go into general practice would spend some time doing locums, for which the average weekly remuneration was three guineas, and would then look for an assistantship with a view to partnership. Those who could raise the necessary capital would buy themselves in, while those who had not enough could often, if they proved themselves useful to the practice, be allowed to pay off their debt to the principal by instalments. The salary of an assistant was usually about £150 a year with keep and lodging. A few were prepared to spend their whole life as assistants, with the knowledge that they were free from financial worry due to the fluctuations of the practice.

What of the conditions of practice? There were, of course, the good class practices, where the doctor made a satisfactory living from his private patients, but there were other practices where the conditions of life were such, that only those who really felt that they were fulfilling a vocation would put up with them. In a country practice I was connected with, one of the partners did over two hundred confinements a year, and his average daily round in a dog cart was over thirty miles. This, year in year out, winter and summer, seven days a week, and for an income which, although it enabled him to enjoy a reasonable standard of life, gave little margin for providing for retirement. Much of the work was done gratuitously. A large number of the patients were members of clubs and paid capitation fees of about five shillings a year, which included the cost of medicines. The fee for confinements was usually one guinea, with no question of mileage. In the towns there were "shilling doctors" usually practising from a surgery with windows like shop windows, and displaying a notice which announced that the doctor was a physician, surgeon and midwife, and that teeth were carefully extracted. The title arose because for a shilling medicine was supplied with the advice given. Not a few of these doctors kept an unqualified assistant,

often a medical student who was in process of getting qualified, or perhaps one who had given up the struggle. In spite of the conditions under which these practitioners had to work, they rendered service to their poor patients out of all proportion to the payment received, and were their trusted friends and advisers. They were remembered with gratitude long after their death. Those who could well afford to pay were of course well doctored. I think it may be truly said that few poor people lacked the necessary medical advice, either by means of the club, or the parish, or the doctor's charity, but many of the middle classes were loath to call in the doctor if they thought they could not meet the bill, and in consequence often went without the necessary medical care.

The practitioners in better class practices would, for the most part, only have private patients, and would be on the staffs of the local hospitals where they acted as honorary consultants. The work really was honorary, as local jealousies would, except in special cases, prevent such men being called in consultation by the colleagues with whom they were competing in general practice. The experience gained in this way as part-time consultant, was most valuable and was a great asset to patients, and many of the most competent eventually gave up general practice and became full-time consultants. There is no doubt that in areas where there was this opportunity for working on hospital staffs, the general level of medicine was much higher than where such opportunity did not exist. In those days there were many fewer partnerships than there are today, and big firms did not exist. The doctor's surgery was nearly always in his own house, and his waiting room often quite inadequate for the crowds which would overfill it in the winter months. His consulting room had the homely look which would not make the patient feel he was attending the O.P. dept. of a hospital. There was much less movement of the population, and much less changing from one doctor to another, and because the doctor usually was not in partnership, the relationship between patient and doctor was more personal, and often carried on in the doctor's line from father to son, and in the patient's to their children and not infrequently grandchildren. The status of the doctor was therefore very definitely that of a family friend and trusted adviser. His social standing would largely depend on whether he was a doctor on the staff of the Hospital and had only private patients, as against the position of the doctor who took club patients, and was often at the same time the "parish doctor" who looked after the Workhouse and what were then called "paupers."

The first great change in conditions of service for the G.P. was the bringing in of the N.H.I. Act in 1911, by Lloyd George. This was received with great disfavour by the profession in general, but there was a general stampede to take on patients owing to the difficulty of maintaining a united front. Considerable concessions and improvements over and above the original proposals were conceded, but even better terms might have been obtained had the profession remained united. In spite of this, there is no doubt that on balance both the public and the profession gained. For employed persons the doctors now received something approaching reasonable remuneration, without the danger of bad debts, whilst the worker could obtain medical advice whenever he needed it.

Did the working of the Act interfere with the doctor-patient relationship, and alter the status of the doctor? I think the answer to the first part of this question is that it made little change. The good doctor still remained a good doctor, friend and adviser to his panel patients, and in as much as the remuneration was better on the whole, and as, on account of the income limit imposed under the scheme, the doctor retained most of his profitable private patients, he could afford to have fewer persons for whom he was responsible, resulting in better pay for the same amount of work and responsibility. With regard to "social status," the stigma attached to being a club doctor was now transferred to the panel doctor, but as these were much more numerous than the former club doctors, the stigma lost something of its sting. Those doctors who were not on the Panel gained as they became a more select body.

I think the only tendency to be observed in the years following the institution of the Panel system, was the gradual building up of "firms" consisting of three or more doctors, often working from a common surgery, one or more of whom, in the smaller towns, would be on the staff of the local hospital. The relative infrequency of change of doctor, and the few complaints brought before the Medical Service Sub-committee of the Insurance Committees, are evidence that patients were satisfied with the service rendered. After the service had been working for a few years, it became obvious that the next thing necessary was to extend the general medical service to dependants, and at the same time to provide dental treatment, pathological facilities, X-rays, and physiotherapy. (Up to 1948, grants in aid for these ancillary services had only been available through Friendly Societies to a very limited extent.)

Then came the N.H.S. Act of 1948, which places at the disposal of every individual, whatever his financial position, General Practitioner and Specialist Services together with Hospital accommodation, convalescent treatment, medicines and appliances, but without be it noted, any guarantee that all or any of these services are available on immediate demand. A large majority in the profession was convinced that the Government, in attempting to make all these services available to the whole population at one fell swoop, was making a very great mistake, and that confusion and dissatisfaction would inevitably result. I am bound to say that experience has proved, after two years working of the Act, that such is the case. Discontented public, doctors, dentists, ophthalmic practitioners, and pharmacists all militate against the smooth and efficient working of the Act.

We are only here concerned with the effect of the Act on the general practitioner. To do this I think practitioners must be divided into three classes. Those who in the past have made their living entirely by private practice, and still have enough private patients to enable them to make a living from those remaining outside the services, amounting approximately to 5 per cent of the population. These practitioners form a limited and diminishing class, and will in time become almost extinct.

The next class is that of the G.P. in residential areas, who up to 1948 made his living mainly from private practice with perhaps a few panel patients. These practitioners when, as very frequently happens, a large percentage of their private patients become N.H. Service patients suffer a severe drop in income and find it difficult, and in some cases even impossible to meet their obligations. It is perhaps this group of practitioners in the past, which has been able to render the best service to both private and panel patients, as private fees subsidised, as it were, the income from the panel, and it was not necessary for the doctor to take on more patients than he had time to give all necessary care and attention. The only hope I can see for doctors in this group, is that a substantial capital sum should be granted, to enable a number of them to set up in under-doctored areas, where they would have the opportunity of again building up their practices. Rural practitioners to some extent come into this class, but on the whole they have not suffered too badly.

Mileage payments have been considerably increased, and the wives and dependants of many of the agricultural workers have come on the panel, whereas previously the small fees they were able to pay contributed little to the doctor's income.

There remains the third class, those practitioners in industrial areas who already had a large panel list which has now become swollen by dependants of the workers. Many of these practitioners are better off than they ever expected to be, but there is no doubt that they earn every penny of their remuneration by the greatly increased demands their patients make on them.

We have been considering the effects of the N.H.S. as it affects the G.P. in reference to his ordinary work, but there are other side effects to review. In the first place, many practitioners were on the staff of the local hospital, both to their own advantage and to the advantage of general practice in the area. Nevertheless the policy of most of the Regional Boards is to abolish the G.P. part-time specialist, and to replace him by pukka specialists.

One hears complaints in many quarters that the status of all G.P.s has been lowered by the National Health Service and that patients now fail to give the physician the honour due to him. I wonder if this really is the case, and whether the status of the individual does not in fact depend on his personality. The individual status of the majority will determine what may be called the status of the profession, and if the status of individuals is declining, it behoves each one of us really to take stock and do a little self-examination. That there are many temptations not to give of one's best must be recognized. The large number of patients who have to be dealt with, the number of trivial cases, the number of forms to be filled, the numberless telephone messages all

occupy valuable time which might otherwise be better spent in carrying out a more detailed examination of patients. There is no doubt that the present set-up is not satisfactory, and that although we have a service which can be made the best in the world, those in authority must realise that changes must be made to make it so. In the first place, the income must be sufficient to enable the doctor to maintain a standard of life equal to members of other professional classes. Secondly the conditions of work must be such that he can fully employ his ability and skill to the best advantage of the community, with sufficient leisure to enable him to get a reasonable amount of enjoyment out of life, and to take his share in the public life of the community if he so desires.

All this means under present day conditions, that the maximum number of service patients on a doctor's list must be reduced, and the capitation fee increased. The suggested weighting of the first thousand on the list would help to achieve this result.

The next most serious need is the opportunity for the G.P. to follow his cases into hospital. In these days domestic difficulties make it imperative that many of the cases which the G.P. has been in the habit of treating at home, should be admitted to hospital. In every town in which a hospital exists there should be beds provided for the purpose. Before the new service came into operation, considerable progress was being made in this direction, and the principle was generally accepted by the more enlightened and progressive County Councils. It is a struggle which must never be given up until satisfaction is obtained. Recently, unfortunately, some Regional Hospital Boards have not admitted the need for G.P. beds as a No. 1 priority, and in some instances have actually taken away those already allotted to this purpose.

There are some other factors to be borne in mind when considering the status of the G.P. and his position as a family doctor. The growth of the clinics of various kinds has been brought about by the failure of the G.P. to realise his responsibility to his patients in the field of preventive medicine. Immunisation clinics, Child Welfare clinics, Antenatal and Post-natal clinics should not really be necessary if every doctor realised that the work they do is his own responsibility. It perhaps can be admitted that every doctor is not equally good with say, children or old people, but, where there are firms one man could concentrate on children, another on old people, and so on. Referring cases to someone in close relationship with the doctor in attendance working in the same building, is quite different from sending the patient off to a clinic, and does not weaken the link which binds the patient to him.

The question whether G.P.s should hold Clinical Assistantships in the Special Departments of a general hospital is often debated. It is surely an advantage that there should be one member of a firm who has some specialised knowledge, say of skins, to whom his colleagues could look for help, without the necessity of referring cases to the O.P. Dept. of a hospital. The same could apply with regard to E.N.T. work, obstetrics, etc. The Clinical Assistant could act as a filter, and could send on to the specialist only those cases which he considered needed specialist attention.

Another factor likely to loosen the doctor-patient relationship is the attempt being made nowadays to shut out the G.P. from midwifery. Almost definite instructions have been issued that the G.P. should only attend at a confinement when sent for by the midwife. If a proper doctor-patient relationship is to exist, this is the time when the patient most looks to the doctor for help, and unless help is given, a most unnecessary psychological upset results. There should be no reason why both the doctor and the midwife should not work in complete harmony in attending on the same case to the great advantage of the patient.

One effect of the new N.H.S. on practice is that it abolishes the right to buy and sell practices, with the consequential disadvantages that whereas in the old days a house nearly always went with the practice, now this will seldom be the case, and the newcomer may have the greatest difficulty in securing suitable accommodation. Up to the present, doctors have practised from surgeries in their own houses, or, if in a group practice, from a common surgery, but the Act proposes that health centres shall be made available, with accommodation for perhaps six or eight doctors. Continuous discussion as to what form these should take, is still going on. Personally, I cannot envisage them being a success, unless all the doctors working in them are bound together by a financial interest. Unless this is the case, no doctor working in a health centre can afford to admit that he is less competent to deal with any type of case, than colleagues with whom he is in competition. The ideal would be for a firm of four or five doctors to have their own health centre with proper waiting rooms, consulting rooms, minor surgery and examination rooms, and with a nurse and adequate clerical assistance.

In conclusion I would say that when some obvious faults in the Health Service have been remedied and deficiencies made good, as I am sure they will be, I see no reason why the service should not provide an attractive career for anyone who is actuated by the desire to lead an interesting and useful life in the service of his fellows and who regards the acquisition of wealth as a secondary consideration.

THE SKIN DEPARTMENT

SOME NOTES ON THE EARLY DAYS *

By A. C. ROXBURGH

I AM indebted to Dr. H. G. Adamson for much of what follows.

From 1867, when it was started, until 1909 when Dr. Adamson was appointed, the Skin Department at St. Bartholomew's Hospital was under the charge of the junior Assistant Surgeon or junior Assistant Physician for the time being, hence the frequent changes I shall refer to. The Department was started in 1867 under Dr. Southey (the inventor of Southey's tubes) and Dr. Andrew. After one year they turned it over, in 1868, to Dr. Gee who had just come to Bart.'s from University College Hospital where there had been a skin department since 1850. The only contribution to dermatological literature made by Dr. Gee that I know of was as follows (referring to chicken-pox): "As much as possible children should be prevented from picking the vesicles and scabs present on the face." Dr. Gee lived until 1911 and there is a story that when the late King Edward VII offered him a knighthood he said, "Thank you, Sir, but I'd rather have a fur coat." He got his fur coat. Dr. Gee handed over to Dr. Dyce Duckworth in 1870 and he in turn to Mr. Morrant Baker, then an Assistant Surgeon, in 1875. Presumably Mr. Baker had been working in the department for some years because the St. Bartholomew's Hospital Reports for 1873 contain his, the first, description of Erythema Serpens, now called Erysipeloid of Rosenbach, as well as Notes by Dyce Duckworth on "Some Cases seen in the Skin Department." Dyce Duckworth's various papers on Skin Diseases dealt with the following subjects, among others: molluscum contagiosum, iodide rashes, scleroderma, purpura haemorrhagica, alopecia areata, rheumatic nodules, perforating ulcer, pemphigus, psoriasis, taches bleuatres, actinomycosis, erythema multiforme, tinea favosa, pemphigus vegetans, diabetic xanthoma and diseases of the nails. Even in 1882 Dyce Duckworth and Morrant Baker kept up their interest in Skins for they were both original members of the Dermatological Society of London, founded in that year. For a time, about 1879, Dr. Wickham Legg was in charge of the department, and in the 1880's Harrison Cripps the rectal surgeon. He was an excellent teacher and though he did not know anything beyond the clinical side of common skin diseases what he taught was of great practical value. For this reason his classes were crowded; possibly also because the students enjoyed his witty remarks, e.g., to the student who enquired whether a captured louse was male or female. "You had better take it behind the screen and see, Mr. H."

Dr. Samuel West reigned during the 1890's. Dr. Ormerod was in charge from 1899 to 1909 when Dr. Adamson was appointed as the first Physician for Diseases of the Skin, having served as Chief Assistant for a year previously. Dr. Ormerod was still on the active Staff as Physician to the Hospital when I went there as a student in 1910. The late Dr. Stowers, who founded the London School of Dermatology at St. John's about 1920, told me this story of the time when he was working as Clinical Assistant

* The substance of some remarks made at a meeting of the Osler Club on January 27, 1950.

to one of the men I have mentioned (he would not tell me which). The Physician was demonstrating a case to the class as one of eczema when a tactless student piped up: "Please sir, Dr. Stowers says it's a case of scabies and showed us the acarus." The Physician sent for Stowers and asked if this were true. Stowers said it was. At the end of the morning the Physician told Stowers he must send in his resignation as a Clinical Assistant as "in his own department he liked to treat his own cases in his own way!"

Under Dr. Adamson whose fame was world-wide the department became well known and the number of patients increased greatly.

TO THE FOUNTAIN CLUB *

(Readers are reminded that the opinions expressed by contributors are not *necessarily* those of the *Journal*.—Editor.)

Alas! Alas! Good master Clerk
Another dinner I must burke;
In fact I fear Good Clerk and Bursar
My absences grow worse and worser!
This wretched nomad job of mine
Finds me at Newcastle-on-Tyne
Too far away to be released
To join you at your menstrual feast—
In circumstances even sadder
Your nomad bard could be no madder!
As once before I hymned my woes
From Manchester, so now here goes—
I take a leaf from out the book
Of Grantchester and Rupert Brooke:—
God! I will pack and take a train
And get me to London once again;
There in the precincts of Soho
Foregather with the men I know,
And practice the convivial arts
With men of Bart.'s, and men of parts
Where meets in Kettner's cosy pub
The Fountain Club, The Fountain Club!
The Fountain's the one club I know
Where men with splendid hearts may go,
And of hospitals I choose
The stately St. Bartholomew's,
The imperial city's chief renown
The pride and glory of the Town.
For *Mary's* men are dull and dumb
When extricated from the scrum
And rarely use their wits at all
Except to catch an oval ball:
They live disputing goals and tries
With certain of the tougher *Guys*,
A wild, uncouth, and savage tribe
Intrepid travellers describe
Inhabiting the southern side
Of London River's muddy tide
They swarm among the fogs and damp
That nurtured Mrs. Sarah Gamp!
But where is *Kings* that used to stand
The guardian angel of the Strand?
In some remote suburban hell
Among the slums of Camberwell
They take the local natives in,
And ply the art of medicine
In their obscure untutored way—
Well may some Dulwich Hamlet say
That there is something rotten still
About the state of Denmark Hill!
In Gower Street I've heard men say
The *U.C.H.* still holds its sway;
Its students swot by night and day
O'ershadowed by the B.M.A.
And some are black, and some are white,
And all of them hermaphrodite!
Of such no longer let us talk,
But come and do a Lambeth Walk
Where Westminster's broad roadway stems
The turbid waters of the Thames:
See *Thomas's* degenerate men
Crouched 'neath the shadow of Big Ben,
And even more abjectly cowerin'
Beneath the shadow of Aneurin.
Unable to escape the eye
Of their dictator, towering Nye,
Such sights and scenes are far from pretty—
Let us return into the City,
And reverently assembled there
Within the purlieus of a Square
And Fountain (not as yet floodlit),
Upon the margin let us sit;
And as the limpid waters rise
Cleanse foul contagion from our eyes!
On once again to mad Soho!
Let Kettner's vintage freely flow:
Assembled round the festive board
Wine-tasters now display your hoard!
Come gentle snifter to thy work!
And thou O most unworthy Clerk
Of aspect grim and saturnine
Read out the minutes line by line!
Announce regrets of absentees,
And pausing while reciting these,
Say how the occasion must be marred
By the default of me, your Bard.
Here certain members murmuring say:
"What is it keeps this man away?
To what must we ascribe our loss,
'An Apple a Day' by Phillip Gosse?"
The Master quells the rash offender—
The Clerk proceeds with the agenda . . .

* These verses were written as an apology for absence from a Dinner of the Fountain Club. Their author is "R.B.P." whose welcome contributions have appeared in the Journal for over forty years.

BART'S IN HOSPITAL RUGBY FOOTBALL

By R. G. D. NEWILL

THE actual date when Bart.'s Rugby Football Club was founded is not recorded, but it was probably about 1860 when some of the hospital students, abnormally energetic for young men of that time, first took the field. They played their matches on a ground in Battersea.

Goals were all important in the early years of the game, unconverted tries being valueless unless the opposing team also had scored no goals. It is recorded that, in 1875, Bart.'s beat the Royal Military College, Sandhurst by one goal to four tries! Until about 1890 the hospital wore black jersies.

The Hospitals' rugby cup was instituted in the year 1875, the first winners being Guy's who beat St. George's in the final. Guy's have always been the most prominent of the hospitals in club rugger, their standard having been consistently high for the past 90 years. Consequently they have tended to monopolise the Hospitals' cup and their name is engraved on it 27 times. Other winners have been St. Thomas's 12 times, St. Mary's 9, London Hospital 6, St. George's 3, and the Middlesex once only, in 1887. St. Bartholomew's have won only five times although we have been in the final on 17 occasions, and our team was generally well to the fore in the period between the wars.

Four years after the cup matches were initiated Bart.'s reached the final for the first time only to be defeated by our traditional "enemies" Guys. In 1881, however, the cup was brought to Smithfield for the first time when we beat the London Hospital on a ground at Putney. The cup passed to St. George's the following year when Bart.'s again reached the final, but in 1883 we relieved this hospital of its responsibility when we beat them 35-1; the single point was awarded for a touchdown in accordance with the system of scoring at that time.

After 1883 rugger at Bart.'s deteriorated, and in 1895 a correspondent to the *Journal* lamented that the captain could hardly be expected to put an effective team into the field when the hospital could only muster one fifteen, and that in cup matches many of the players were taking part in the first rugby game of their lives.

It was 41 years before we won the cup again. Eight generations of Bart.'s students came and went without being able to carry it back through the Henry VIII gate. But in 1924 it was only a replica of the original cup which was triumphantly brought across the river from Southwark; the original had been won outright by St. Thomas's as a result of ten consecutive wins from 1888 to 1897, and is still in their possession.

In 1924 Bart.'s met King's College Hospital in the final and beat them 14-6; the real "final" however had been the semi-final match against Guy's, whom we beat 6-0 after a hard-fought game. This was our real triumph: our old opponents had at last been humbled, and one of the Bart.'s three-quarters, L. C. Neville, was chaired off the field for being the first Bart.'s man for countless years to score a try against Guy's. The Guy's team in this match contained seven South Africans, and like many of this hospital's fifteens since, it read like a Boer commando. 1924 was a doubly victorious year as we also won for the first time the Inter-Hospitals' Junior Cup, instituted in 1901.

The hospital maintained a good standard of football until 1939, although the sudden rise of St. Mary's as a power in the rugby world in the '30's tended to eclipse us in cup matches. We won the cup twice more, in 1928 when we beat the London, and in 1931 when we beat St. Mary's having previously eliminated Guy's and King's.

Nineteen hundred and twenty-four was, however, the "golden year" of Bart.'s

rugger. In that year our team contained two internationals, three "blues," three 'varsity trialists, and an extremely energetic captain in G. W. C. Parker. Our fixture list included all the leading London clubs, and such well-known clubs as Richmond, Harlequins, and London Irish left the field vanquished by the black and whites. Annual matches were also played against Oxford and Cambridge, which perhaps helped to persuade players at these universities that Bart.'s was a good hospital to come to.

Prior to 1937 the hospital ground had been at Winchmore Hill in North London, and it is interesting to note that the railway fare from Farringdon Street was only 1s. return. In December of this year we took over our new ground at Foxbury.

The post-war passion for poring over text-books has resulted in a decline, only temporary we hope, in the hospital's rugby fortunes. However I believe that a doctor's principal training comes after his qualification, and that no small part of the life of a student who comes to Bart.'s straight from school should be devoted to character-building occupations, of which some active sport for the hospital is a "sine qua non." Despite the female influx we still have sufficient male students to prove that the captain of the United Hospitals Rugby Club was being unduly pessimistic when he said recently that the days when a hospital could put into the field a team of the highest standard were over.

CORRESPONDENCE

CAMPBELL DE MORGAN SPOTS

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

Dear Sir,

I was interested in Mr. Rosser's article on Campbell de Morgan and his Spots as the last part of the title has intrigued me for a long time. My attention was first brought to the subject in 1925, when an old gentleman of 85 asked me to see him because of a "lump in the stomach covered with a red spot."

On examination the patient proved to have an obviously malignant mass in his upper abdomen with a large Campbell de Morgan spot on the skin covering it. He was an educated man and was most insistent that the spot appeared at the same time as the underlying tumour.

Since that date I have watched for Campbell de Morgan spots in patients on the operating table, particularly those suffering from diseases of the breast. In 26 years there have only been four patients proved to have had malignant disease of the breast without these spots, and on one of these patients I did not examine the back. At a conservative estimate I have seen at least 2,000 breast cases during this time and I have been so certain of this phenomenon that on three occasions I have, against the surgeon's opinion, hazarded the view that the tumour was not malignant, solely on the absence of spots. On each occasion this view was correct although two of the three patients underwent radical mastectomy.

Another point worth noting is that in malignant disease of the breast most of the patients have more spots on the affected side than on the unaffected one, and frequently there is a spot directly over the swelling. Several investigations have been made into this question but most of these have been concerned with the proportion of patients exhibiting Campbell de Morgan spots who have malignant disease and those that have not. This type of investigation gets nowhere. From my own observation I would suggest the following propositions :—

1. The incidence of Campbell de Morgan spots increases with the age of patients, and of all patients over 50 years of age, slightly over 50% show these spots.
2. Of patients exhibiting Campbell de Morgan spots, the vast majority have not got malignant disease.
3. Of all patients having malignant disease, especially of the breast, the majority have Campbell de Morgan spots.

Although I have not the temerity to make the suggestion to my surgical colleagues, I would respectfully submit that in a breast tumour of doubtful nature (and there are still many such) it might be worth while noting the *absence* of Campbell de Morgan spots, although their presence is of no diagnostic value.

Yours faithfully,

C. LANGTON HEWER.

St. Bartholomew's Hospital.
April 24, 1951.

THE DAY OF THE LEECH

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

Dear Sir,

In case no one else has answered Professor Kennaway's letter, it may interest him to learn that leeches were still being used within the last quarter century.

When I was still in practice at Eton one of our Windsor colleagues was laid low by a very acute streptococcal pharyngeal infection. Apart from almost complete aphonia he was suffering from very distressing dyspnoea. Several of us were called in to suggest treatment, and when my turn came I hurried back to Windsor hospital and was able to find half a dozen leeches which I applied to the front of the neck. The result was almost spectacular, and breathing became comparatively easy. Later, Lord Dawson of Penn was called into consultation, and his first question was to enquire who had applied the leeches. He gave me a pat on the back and said that he would have done likewise. Unfortunately our patient developed a streptococcal endocarditis which of course left him in a state of chronic invalidism.

Our native leech belongs to a species which is distinct from that which was used in medicine. Not only is it smaller but it has not the jaw power to deal with anything so tough as the human skin. Its prey consists of fish and frogs, but it can pierce the lips or tongues of horses and cattle which come to its ponds to drink.

Yours etc.,

MAURICE AMSLER.

Hawkhurst.
April 10, 1951.

LETTER FROM A SHIP'S SURGEON

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

Dear Sir,

It is not unusual nor novel for a Bart.'s man to take a job as a ship's surgeon, but I feel an urge to record what a pleasant experience it has been, in order that others who, like myself, are compelled by age to live in enforced idleness, may try the experiment.

It was rather bold to try to become a physician after 35 years as a gynaecologist, but fortunately the work was light and most of it could have been carried out by a person in possession of a first aid certificate.

It was the dermatological patients who gave me a headache. Possibly this was due to my ignorance of long names, although my education in this respect was improved when I sent a man ashore for an opinion, and received the reply that it was a case of "erythemato-squamous dermatitis." I in my ignorance had diagnosed it as a "rash." However I passed the test for a dermatologist mentioned by Dr. Adamson in your February number; I never lost a patient, but sometimes wished I could; I never cured one, but some got well of their own accord: I was never called out at night.

When we arrived at Capetown my surprise and pleasure can well be imagined on finding two old Bart.'s men, Drs. Lee and Saltman distinguishable by their hospital ties, waiting on the quay to take us to a champagne lunch. Apparently rumour had reached them from Underwood in Johannesburg that I was on the ship.

In East London I met Dr. Waddell, a Fellow of the R.C.O.G., who having lived among the country natives all his life, talked their language fluently, and had a profound knowledge of their customs and psychology. He was most interesting, and I hope that he will write a book on the subject. In Durban there are many Bart.'s men, and Brian Murless gave a cocktail party at which I met the two Mundys and MacFayden. Most of the doctors I met seemed to possess a charming wife, a delightful cool house, a beautiful garden, and above all a magnificent new high powered car. On the return journey Murless and Standing, Member and Fellow respectively of the R.C.O.G., invited me to give a lecture on "Education of the Public concerning cancer and early diagnosis," to a mixed audience of medical men, members of the Red Cross, and lay people. About 200 people attended and at the end of the meeting decided to form a Durban Cancer Education Committee.

In South Africa if one reads a newspaper, it is at once realised that there is a political upheaval taking place, and that there are several controversial bills before Parliament. It would be quite absurd to express an opinion on the many problems after only visiting a few ports for a few days, but I talked to many people and realised the difficulties. The colour question is really a three colour problem Natives, Coloured people, and Indians. Perhaps a fourth colour—White—should be added, because it is quite obvious that Nationalist Africaners do not see eye to eye with British South Africans and the former are anxious to squeeze the latter out of all official positions. I also gathered from conversations that there is a great difference in the way the two treat the natives. Seeing a native has for many Africaners the effect that a red rag has on a bull. This was demonstrated to me when a dock labourer with a swollen septic leg was limping along the dock. The official quite properly searched the man, but as roughly as possible, cursing him the whole time. As the native had never spoken a word it seemed a bit unnecessary. Under these circumstances it is not surprising that it is unsafe to walk about after dark even in cities like Durban. Most people seem to think that immigration of several million Europeans is essential to solve some of these problems, but if it is to be successful it would appear to be necessary for the nationalists to change their method of greeting such newcomers, and not to treat them as second class citizens.

Everybody who visits South Africa must be impressed by the flowers and flowering trees, and I shall long remember the blue, red, yellow and white waterlillies, also the dark blue convolvulus twining its way amidst a scarlet flowering shrub.

The fact that the shipping company raised no objection to my wife taking a cabin as an ordinary passenger made all the difference to our enjoyment. I strongly advise all those who have joined the Idle Poor to follow my example.

Yours truly,

MALCOLM DONALDSON.

APPOINTMENTS

The undermentioned appointments to the Junior Medical Staff have been made with effect from the dates indicated :—

Mr. Corbett's firm . . . Registrar: Mr. A. G. Dingley (from 1.5.51)
Children's Department . . . Junior Registrar :Dr. D. S. M. Brierley (from 1.6.51)
Gynaecological and Obstetrical Department . . . Junior Registrar : Mr. J. D. Andrew (from 1.5.51)
Surgical Unit . . . Senior Registrar : Mr. G. M. Lunn (for 6 months from 1.4.51)

PARLIAMENT AND THE PROFESSION

1511-1946

By W. M. LEVITT

STAT. (1511) 3 HEN. 8, C.11

An Act concerning Phesicions and Surgeons

FORASMOCHE as the science and connyng of physyke and surgie to the pfecte knowlege wherof bee requisite bothe grete lernyng and ripe expience ys daily this royalme exe'cised* by a grete multitude of ignoraunt psones . . . soofarfurth that comon artific's as smythes wevers and women boldely and customably take upon them grete curis and thyngys of grete difficultie in the which they partely use sorcery and which crafte partely applie such medycyne into the disease as be very noyous and nothyng metely therfore to the high displeasoure of God great infamye to the faculties and the grevous hurte damage and distruccion of many of the Kyngs liege people most sp'ally of them that cannot descerne the uncunying from the cunyng; be it therfore . . . enacted that

Noo p'son within the citie of London nor within vij myles of the same take upon hym to exe'cise and occupie as phisicion or surgion except he be first examined approved and admitted by the bisshop of London or by the dean of Poules, for the tyme beyng callyng to hym or them iiij doctours of phisyk and for surgie other expt psones in that facultie and for the first examynacion such as they shall thynk convenient; and aft'ward alway iiij of them that have been soo approved upon the payn of forfeytour for ev'y moneth that they doo occupie as phisicions or surgeons not admitted nor examined after the tenour of thys Acte of v i to be employed the oon half therof to thuse of our sov'aign lord the Kyng and the other half therof to any pson that wyll sue for it by accion of dette in which no wageour of lase nor p'teccion shalbe allowed.

And of thys that noo pson out of the scid citie and p'cincte of vij myles of the same except he have been as is seid before approved in the same take upon hym to exe'cise and occupie as a phisicion or surgeon in any diocese within thys royalme but if he be first examined and approved by the bisshop of the same diocese or he beyng out of the dioccese by his vicar gen'all either of them callyng to them such expert psons in the scid faculties as there discrecion shall thynk convenyent and gyffing ther lett's testimonials under ther sealle to hym that they shall soo approve upon like payn to them that occupie cont'rie to thys Acte as is above seid to be levyed and employd after the fourme before exp'ssed.

It would appear that the qualified physicians and surgeons did not prove to be entirely worthy of the confidence which had been reposed in them by this Statute, and some thirty years later their privileges were largely nullified by further legislation. There is probably no other instance of such a damning indictment of a whole profession in an Act of Parliament.

STAT. (1542-3) 34 & 35 HEN. 8, C. 8.

(Physicians and Surgeons.)

An Acte that persones being no coen Surgeons maie mynistre medicines owtwarde.

Where in the Parliament holden at Westm in the thirde yere of the Kings moste gracious reigne, amongst other thinges for the advoyding of sorceryes witchcrafte and other inconveniences, it was enacted, that no psone within the citie of London, nor within seven myles of the same should take upon him to exercyse and occupie a phisician or surgeon, except he be first examyned approved and admytted by the bisshop of London and other, undre and upon certaine peynes and penalties in the same Acte mencioned; sithens the making of whiche saide Acte the

* The old spelling has been retained wherever possible. Where the original contained symbols not available in the modern type fount, they have been replaced by an apostrophe. These symbols usually marked the use of an abbreviated spelling. —Editor.

companie and felowship of surgeons of London, mynding oonelie theyre owne lucres, and nothing the profite or ease of the diseased or patient, have sued, troubled and vexed divers psones aswell men as women, whome God hathe endued with the knowledge of the nature kinde and operacion of certeyne herbes rotes and waters, and the using and mynistering of them to such as been pained with customable diseases, as womens brestes being sore, a pyn and the web in the eye, uncoomes of hands scaldings burnings sore mouthes and the stone strangurye saucelin and morfew, and suche other lyke diseases, and yet the saide psones have not taken any thing for theyre peynes and cooninng, but have mynistred the same to the poore people oonelie for neighbourhode and Goddes sake and of pitie and charytie; and it is nowe well knowen that the surgeons admytted wooll doo no cure to any psone, but where they shall knowe to be rewarded with a greater soome or rewarde than the cure extendeth unto, for in cace they wolde mynistre theyre coonning to sore people unrewarded, there shoulde not so manye rotte and perishe to deathe for lacke othelpe of surgerye as dailie doo, but the greatest parte of surgeons admytted been muche more to be blamed than those psones that they trouble, for althoughe the most parte of the psones of the saide crafte of surgeons have small cooning, yet they wooll take greate soomes of money and do little therfore, and by reasone therof they doo often tymes impaire and hurt theyre patients rather thenne doo them good: IN CONSIDERACON wherof and for the case comforte socour helpe relief and healthe of the Kings poore subjects inhabytaunts of this his realme, nowe peyned or diseased, or that hereafter shallbe peyned or diseased, be it ordeyned establisshd and enacted by thauctorytie of this pnt Parliament, that

At all tymes from hensforthe, it shalbe lefull to every pesone being the Kings subject having knowledge and experience of the nature of herbes rotes and waters or of the operac'on of the same by speculac'on or practyse, within any parte of the realme of Englande, or within any other the Kings domynions, to practyse use and mynistre in and to any outwarde sore uncoom wounde appostemacons outwarde swelling or disease, any herbe or herbes oyntements bathes pultes and emplasters, according to theyre cooning experience and knowlege in any of the diseases sores and maladies aforesaide and all other lyke to the same, or drinkes for the stone strangurye or agues, without sute vexacon trouble penaltie or losse of theyre good. The foresaide statute in the foresaide thirde yere of the Kings most gracious reigne, or any other Acte ordinance or statute to the contrarye hertofor made in any wise notwithstanding.

This Statute remains on the Statute Book and is still law. Accordingly, any person "having knowledge and experience of the nature of herbs, roots and waters, or of the operation of the same, either by speculation or practice, may treat outward sores, stone, strangury or ague, and similar conditions, and there is no prohibition against the charging of fees therefor. It may further be remarked that the common law has long established that unqualified practitioners may treat any disease provided that they have the requisite skill and care. However, by the Medical Act of 1858 (S.32), none but a medical practitioner may sue for fees.

(*To be concluded*)

SO TO SPEAK . . .

"Do not imagine, boys, that an ulcer on a Bishop's leg cannot be syphilitic because it is covered by an episcopal gaiter."

—*Mr. Harrison Cripps in* 1895.
(Related by Dr. Josiah Oldfield.)

Noises off:

Lecturer: "The remarks I have made up to this point will have been generally acceptable. But not everyone may agree with what I am going to say now . . ."

Voice of a passing cleaner: "You're dead right there."

—*A Psychiatry lecture.*

CLINICAL CASE-BOOK

Mr. A., aged 61, printer's reader, complaining of weakness of the L. wrist.

History of present condition

Twenty years ago—transient weakness of L. wrist.

Three years ago—swelling appeared on dorsum of L. wrist and extended to the knuckles within 6 months. The swelling subsided slowly. No pain, no disability.

He then noticed weakness of L. wrist and middle and ring fingers. Gripping power impaired.

One month later—index finger of L. hand affected and weakness progressed. During cold weather all fingers, except thumb, and palm felt numb. No pain. No paraesthesia.

Past history

1939—Attack of 'flu left patient deaf in both ears, especially in left.

Social history

Until 1929 had worked for a number of years as a compositor setting lead type. Mild smoker. No alcohol.

On examination

Eyes. Movements, visual fields and fundi all normal; pupils central and irregular, react normally to light and accommodation.

Ears. Bilaterally deaf.

Cranial nerves otherwise normal.

Arms: *Right*—Brisk reflexes; otherwise N.A.D. *Left*—1. Wasting of forearm extensors and thenar eminence. 2. Power normal in muscles acting on shoulder and elbow joints. Flexion of forearm and hand normal. Marked weakness of Exts. carpi radialis longus and digitorum. Some weakness of Exts. indicis, digiti minimi, pollicis longus. 3. Sensation on back of hand, from wrist to base of middle 3 fingers, impaired to pin prick. Sensation otherwise normal. 4. Reflexes brisk.

Legs. N.A.D.

Differential diagnosis

1. Lead palsy. *For*: Patient associated with lead for many years; long extensors of forearm affected with escape of brachioradialis and ext. pollicis brevis; muscle wasting; numbness; absence of pain and paraesthesia. *Against*: Loss of sensation to pin prick; no history of abdominal upset; no blue line on gums; no ocular disturbance; no tremor or muscle cramps; no mental changes.

2. Progressive muscular atrophy. *For*: Age at onset; wasting; increased jerks, no muscle tenderness. *Against*: Loss of sensation; no wasting elsewhere; no fibrillation; absence of associated neurological signs, e.g., in R. arm; paralysis the dominant feature in this case, not wasting as in P.M.A.

3. Peripheral Neuritis. *For*: Loss of sensation associated with loss of power; peripheral character of the lesion; wasting present. *Against*: Not bilateral and legs not affected; jerks not reduced; no spontaneous pain; no vasomotor or trophic changes; only pain sensibility impaired.

4. Syphilis. In any unusual neurological case this must be considered. *For*: Irregular pupils; bilateral deafness. *Against*: No evidence of change in the post. columns of cord; no other evidence of syphilis.

Special investigations

1. Urinary lead content was found to be less than normal.

2. No punctate basophilia.

3. C.S.F. Initial pressure 100 mm water, moved freely on coughing; on jugular compression rose slowly to 100 mm and no higher even with strong pressure. *Contents*: 15 lymphocytes/cc; Protein globulin fraction raised. W.R. and Kahn test both positive. Paretic colloidal gold curve.

4. Positive blood W.R.

Probable diagnosis

Chronic syphilitic meningitis; probably a localised gummatous formation in region of root C. 7.

Treatment

1. *Penicillin.* Distaquaine I.M., starting with 10,000 units B.D., increasing to 300,000 units B.D. on twelfth day until 8 megaunits had been given.

2. A course of *potassium iodide* was started, but was abandoned on the third day because of toxic signs:—watering at eyes and nose, abdominal colic.

3. *Physiotherapy* and a splint for the affected hand. A re-examination and clinical assessment should be carried out in 3 months.

Points of special interest

1. The wrist-drop with escape of brachioradialis, together with the fact that the patient had been in contact with lead at once suggested lead palsy. This was, however, not entirely born out by the clinical findings, and was later ruled out by the special investigations.

2. The most probable cause of the wrist-drop is syphilis. French workers have reported a number of similar cases of wrist-drop closely resembling lead palsy. In these cases the brachioradialis escaped paralysis, but no evidence was found of lead poisoning. In each case there was, however, evidence of syphilis, and it was concluded in every case that a spirochaetal lesion was responsible.

3. If the spirochaete is responsible for the lesion it is curious that this, the deafness and the slight pupillary changes are the only neurological evidence of syphilis.

We wish to thank Dr. Aldren Turner for permission to publish this case and for his helpful criticism.

L. F. & J. G. R.

EXAMINATION RESULTS

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March, 1951

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Bee, D. L.	Dowie, L. N.	Kneebone, J. M.	Stevens, J. H.
Blofeld, A.	Ellison, C.	Landau, N.	Tamlyn, G. W.
Bowman, J. L.	Fielding, M. E.	Malpas, J. S.	Thould, A. K.
Bromwich, L. R.	Fletcher, L. O. A.	Meredith, H. D.	Voysey, M. M.
Cassou, A. J.	Forget, Y. N. P.	Morgan, D. T. G.	Weir, D. A. D.
Catchpole, H. M.	Foulds, H. P. S.	Murrell, J. S.	Wickham, J. E. A.
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Cook, W. A.	Gampell, B. I.	Perkins, M. V.	Winton, F. W.
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The following students have completed the examination for the diplomas M.R.C.S., L.R.C.P.:—

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Carroll, D. S.	Holbrook, B. W.	Sims, A. J.	Williams, D. K.
Connell, P. H.	John, A. H.	Smith, D. P. Q.	

SPORT

RUGBY CLUB

Inter-firm 7-a-side Competition.

This year's competition was held at Chislehurst on April 7. Eleven teams entered and the eventual winners were the favourites, the 2nd Year Pre-Clinical (1). They became champions by eventually beating 3rd Year Pre-Clinical by 3-0 after some hours of extra time. The quavering voice which struck up "roamin' in the gloamin'" definitely had the right idea of things.

Conditions for Rugby were atrocious and we had a rare mixture of snow, rain, hail and sunshine, which resulted in the two pitches getting into a dreadful mess by the end of the day.

The tit-bit of the afternoon was a fifteen-a-side match between the Houseman and the Chief Assistants. At 4.21 precisely the Houseman entered the arena—forty-five minutes later the Chief Assistants emerged from the pavilion looking a little bit weary, but nevertheless confident! After a lot of haggling between the two captains the game got under way, refereed by Mr. Capps—who was nearly trampled under foot during the first charge by the Chief Assistants' Light Cavalry. As the game went on, it became quite obvious that the players were playing to the crowd, for the game never swung beyond the ends of the stand, to left or to right. The first player to strike the eye was Mr. Borrie playing upon the left wing for the Chief Ass's—he was neatly attired in a khaki shirt and a pair of sky-blue shorts. Later this same gentleman made a soul-stirring dash from his own wing to the opposite side of the field—why, we shall never know, as play happened to be on the left wing at that moment. Mr. John Stevens was doing stirling work at the base of the scrum, whilst in the scrum Dr. MacPherson carried all before him and Mr. Hadfield hooked the ball regularly and also a box of matches from the opposite hooker's pocket.

For the Houseman Mr. Green on the right wing sidestepped continually, even if he didn't have the ball and created chaos in the opposing ranks. Mr. Baker at full back was outstanding and played one of his best games, even scoring a try. This try was in reply to a really first class penalty goal kicked by Dr. MacPherson for the Chief Assistants.

As I left I heard our Captain say, "How I wish we had a crowd like this down here each Saturday." I can only reply that if the Housemen and the Chief Assistants played against each other every Saturday the crowds would roll along.

Our thanks for a very pleasant day must go to Mr. Havard and Mr. Davies who organised the event and also to that "backroom boy" Mr. Laurie White who, as usual, coped so courageously with the catering and the etcetera. Let us now hope that next year's tournament will be as popular and as successful as was this year's.

v. MOSELEY at Birmingham, March 31.

Result: Lost 3—9.

The last match of the season was played against Moseley at Birmingham, and resulted in a win for Moseley by three tries (9 points) to a try (3 points). Although the ground was heavy, the surface was dry and the ball easy to handle. Moseley opened the scoring ten minutes before the end of the first half the kick failing. In the second half, Moseley were awarded numerous penalties in front of the posts, but luckily they missed them. However, as the result of two quick heels, they gained two more tries, neither of which was converted. Just before full-time Havard broke away from a loose maul on the half-way line and ran like a wing three-quarter for the line. He was pulled down just short of it, but Murphy, following up well, gave Bart.'s a try. It was indeed fitting that the captain, to whom we owe so much for keeping us together throughout should be responsible for the final try of the season.

Team:—V. G. Caiger; J. L. M. Corbet, J. M. Kneebone, M. G. Taylor, J. K. Murphy; K. A. Clare, L. Cohen; A. J. Third, P. Knipe, F. I. Macadam, C. W. H. Havard (Capt.). W. D. Williams, J. Tallack, J. F. A. Maskell, A. R. Jones.

Awards:

Honours have been awarded to C. W. H. Havard and A. J. Third.

Colours have been awarded to A. M. Baker, V. G. Caiger, J. L. M. Corbet, K. A. Clare, M. G. Taylor, J. K. Murphy, M. J. A. Davies, A. Mackay, A. J. Third, P. Knipe, F. I. Macadam, C. W. H. Havard, D. W. Roche, D. M. Cuthbert, G. W. Mears, M. V. J. Fitzgerald.

HOCKEY CLUB

Hospitals' Junior Cup

The Hospitals' Junior Hockey Cup has been won by Bart.'s.

The final, between Bart.'s 2nd and Guy's 2nd, was replayed on Wednesday, April 25, on St. Mary's Hospital ground, Teddington. At the end of the first half the score was one all, but two quick goals soon after the interval gave Bart.'s a lead which was held to the end of the game. The final score was 4—1.

CHESS CLUB

This season the number of active members of the club increased, and we were very pleased to find that the majority of the new members came from Charterhouse Square. In spite of this, the past season was not as successful as the previous one, the club no longer holding its unbeaten record.

The club again entered the London University League, Division II, and again finished second to Sir John Cass College; this time losing heavily to Sir John Cass College who had a strong team. We won against Woolwich Polytechnic and Bromley Chess Club. In the latter match we were entertained by Dr. France, and spent a most enjoyable evening.

A Tournament, run on the American system, has been played this year and is still continuing. We hope, this term, to hold another Lightning Tournament, and hope that all those interested will be able to come.

BOOK REVIEWS

CASE STUDIES IN THE PSYCHOPATHOLOGY OF CRIME, Vols. III & IV, by Ben Karpman. Medical Science Press, Washington, pp. xxxv + 834, xxxv + 875.

Volume II of these case studies was reviewed in this Journal some years ago. Volumes III and IV have now appeared and follow the familiar lines of previous volumes. In these days of paper shortage and poor binding the production of these books fills one with envy. The cost must have been prodigious, and could only have been made possible by means of large subsidies.

The case studies presented in the volumes under review are even more fascinating than those contained in the first two volumes. The Americans are very touchy when it comes to criticism from outside, but they are pitiless self-critics. The picture of the contemporary American scene that emerges from this series of pathographies could not make the most complacent American feel at all happy.

Life in Approved Schools and Borstal Institutions (or their equivalent) in the North American Continent, for example, would appear to turn young offenders into incurable, criminal psychopaths; and the social setting in which most of these human dramas was played makes one's second thoughts on the British Welfare State warmly appreciative.

One must again be thankful to the American author and the American Organisation that made the publication of these volumes possible for the more-than-honest portrait of the American underworld, police, criminal law and prisons. It is indeed astonishing and gratifying that psychiatric methods, the exact nature of which has been left largely to the imagination, appear to have been successful in rehabilitating some of these tragic social misfits.

E. B. Strauss.

PHYSICS IN MEDICAL RADIOLOGY, by Sidney Russ, L. H. Clark and S. R. Pelc. 2nd Edition, 1950. Chapman and Hall, pp. viii + 296, illus. 106. Price 25s.

"Physics in Medical Radiology" is intended to meet the needs of those who wish to keep up with the physical and technical developments of Medical Radiology. In this second edition there has been considerable revision of the text; the section on photography has been re-written, while a section on Tracer Techniques has been added.

Starting from Electrostatics and Current Electricity, the book continues with the Conductivity of Gases, Electro-magnetic Radiations, Production and Properties of X-rays, the Measurement of X-ray Intensity, Wavelength Determination of X-rays to Planck's Quantum Theory. This arrangement, with the Quantum Theory coming after subjects the explanation of which depend primarily upon it, seems, at the least, peculiar.

We are then led through Natural Radioactivity, Radioactive Emanations to Atomic Structure; another anomaly in arrangement, and so to Dosage in Radium Therapy.

Part II commences with a most comprehensive chapter on Photography, which everyone should read, and a short but illuminating dissertation on Radioactive Tracer Techniques. The book would have been considerably enhanced by more about this relatively new and absorbing subject. The rest of this part of the book is given to X-ray Tubes, Alternating Current Phenomena, High-tension Generators and Apparatus ending with a useful appendix on Protection, a subject to which one of the authors has contributed considerably in the past.

As a reference book, "Physics in Medical Radiology" should be useful to students studying for their F.S.R. or D.M.R. diplomas, although in itself, it does not cover the practical aspects of the subjects sufficiently, while going too deeply into the purely physical side.

G. S. I.

CROSSWORD SOLUTION

The following is the solution to the crossword published in the May *Journal*:—

Across:

1. Mixed tumour; 8. Bowels; 10. Braise; 11. Spelt; 13. Torn; 15. Ada; 16. Germ; 17. Dissected; 20. Dim; 21. Ken; 22. Corollary; 25. Tour; 26. Deo; 27. Earl; 28. Ditch; 30. Oxalic, 31. Kernig, 32. Perchloride.

Down:

2. Inward; 3. Ells; 4. Mort; 5. United; 6. Obstruction; 7. Dermatology; 9. Spasmodic; 10. Blacklock; 12. Ede; 14. Nidor; 16. Genre; 18. Sir; 19. Tea; 22. Curare; 23. Let; 24. Yarned; 28. Disc; 29. Heir.

RECENT PAPERS BY BART'S MEN

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——. Hendrik van Deventer (1651-1724). *Brit. Med. J.*, March 17, 1951, p. 581.

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*NASH, D. F. E., Surgical aspects of renal damage in childhood: assessment, salvage and aftermath. *Ann. Roy. Coll. Surg. Eng.*, 8, March, 1951, pp. 193-212.

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*Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

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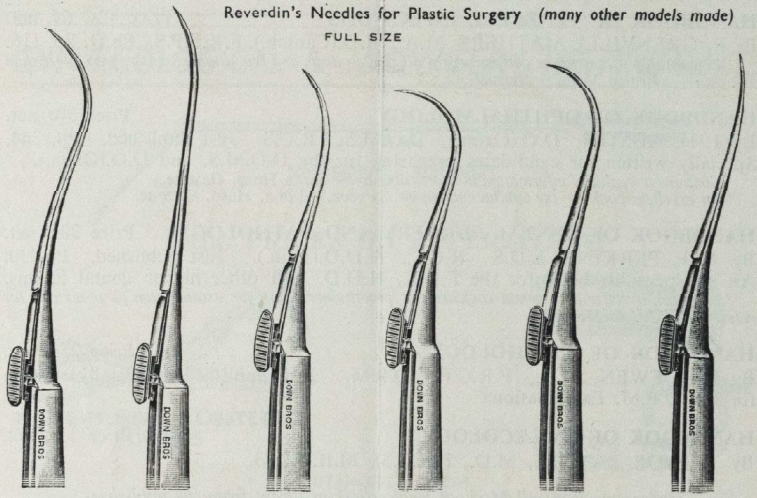

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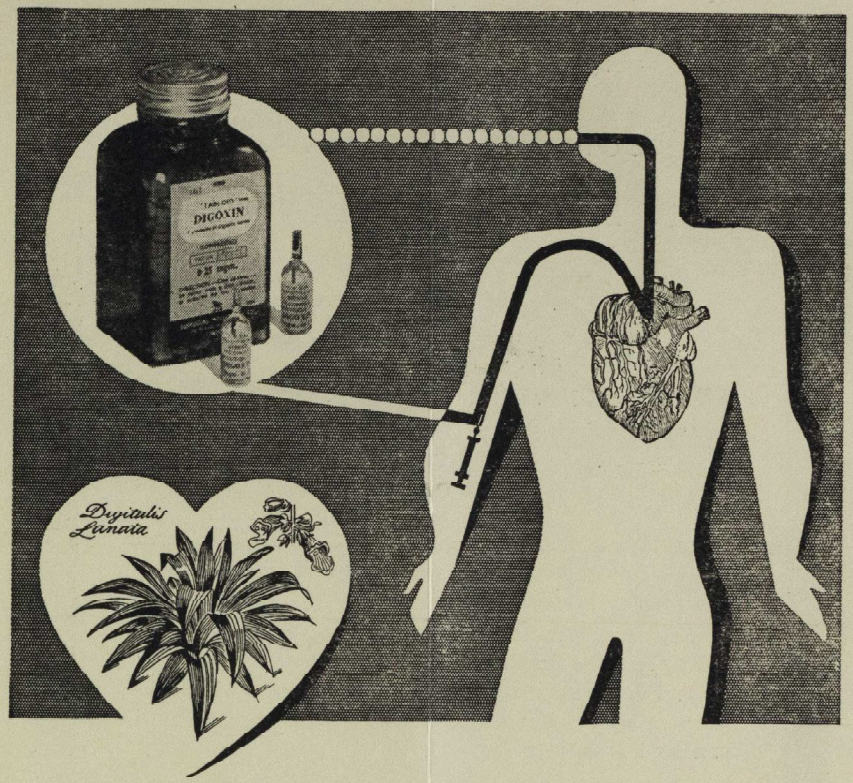


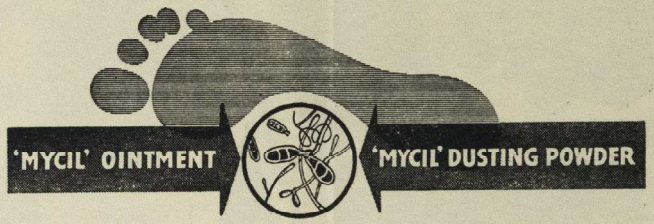
SAFETY and CERTAINTY

For initial digitalisation or for maintenance, Digoxin produces the desired result quickly, safely and with certainty. Being a single crystalline glycoside of definite composition and potency, it ensures a degree of accuracy unattainable with digitalis leaf products. Orally, Digoxin is effective in a few hours: intravenously, in a matter of minutes. It is particularly suitable for maintenance in the ambulant patient because the dose may be adjusted precisely, and risk of toxic effects is reduced.
'Tabloid' brand Digoxin, 0·25 mgm., for oral use; 'Wellcome' brand Sterile Alcoholic Solution of Digoxin (for the preparation of Injection of Digoxin).

DIGOXIN 'B.W.&CO.'

BURROUGHS WELLCOME & CO. *(The Wellcome Foundation Ltd.)* LONDON

COMBINED ATTACK ON FUNGAL INFECTIONS



THE COMBINED APPLICATION of Mycil Ointment and Mycil Dusting Powder is effective in the treatment of fungal infections of the skin and particularly of tinea pedis.

The dusting powder used alone prevents reinfection when clinical cure has been effected. Its absorptive properties are effective in the treatment of excessive perspiration. Mycil preparations are non-mercurial and may safely be applied over a prolonged period.

'MYCIL'

Contains Chlorphenesin (p-chlorophenyl-α-glycerol ether)

Ointment in collapsible metal tubes.
Dusting Powder in sprinkler drums.

MEDICAL DEPARTMENT
THE BRITISH DRUG HOUSES LTD. LONDON N.1

Myc/E/10a.

The Exoma Press. Ltd., 255/7 Liverpool Rd., N.1.