

ST. BARTHOLOMEW'S



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"ODDLY ENOUGH"

(With apologies to Paul Jennings)

Who says that there's no magic in London? Well, of course, if you mean strange numinous presences, I suppose you must be right. There are no nymphs in St. John's Wood, nor zephyrs up on the Heath, and who has seen Pan in Arnos Grove? But folk must be dull, dull indeed if they can find nothing lightly fantastical as they travel about London, and after all it is only whilst we travel that we can spare a moment to let thoughts wander from the narrow path of our busy lives, to lay down the blinkers and strait-jackets of convention, and exercise our atrophied imaginations.

Carried down into the netherworld of the "Underground" by an ever-moving staircase, endless advertisements of female accoutrements float before our unseeing eyes. There can be no situation so anaesthetic to the ordinary processes of the mind as being on a "down" escalator. Thoughts become less and less practical, more and more speculative. We step off at the bottom in an abstraction.

Look around. Isn't the whole place filled with mystery? Where do all those people disappear to down "No Exits"? Try to follow one of them and he vanishes leaving you in a tunnel full of Tube-smelling draught. Pursue him and you end up in that banana shaped chamber one can sometimes see lit up between the moving stairs. Tell me, why do only half the trains dare to stop at Mornington Crescent? And, according to what natural law do they clip your ticket on some days and not on others. Answer that!

Borne away into darkness like Lohengrin in his swan-drawn craft, bound for the Holy Grail, we find ourselves arbitrarily paired into anonymous couples, uneasily aware of one

another's presences, undergoing a curious chair-like motion some hundreds of feet below the earth's surface. This is the time for meditation. Look at those close-lipped women, freed for brief hours from their bed-sitting rooms. Regard the bowler-hatted, horn-rimmed, men returning to the fetters of their family. Contemplate that gaunt and lifeless figure hanging from his leather noose, or better by far, study the *Tube map*.

The map as a whole presents an attractive design, but now take it to bits, look at the modern streamlined no-nonsense Bakerloo, and the rambling, vague, ample, wandering District (alias Circle and Metropolitan), as though it couldn't make up its mind which to be, or where to go, or, indeed, where to stop. Personally, I like the Central Line the most, because it calls at both Gants Hill and Shepherds Bush. Gants Hill seems related to Gads Hill and surely must be peopled by fantastical Falstaffian characters marching at the head of a disarrayed army. At the other end of this line, rich with such mellifluous names as Snaresbrook, Theydon Bois, Blake Hall, Ongar and Fairlop, is Shepherds Bush where some herd boy plays a country air upon his reed pipe (vaguely reminiscent of that bright-young-thing practising on that wretched plastic recorder in the flat below). Then there are other stations of character: Wapping—here is the sound of the slap of greasy tides against the stern of Thames wherries, low angry voices and paddles splashing in the river fog. Ashore the great gates of eerie warehouses are padlocked across sweaty glistening cobbled alleyways, and in the dark you can hear the trundling of a handcart past all-night coffee stalls. Hendon, here are terracotta birdbaths and

1924-ish parties, women in cloche-hats and young men in flying helmets and privately-owned biplanes. On Sunday afternoons at Tooting Bec large men kick soggy footballs amongst the endless allotments and rumbling, gibbering, squeaking trams. Ravenscourt Park is but a polite name for some Castle Dracula, where dark vampires clamber up and down the creeper-covered trelliswork. Mill Hill, you see, is on that Northern branchline, which was specially extended by the private petition of the rich Mill owner in prosperous 1850. But things have changed, and there is little life now amongst the black brick sidings, the empty waiting rooms with their advertisements for cheap rates to Pontypool peeling from the damp walls behind the rusting weighing scales. The Old Mill no longer turns and the track is over-grown with ragwort and wild columbine. Dollis Hill was a name I had always cherished upon the Tube map. The High Street curved up the Hill between the old stone houses, corn chandlers, furriers and sweet shops, where grey-haired sisters weigh out bullseyes from tall glass jars, and the Post Office sells staples and rabbit wires wrapped up in a copy of

In this issue of the *Journal*, most of the articles focus our attention upon some of the literary facts of the doctor's life. We are honoured by an article on the preparation of material for the medical press by an old Bart.'s man, Dr. Hugh Clegg, the editor of the *B.M.J.* Sir Ernest Gowers in his article on "Jargon" carries his battle against those who misuse our language right into the medical camp. We are very pleased to print another article on four Bart.'s men, who did much for *Punch* in its early days, by Philip Gosse, one of our most distinguished old students, who has been contributing to the *Journal* for over fifty years.

A Lost Pharmacopoeia

In 1614 an "apothecaries shop" was first erected in the hospital; brass mortars and weights were provided, as well as herbs and drugs. Since then frequent entries in the hospital records refer to it and its modern successor, the Pharmaceutical Department. It had of course, records of its own, and some are kept in the Archives Room. We have three account books, and a few pharmacopaeias, the earliest of which is dated 1768. There must have been more,

the *Farmer's Weekly*. To me, it was the kind of place where you are met at the station, and rattle home in a dogcart to a fire-lit tea of toasted scones, butter and ample jam. At least, so I thought, until I visited my friend, Barleycorn, last week. I stood on Dollis Hill Station in the drizzle at the doldrum-hour of nine o'clock, surrounded by the fish-and-chip bars and great panel-beating works of North London. At Dollis Hill I learnt what disillusion was.

Now groaning and swaying one of those curiously fashioned Waygood-Otis lifts with four sides and no angle a right-angle, we rise to ground level again. The gates crash open on whichever side we happen not to be standing. We step into reality. A bustling shoddy road, where it is always Saturday afternoon and the crowds shuffle past dismal shops of chromium kettles, lampshades and dreary pink underwear. First left, then right, and your latchkey turns in the lock.

* * *

You get so little time to meditate, be it on Tube Maps or less important things, so make the most of it!

and we would be very grateful for any information whatsoever about them. It is known that some of them were seen in the hospital not long ago; but their present whereabouts are a complete mystery.

The Royal Hospital of St. Bartholomew

A short history of the hospital written by our archivist, Dr. Gweneth Whitteridge, has just been published. The text is new, and corrects several errors in an earlier edition. It is excellently illustrated and well presented, and forms as complete an introduction to the history of the hospital as one could wish for. *The Royal Hospital of Saint Bartholomew* may be bought from the Librarian. Its price—one and sixpence.

Art Amongst the Doctors

As a correspondent points out (see page 299), the attitude of the Arts Council is not only strange and biased against some students, it is also short-sighted. In these days the medical student is no better provided for by grants than is the Art student, and it seems unfair that we should not be granted similar privileges in visiting Art exhibitions.

The excellent attitude of the foreigner in preferring one original painting by an unknown artist, to a number of familiar prints of the "Old Masters" can hardly be called popular in this country. It is high time that the future potential private patrons of the Arts, for that is what we are, were encouraged to interest themselves in modern art from abroad, and the work of our own artists, by visiting these exhibitions. A reduction in the entrance fee would certainly be an inducement.

George Medallist

The *London Gazette* has announced the award of the George Medal to Surgeon Lieutenant James G. H. Shepherd. On April 27th this year, a lighter was being loaded with ammunition from the Naval Auxiliary vessel *Bedenham*, in His Majesty's Dockyard, Gibraltar,



By kind permission of the B.M.J.

when a minor explosion occurred. Immediately, Shepherd went to the wharf to search for casualties. After he had rescued a badly burned man from the water, a second and much larger explosion occurred, cutting the *Bedenham* in two and sinking her. Despite being only fifteen yards away he fortunately escaped unharmed and at once began to administer first-aid to the seriously injured on the wharf. The citation reads:

"He showed a complete disregard for his own safety and his single-minded determination to do all within his power to seek out the casualties, care for them, and relieve their pain was worthy of the highest praise."

Shepherd came to St. Bartholomew's Hospital in 1943. He qualified in 1948, and later volunteered for the Navy. We send him our congratulations.

Bart.'s THE Rowing College

We congratulate the Boat Club, who have once again won the United Hospitals Challenge Cup. This was by no means the only Bart.'s success at the United Hospitals Regatta, where we also carried off both the Junior Eight and the Junior Four trophies.

John Currie, who stroked the first eight for the fourth year running, is the first Houseman to row for Bart.'s for many years—we hope that his precedent will be followed in the years to come. The stern four of the second eight deserve special mention for winning the Junior Fours final almost immediately after a neck-and-neck race in the eight. Few people at the Hospital, to judge by the small number of supporters, realise that the Bart.'s Boat Club very often wins its races.

A Local Shrine for Troubled Wives

The life of St. Uncumber or St. Wilgeforte is of considerable interest. She is said to have been born one of nontuplets. Later in life, despite her wishes and a vow of perpetual celibacy, her father arranged a marriage for her to the King of Sicily. She prayed hard and long, and divine help came in a curious form,—an adreno-genital syndrome—and she grew a beard and moustache. As soon as the King of Sicily saw this strange transformation, he cancelled the wedding. The bride's father was so angry that he had his daughter crucified. Wives afflicted with troublesome husbands may invoke her by presenting a handful of oats. There is such a shrine in St. Paul's. I have been asked to add that the shrine is no longer in action.

Cambridge Sherry Party

The Sherry Party, held by the hospital Cambridge Graduates' Club, was the first to be attended by lady guests and members. The Library was in festive mood, with an interesting exhibition of prints in the gallery, and the librarian's desk transformed into a bar. Dr. A. C. Roxburgh must be congratulated as President of the Club, for giving us what we shall hope in the future to regard as the first of many happy occasions.

ENGAGEMENT

The engagement is announced between Ronald Cathcart, son of Dr. and Mrs. A. C. Roxburgh, of 5, Redington Road, and 121, Harley Street and Miss Angela M. E. Grylls.

MARRIAGES

The marriage took place between Miss Nancy Heywood and Gilles Kaan at St. Margaret Mary and the Sacred Heart, Fullwell, on Saturday, November 17th.

The marriage took place between Miss Kathleen M. Herbert and Dirk J. Boet, at Emmanuel Church, Southport, on November 24th.

SOME NOTES ON PREPARING MEDICAL PAPERS

By HUGH CLEGG

If an author does not express himself clearly, does not know how to use punctuation marks, mis-spells words, gives inaccurate references styled according to no plan, produces an untidy-looking typescript, spaced singly and with little or no margin at the left of the page, then any editor will conclude that the author's mind, and so his work, resembles his product. If one has to read, as I do, hundreds of manuscripts a year then one will inevitably look more favourably at those which cost one the least effort. It is true that a pearl is concealed in a most unlikely place, but it is unwise to expect an editor to spend much of his time prizing open shells on the off-chance of finding something valuable inside.

Science, to repeat the well-worn cliché, is measurement, and now that medicine is becoming more scientific measurement is something that must be given its full value. Many painstaking investigations have failed for the simple reason that the investigator has neglected measurement. Medical statistics is an indispensable tool in medical research, even though such research may be of a relatively simple nature such as the tabulation of certain facts in a collection of cases. If the would-be author finds, as I do, medical statistics a bit of a headache, then he would at least be wise to seek the advice of those competent to give it. Too often a paper will come into an editorial office with numerous tables from which the author has drawn conclusions that do not stand up to simple statistical analysis. I remember one conscientious author who had spent nearly two years collecting facts on different methods of treating a certain disease, and with his paper there were tables from which he claimed to draw firm conclusions. Most unfortunately the conclusions were unrelated to the facts. When this was pointed out to him, he, far from being grateful, stormed up and down my office muttering such sacred words as "clinical intuition." In fact, he was so worked up that when he sought another interview he asked to bring his mother with him, which did not seem to me to be relevant to the case. This man could have saved himself a lot of trouble and disappointment if he had planned his investigation with the aid of a medical statistician. The statistician

comes in at the beginning, not at the end. It is the custom of more and more editors of medical journals to send articles which have numerical data to statistical referees, and they tend to be ruthlessly objective in their assessment of what they are asked to judge.

In his Notes on the *Preparation of Papers for Publication*, the late G. H. F. Nuttall said there were certain golden rules which every author should follow: he should (a) try to imagine himself in his reader's place; (b) proceed on a definite plan; (c) study compression; (d) revise his manuscript carefully; (e) read and correct his proof conscientiously. One might add to these: (f) check all references; (g) make sure that the totals in tables add up correctly (they hardly ever do); (h) end the paper with a full and intelligent summary.

Apart from the present enormous costs of production, with the price of paper more than 200 per cent. what it was at the beginning of 1950, how one wishes authors would take more notice of Dr. Nuttall's golden rule "to study compression." Learning to write is like learning to ride a bicycle; one cannot help falling off to begin with. Some people have a natural facility, but most have to learn by trial and error. There are plenty of good guides. One has the impression that the young author thinks that if he uses long words and involved sentences he will pass for being a member of a learned profession. So many sentences are written rather like this: "It is my considered opinion that all the accumulated facts go to show that there might be in this disease some unknown and imponderable factor, the discovery of which will illuminate this highly complicated problem." This could be put more succinctly thus: "What evidence there is suggests an unknown factor as the basis of the problem of this disease." Then there is the abominable use of medical jargon. "Case No. 40 died of shock." Cases do not die, but patients do. "This patient had an unusual pathology." Pathology is defined in a well-known dictionary as "that branch of medicine which treats of the essential nature of disease, especially of the structural and functional changes caused by disease." How can a

patient, or even a case, have this? Another abomination: "He was a carcinoma stomach." Then there is that word which, even for editors, has a deadly fascination—"marked." "He had a marked murmur." "She had a markedly enlarged spleen." "She had a marked growth of hair on her upper lip." This word "marked" really means nothing at all. One assumes that the "marked murmur" was a loud murmur, that the "growth of hair" was profuse; and why not be accurate and state that the spleen was so many inches or centimetres below the lower costal margin? If only authors would remember that most sentences have a subject, a verb, and an object; that the active voice is more effective than the passive; that short words ram home the point more clearly than do long words; that there is no merit in a long sentence; that adjectives and adverbs should be used sparingly and only when they add to the meaning, they would save themselves and their readers a lot of trouble. Medical writers often like to talk about a "meticulous" examination. As Fowler says in *Modern English Usage*: "What is the strange charm that makes this wicked word irresistible to the British journalist?" One of my own fads is the wrong placing of the word "only" and I was disappointed to see Sir Ernest Gowers, in his recent *A.B.C.*, excuse this on the grounds that so many people do it. "I only met Jones yesterday," someone says. If you turn this sentence round you will see it makes nonsense. "Yesterday I only met Jones"—a day, I word "only" should come before the word should say, not well spent. Obviously the it qualifies—yesterday.

So I would say at the beginning of these few notes that anyone sending in an article for publication should have it typed clearly on one side of quarto paper, with double spacing and a left-hand margin of 1½ in. to 2 in., so that editorial corrections can be easily made. Many authors, incidentally, forget to number their sheets of typescript. Tables, charts, and graphs should be on separate sheets of paper, and it should be indicated in the text where these should appear. References should also be on a separate sheet of paper, and they should be styled according to the custom of the periodical in which the author is seeking publication.

Many journals now adopt what is wrongly called the Harvard system of giving references. The references are arranged alpha-

betically. The author's name comes first, followed by his initials; then comes the date of the publication in parentheses, then the title of the book or periodical in italics, and, lastly, the volume numbers in bold Arabic numerals and the first page number in ordinary Arabic numerals. In some journals the first and last page number of an article are given: this is useful because it does give some idea of its length. The reference in the text is given thus: "Some authors (Dejean, 1947; Laroche, 1947b) have reported Addison's disease with rheumatic joint lesions . . ." or "Selye (1949) noted that rats treated with large doses . . ." This system replaces the older one of giving references numerically. This is not the place to argue for and against these two methods, but the so-called Harvard method, which is adopted in the *British Medical Journal*, is advocated by the Royal Society.

There are one or two other points about the preparation of a manuscript that might be mentioned here. A long paper should be broken up by cross headings that indicate the main divisions of the paper. All except very short articles should have a concise summary of the principal findings and deductions from them. Incomplete or inadequate summaries are the rule rather than the exception, and even experienced authors seem at times to be unaware of the value of a good summary. Most readers of scientific periodicals probably read the summary first, and if their interest is stimulated by this will go on to read the full article. Not only that, but a good summary is invaluable to those conscientious and hard-pressed workers who prepare abstracts for the various abstracting journals and sections of journals.

Graphs should be drawn in black ink on stout white paper or Bristol board, and letters and figures should be written lightly in pencil, not in ink. Graphs usually have to be reduced in size for reproduction, and those responsible for this have to put in letters and figures of such a size as will be legible after reproduction. When illustrations have to be reproduced by the half-tone process authors should send X-ray films rather than prints. Photographs should be on glossy paper and only slightly larger than the size of reproduction in the journal in which publication is sought. What the customary sizes are can be discovered by looking at a few copies of the journal. Pictures to be reproduced by the half-tone process suffer if the

reduction has to be too great. Photomicrographs, too, must be printed on glossy paper and the legends to these should be typed on a separate sheet of paper. Authors would help editors a lot if they were to indicate what parts of an X-ray film or of a photomicrograph should be especially brought out.

This is all rather obvious stuff about preparing a paper, and much more could be, and has been, written about it. Yet many authors tend to overlook the obvious, and in doing so unwittingly exasperate those who have to handle the numerous manuscripts, bad, good, and indifferent, which day by day come into an editorial office.

But before beginning to write a paper it is important that an author should decide whether or not he has something really worth saying. In these days of merit awards and job-hunting in the face of intense competition, publication of articles in a medical journal is more than ever the stock-in-trade of those anxious to get on in the world of medicine. The aspirant to higher things, one would guess from what one reads, searches desperately for a subject on which to write. Either he collects cases in the hope that something will turn up from a mass of ill-assembled facts, or he will start an investigation with

the same pious hope. By not exploring the ground in advance many authors fail to achieve their aim of publication. In printing, an important operation is known as the "make-ready," and a good printer will spend any amount of trouble and time in attending to his machines, looking to the ink ducts, and making quite sure that the right amount of backing is given to illustrations, and so on and so forth. If only those who wanted to have their words printed would take the same trouble they would get much better results. Anyone with a bright idea should, therefore, make quite sure that the same idea has not occurred to someone else. This he can do by reading the literature and by consulting those more experienced than himself. If he finds that the idea is original—within the wide limits of originality—then before starting on an investigation he should spend a long time in planning it.

These notes, I fear, are rather disconnected and written in haste. With more time I might have written something shorter. One last word I might add. When an author has finished his first draft he should persuade one or two brutally candid friends to criticize it, because it is impossible to spot one's own mistakes.

JARGON

By SIR ERNEST GOWERS, G.B.E., K.C.B.

I deprecate the common use of the word *jargon* as a term of abuse to be applied to any writing one thinks inferior to one's own. Its original meaning is more precise, and it is bad for a language when the sharp edges of its words are blunted. I should like to see *jargon* confined in meaning to technical terms peculiar to particular pursuits—whether arts or sciences, professions or trades, games or sports. It should be regarded as a neutral word, not necessarily a disparaging one. Up to a point *jargon* is harmless, and indeed useful and necessary. A word may have to be invented to denote some new thing or concept for which there is not yet any word in the language. What would golfers do if there were no golfing *jargon*, and a stymie had to be described by some elaborate periphrasis? But the origin of *jargon*-words is not always so blameless. The thing or concept may really not be new. There may be already a word for it, but a

jargon-word is invented so as to create an illusion of newness. This questionable practice is becoming sadly prevalent. I recently read an article in which an eminent man of letters looked forward apprehensively to the day when increasing specialisation and an increasing use of *jargon*-vocabularies will leave us with no common vocabulary with which to convey our thoughts to one another, so that *babel* will overtake the English language.

I think the chief sinners are the newer sciences, especially psychology and psychiatry and sociology and, to a less extent, economics. These are no doubt entitled to their *jargons*, within reason. I do not myself pretend to know just what the *id* is, and I am not greatly wiser when I consult my most modern dictionary, and find the definition to be "the sum total of the instinctive forces in an individual." But I am ready to believe that no existing word has quite the same

meaning, and a new one was necessary. And I am ready to concede that, given the need for a *jargon*-word, a less pretentious one could hardly have been found: never can so much meaning have been packed into so small a space since the sentence "Thy kingdom is divided and given to the Medes and Persians" was compressed into the word *upharsin*. But these praiseworthy attempts to enrich the language are not the whole of the story. Our mother-tongue is at the same time being debased by an itch to give new names to things that are not really new. *Circumstances* must be called *environmental factors*; *groups* must be *brackets*; *living* is swallowed up by *viable* and *combine* by *synthesise*; familiar words like *character* and *behaviour* will no longer go by themselves: they must be put into double harness with *structure*, *pattern* and the like. I have known a writer suffering from this itch to refer to what old-fashioned people would call *fornication* as "bilateral erotic experiment outside marriage," and another to tell his readers that:

"Reserves which are occupied in continuous uni-directional adjustment of a disorder are no longer available in the ever-warring interplay of organism and environment in the spontaneity of mutual synthesis."

What causes this itch? Do those who study these subjects feel that a science cannot really be a science unless it has a *jargon* of its own; it must discover new things, and unless new words are found for those discoveries no one will believe they are really new? Or is Mr. Ivor Brown's explanation the right one? He says that *jargon* is a kind of uniform:

"The English love to wear ritual clothing and so cherish a ritual verbiage too. The barrister will not put away his wig; the parson has his dog-collar; the official has his pin stripe trousers. There is a gobbledygook of the Law, of Theology, of Finance, of Sport, of Criticism. The users will no more drop the lingo than they will abandon the insignia and haberdashery of their professions."

Doctors are exceptions to this rule of sartorial conservatism. They have abandoned the top-hat and frock-coat that were until recently the insignia and haberdashery of their profession. I wish I could add that, with their ritual clothing, they are discarding their ritual verbiage; but I suspect the contrary to be the truth: that losing the one is making them rely the more on the other. They have of course a large and well-established vocabulary of highly respectable *jargon*. *Diagnosis* and *prognosis* are indispen-

sable *jargon*-words, because there are no words in general use that have quite the same meaning. For *treatment* the good English word serves well enough, and one might have expected the same to be true of *causation*. But perhaps *aetiology* does not mean quite the same as *causation*: anyway, since *aetiology* has been established for at least three hundred years it cannot be cited as evidence of the contemporary growth of *jargon*. But the same indulgence cannot be extended to the habit of speaking of an *aetiological factor* instead of a *cause*, and I can think of no explanation other than the ritualistic one for the disappearance recently of the word *walking*, and its supersession by *ambulant* and *ambulation*. The following comparison is significant.

"The patient can walk with assistance, and should be encouraged to do so." (From a lecture delivered in 1886).

"There is no need for bed all the time; the patient should be advised to take intermittent ambulation." (From an article written in 1951).

It may no doubt be argued that *ambulation* does not mean quite the same as *walking*, but that does not justify its throwing *walking* out of business altogether.

I have elsewhere commented on the queer fact that the specialist who in my boyhood was called a *mad-doctor* has since passed through the chrysalis of *alienist* into the butterfly of *psychiatrist*. Surely, I said to myself, this cannot be the same person; I must be doing the profession an injustice. So I consulted that unimpeachable authority, the Oxford English Dictionary. These are the definitions I found there:

Mad-doctor: a physician who treats mental diseases, an alienist.

Alienist: one who treats mental diseases.

Psychiatrist: one who treats mental diseases, an alienist.

It would appear then that the only difference is that the *mad-doctor* has to be qualified and the *alienist* and *psychiatrist* need not be. So I was disappointed, and could only conclude that this succession of names represented new issues of ritual clothing made from time to time to replace what had become old-fashioned or worn-out. Perhaps euphemism had something to do with it. *Mad-doctor* is not a pretty designation. I remember it used to be given to us at school as the stock example of what grammarians call the "transferred epithet." But that may have seemed to the *mad*-doctors themselves

inadequate protection against misunderstanding, and they cannot be blamed for wanting a title free from all ambiguity.

In deprecating an excess of jargon, we must not fall into the error of being indiscriminating in our opposition to it. Philologists in this country are resistant people: they do not take kindly to new words, especially of American origin. Some of these would-be immigrants are indeed showy impostors seeking only to take over the jobs of honest hard-working English words. Any attempt to refuse admission to words of that sort deserves the support of all of us. But a word ought not to be rejected merely because it is new, even though it may come from America. The language is not static; it is changing all the time, and America has greatly enriched it in the past. New words applying for an entry-permit ought to be asked to produce their credentials by showing both that they fill a gap and that they are not aesthetically or etymologically abominable. To *hospitalise* is not a pretty word, but we cannot deny its claim to say what otherwise cannot be said in one word, and I think it may have come to stay, whether we like it or not. To *special* seems to have established itself in the nursing service jargon, and we must admit its convenience. But it would be well if everyone tempted to coin or adopt a new piece of jargon approached the question in the same spirit as Dr. Julian Huxley, who said in a recent broadcast:

"We need a term for the sum of these continuities through the whole of evolutionary time, and I prefer to take over a familiar word like *progress* instead of coining a special piece of esoteric jargon."

No doctor of middle-age or upwards who was educated at Cambridge University has any excuse for excessive addiction to jargon.

DEATHS

GERARD OLIVER HOLMES.

We announce with much regret the death, following a motor-cycle accident, of Gerard Oliver Holmes. He had come to Bart's from Rugby School and Balliol College, Oxford, in April. Apart from his work, he was keenly interested in other activities, a cellist and musician, a practical photographer, and naturalist. We send our sincere sympathy to his parents at Quorn, Leicestershire, and to his many friends.

The death was announced on November 27th of Clement Alexander Francis, M.A., M.B., B.Ch.(Camb.), of 75, Wimpole Street. He qualified from St. Bartholomew's Hospital in 1925.

for he must have come under the influence of Sir Clifford Allbutt, who attacked it unceasingly. Allbutt, who was Regius Professor of Physic from 1893 to his death in 1925, was a remarkable man. Tall, handsome, suave and distinguished, he was the sort of person that Buffon must have had in mind when he made his famous remark about the style being the man. He hated sloppy thinking and woolly writing, and found too much of both in the eighty-odd theses for the degree of M.B. and the thirty-odd for the degree of M.D. that he tells us he had to read every year. "The prevailing defect of these compositions," he said, "is not mere inelegance: it is such as to perplex, and even to travesty or to hide the author's meaning." So he wrote a little book for the benefit of medical students which he called *Notes on the Composition of Scientific Papers* (Macmillan). "It is far from my intention," he wrote, "in these simple instructions to advocate a manner of writing in which pith and character are lost in polish and affected elegance; indeed my purpose is literary only so far as to insist on the qualities of clearness, precision and definition." Thus there was published nearly fifty years ago for the special benefit of budding doctors a book which anticipated almost all that is useful to the ordinary writer in what Fowler and others have since said about clarity and simplicity of expression. It would be a good thing for the medical profession and indeed for every profession if a thorough knowledge of this book was made a qualification for entry into it. As Allbutt says:

"By disorderly and hazy writing we fall into worse things than muddle; we blunt the probity of our minds; we slur over difficulties and cover up ignorances. . . Force, lucidity, unity, simplicity, economy of expression, are virtues which we may all obtain; originality will be as God pleases."

The sudden death was announced on October 25, of Henry David Kelf, M.R.C.S., L.R.C.P., D.P.H., of 214, Sandbanks Road, Parkstone, Dorset, at the age of 79. He qualified from St. Bartholomew's Hospital in 1919.

FOUR HUMEROUS WRITERS FROM BARTS

By PHILIP GOSSE

Our *Journal* has a long and distinguished record of some sixty years, but we cannot but regret it was not founded some fifty years earlier, say about the year 1840. Had this been so, it would no doubt have had as

editor and contributors a most remarkable coterie of literary-minded students, who took a leading part in the birth and early years of that most venerable of all humorous periodicals, *Punch*. It was an extraordinary chance that these men should all have been studying medicine at Bart's at the same time, all four of whom were to become famous in their day, not as doctors but as writers or artists on the staff of *Punch*.

It may interest some of the present generation of Bart's men—and women—

to be reminded of them for they brought no little glory to our Hospital. The four were, John Leech, Albert Smith, Percival Leigh and Gilbert à Becket. There seems to be some doubt, however, about the last, for although it is known he shared "digs" with John Leech, it is not certain if he ever studied medicine before reading for the Bar. Taking them in the above order, we will

* Published one hundred years ago at a time when there was a small difference of opinion over the State of Oregon.

begin with *John Leech*, the humorous artist who was born in London in 1817, his father being the proprietor of the London Coffee House in Ludgate Hill. At the early age of seven little John was sent as a boarder to

the Charterhouse, close to the Hospital, much to the distress of his devoted mother, who, secretly, hired a room with a window overlooking the playground so that she could watch her son at play. After nine undistinguished years at *Grey Friars*, at the age of sixteen John Leech began to study medicine at Bart's, where he met as fellow students, Smith, Leigh and à Beckett. His career at the Hospital was only notable for his proficiency in making anatomical drawings which were greatly admired by Mr. Edward Stanley, F.R.S., who held the post of lecturer in anatomy as well as being a full surgeon and was then the most celebrated clinical teacher in London*.

It would be most interesting if any of Leech's anatomical drawings should be found to exist†. His father had intended placing his son with Sir George Ballingall

* Alfred Wetli's account of Edward Stanley in the *Journal*: 1894, 1, 147.

† There are none preserved in either the library or the museum.—Editor.



An example of the Political Cartoons of John Leech* By kind permission of the proprietors of *Punch*.

the distinguished Edinburgh surgeon, but finding he could not afford the high premium for this, John was apprenticed to a medical man of quite a different pattern, an apothecary, Mr. Whittle of Hoxton "who combined a great deal of pigeon fancying and the kind of athletics in favour with strong men at fairs." Mr. Whittle's love of animals was not confined to pigeons, for he kept rabbits and guinea pigs and ferrets as well. The area of his house was filled with poultry; at every window hung cages of singing birds; while the whole of the roof was converted into an enormous trap for catching his neighbours' pigeons. Here, on fine days, Mr. Whittle would sit for hours on end, smoking his pipe and sipping brandy and water, while he watched his neighbour's pigeons enter his trap. In due course it dawned upon Mr. Whittle that medicine was not his true vocation so he married the widow of a local publican and took an active part in dispensing drinks from behind the bar.

By this time Leech and his fellow apprentices had decided to look for other teachers, and John was apprenticed to a Dr. John Cockle, son of the inventor of the famous Cockle's Pill. Perhaps a contemporary description of Whittle may not be out of place. He is described by one who knew him as "an extraordinary person for a medical practitioner. At the age of 38, he was of Herculean build, except for his short legs; broken nose—the result of some hospital skirmish when a student—and a pair of luxuriant black whiskers which met under his chin."

But Leech too began to doubt if he was cut out for a doctor, and decided to devote himself entirely to drawing, so when his father failed in business—coffeehouses were being killed by the increase in clubs—he finally abandoned medicine for art. In August, 1841, at the age of 24 he became a regular contributor to *Punch* until his death at the age of 47 from *angina pectoris* or "breast pang," brought on, it was thought, by a "disturbance of his nervous system caused by the continual visitation of street-bands and organ grinders," but, according to his friend Dr. John Brown in his *Horae Subsecivae*, by the strain of fox hunting, Leech being an indefatigable follower of the *Puckeridge* and the *Pythchley*.

Our next Bart's student who became a member of the staff of *Punch* was Percival Leigh, who continued a life-long contributor

under the pen name of *Prendergast*. He had a brilliant career at the hospital:—Sir James Paget declared he was the best man of his year, and "admirable in diagnosis." He took the L.S.A. in 1834 and the M.C.S. a year later when he began to practice, but soon abandoned medicine for literature. On the foundation of *Punch* in 1841, Leigh became a member of the staff and continued to write for it until his death in 1889, at the age of 76. All through his life he was known to his friends, and he had many, as the *Professor*. Leigh was an enthusiastic and accomplished amateur actor and often appeared with Dickens, Leech and Douglas Jerrold of *Punch*. Leigh published several humorous books, the most popular being *Ye Manners and Customs of Ye Englyshe*. Most of his books were illustrated by Leech. Quite another type of man to the friendly easy-going Percival Leigh was his one-time fellow student and fellow writer to *Punch*, Albert Smith. Son of Richard Smith, a surgeon practising at Chertsey in Surrey, he was educated at Merchant Taylors and at the early age of 15 went to the Middlesex Hospital before going on to Bart's, where he shared lodgings with John Leech and Gilbert à Beckett. In 1836, at the age of 22 he became a licenciate of the Society of Apothecaries, and a member of the College of Surgeons, and then joined his father in practice. In January, 1841, he turned author with the first of a series of articles entitled *The Confessions of Jasper Buddle, A Dissecting Room Porter*. In the same year he settled in Percy Street, off the Tottenham Court Road, as a surgeon-dentist; he had by now become a regular contributor to the newly-founded weekly—*Punch*.

In the same year appeared his *Physiology of the Medical Student*, a boisterous but still amusing description of the daily and nightly life in the eighteen forties of a Bart's medical student. In those days, before the invention of organised sports, there was a lecture in physiology at two on Saturday afternoons. First-year students went with the lecturer in Botany for rambles in the wilds of Wandsworth and Wimbledon and on the hills of Highgate and Hampstead. The mantelpiece in the dissecting room was always crowded by beer mugs, and the dissecting room porter was ever ready to go round to the market to fetch more. Also the students used to broil sprats and red

herrings in the coal shovel over the roaring fire—whenever the demonstrators were called away to attend a private patient.

The next year there appeared the most popular of all his novels, *The Adventures of Mr. Ledbury*. From this time onwards Smith was continually turning out a regular stream of verse, epigrams, jokelets and articles on current events, until he quarrelled with Mark Lemon, part-founder and first editor of *Punch*. He already had quarrelled with most of his fellow contributors, almost all, indeed, but the good-natured John Leech. It was Douglas Jerrold who once remarked that Albert Smith's initials were "only two-thirds of the truth." Another writer described an early call at Percy Street where he found Smith—like a typical Bob Sawyer—"with his heels upon the table playing the cornet as a grand finale to his breakfast." After the break with *Punch*, Smith discarded writing for a new and, as it turned out, most profitable career. This was as lecturer and popular entertainer, and for many years he addressed crowded houses at the Egyptian Hall on a variety of subjects. This venture was not only profitable but was said to have brought about a great change in his character, in fact, one who

claimed to know Smith well, said that "though vulgar and bumptious in manner, he became polished by consorting with swells, after becoming a public entertainer." As his agent and business manager, he employed his brother Arthur who also was a doctor, but gave up practice to devote his whole time and energy to looking after his brother's affairs.

At the early age of 44 he died, "the best abused humorist of his day."

I stated at the beginning of this article that the fourth of the Bart's friends all of whom became closely associated with the founding of *Punch* was Gilbert à Beckett, who shared "digs" with John Leech and Percival Leigh. Whether à Beckett was a medical student for a while is uncertain, but his brother Arthur who was at Bart's, qualified and served with distinction in the Army Medical Corps.

It is a pity so little is known about the daily round of a London medical student in the early part of the last century. Indeed, at Bart's there is actually no list or record of the names of the students who learned their medicine at our hospital under such great teachers as Stanley and Paget.

SO TO SPEAK . . .

To conclude an experiment with a spirometer :

" . . . expire gently into a Gladstone Bag . . . "

A physiology examination candidate.

Even his best friends . . .

" . . . he bought twelve cases of mouthwash and then found his friends didn't like him anyway."

Alexander Woolcott.

Was it Rabies?

BARKING SCHOOLBOY SHOT.

Headlines from a local paper.

On being awarded an Honorary Doctorate of London University.

" . . . it is a great honour, and anyway one's wife likes these things."

Professor Van Slyke.

This England.

"Under the National Health Scheme people can have drugs supplied to them, that is all right for those people who have no intention of taking their life, but for people who are fed up, such a state of affairs gives them the opportunity to end their lives. Such people are abusing the advantages given to them."

Walthamstow Post

Three Aphorisms :

On the use of purgatives—

"Sometimes then and now, but my God, always never."

"There is a place in the world for everyone, even the worst of us can serve a horrible examples."

"A doctor should know a little about everything, including medicine."

Voltaire

THE SURGICAL TREATMENT OF CONGENITAL HEART DISEASE

By GEORGE KAZANTZIS

Much progress has recently been made in a new field of surgical endeavour, that of the heart and great vessels. Many forms of congenital heart disease can now be treated successfully by operation, and the accurate diagnosis of this condition, until recently an academic exercise, has assumed great practical importance. The progress which has been made is reflected in the increasing amount of cardiac surgery now being performed on the Thoracic Unit at Hill End.

Congenital heart disease constitutes 1.5 to 2.5% of all cases of organic heart disease, and it may be argued that this branch of surgery is small and highly specialised. Every cardiac operation performed, however, gives us information on the reaction of the heart to surgical interference, and furthers the development of a technique in this new field.

Thus the way is being opened for the surgical relief of the more important field of acquired heart lesions. Mitral valvulotomy, the intra-cardiac operation for the relief of mitral stenosis, has been performed at Bart.'s on about a dozen occasions, and will be performed with increasing frequency in the near future. It is not too much to hope that the day will soon come when the many thousands who suffer from valvular heart disease will be afforded radical treatment for their incapacity.

The history of cardiac surgery is short, and can be traced back to 1897 when Rehn described the successful suture of a cardiac wound.

Isolated attempts were made to divide stenosed valves by Doyen and Tuffier in 1913, by Souttar in 1926 and by Cutler in 1929, but modern cardiac surgery really commences with the first successful ligation of a patent ductus arteriosus by Gross and Hubbard in 1939¹.

In November, 1944, Blalock² performed his first "blue baby" operation in America, and in the same year a coarctation of the aorta was resected by Crafoord and Nylin in Stockholm³. In 1948 Brock performed his first direct cardiac operation on the pulmonary valve⁴ at Guy's Hospital, and a year later, he successfully split a stenosed post rheumatic mitral valve⁵.

These epoch making advances were made possible by a number of developments in the

preceding years. The perfection of anaesthesia with the use of curare and controlled respiration, making exacting work like arterial suture on a mobile mediastinum technically possible; the technique of thoracotomy and closed drainage; intravenous infusion of fluids and blood; chemotherapy and pre- and post-operative care of the patient, are some of the vital accessories which have made cardiac surgery possible. The physiological basis of all this work must not be forgotten.

Patent Ductus Arteriosus

This condition is often symptomless in young children, the cardiac murmur often being first heard on routine examination. Some children have a retarded physical development, and are more than normally liable to intercurrent infections.

The open ductus is, in effect, a fistula which at first shunts blood from the aorta into the pulmonary circulation. Left ventricular enlargement occurs in time, with dilatation of the pulmonary arterial tree. These patients are particularly susceptible to sub-acute bacterial endocarditis, which claimed a high toll before the introduction of penicillin. Very few lived beyond the age of forty, those not succumbing to infection, dying of heart failure.

The diagnosis is made on the machinery murmur; and on radiography which shows a prominent pulsatile pulmonary arc with increased hilar shadows. In more difficult cases the ductus may be visualised on angio cardiography or retrograde aortography. Cardiac catheterisation may show an increased pulmonary arterial pressure, and blood samples obtained from the pulmonary artery a raised oxygen saturation due to admixture of arterial with venous blood. A lowered diastolic blood pressure is present in many cases.

A ductus complicated by bacterial endocarditis was first successfully ligated by Mr. O. S. Tubbs in 1941⁶, the blood culture becoming sterile on the second post-operative day, thus providing the first cure of, till then, a fatal disease.

Operation, usually consisting of simple ligation of the ductus, is advised in children between the ages of five and fifteen unless there is a specific contra-indication. Here is a typical example.

Muriel—Age 5½

Asymptomatic, patent ductus discovered on routine examination at age of 2½.

The patient was a healthy child with normal development. A systolic thrill was palpable in the 2nd and 3rd left intercostal spaces, where a continuous murmur was audible maximally. The blood pressure registered 110/50.

30.3.51. Operation: Theatre "C." Ligation of patent ductus arteriosus by Mr. I. M. Hill.

Anaesthesia by Dr. R. A. Bowen. Pre-medication with seconal and atropine, then pentothal, gas, oxygen, ether and curare.

A left posterolateral thoracotomy was performed through the fourth rib bed. The upper lobe of the lung was held back with a retractor and the mediastinal pleura incised between the vagus and phrenic nerves. The recurrent laryngeal nerve was defined curving below and behind the arch of the aorta, and the ductus, which was short and wide, was identified medial to it. The most exacting part of the operation is the careful dissection of the ductus, which has to be cleared completely. When the ductus was quite free, it was ligated first at the aortic, then at the pulmonary end with floss silk, and then transfixed and tied again between these ligatures with thread.

After ligation the blood pressure registered 110/80 and the continuous thrill could no longer be felt. The lung was re-expanded, a basal drain inserted and the chest closed in layers with nylon. Post-operative recovery was uneventful, the drainage tube being removed on the second, and the child being discharged home on the tenth post-operative day.

Tetralogy of Fallot

Failure of the normal development of the heart producing some form of pulmonary stenosis, a ventricular septal defect, dextro-position with over-riding of the aorta so that it communicates with both ventricles, and a hypertrophied right ventricle, is the commonest form of congenital cyanotic heart disease.

The reduced blood flow through the lungs and the right to left shunt produces a decrease in the oxygenation of the arterial blood, which is responsible for the patient's symptoms. The object of surgery is to provide a means whereby the oxygen saturation of the blood can be increased.

Blalock accomplished this by anastomosing a systemic to a pulmonary vessel, thus

increasing the flow of blood to the lungs by by-passing the obstruction. The operation has had brilliant results. However, it neither relieves the obstruction nor alters the flow of venous blood into the arterial circulation through the patent septum. It can be seen that, in effect, an artificial patent ductus arteriosus is created, and the patient is left with an arterio-venous fistula, a condition in itself bearing a doubtful ultimate prognosis.

Brock has dealt with the problem by a direct attack on the stenosis by performing a pulmonary valvulotomy—i.e. dividing or dilating the stenosed valve, approaching it through the wall of the right ventricle. Thus, the obstruction relieved, not only is the pulmonary blood flow increased, but as a result of the fall in pressure in the right ventricle, the right to left shunt is diminished.

Pulmonary valvulotomy has been performed in cases of pulmonary stenosis without ventricular septal defect where the Blalock type of operation is unsuitable, also in those cases where the Blalock operation is not anatomically possible due to the arrangement of the great vessels.

Barrett has attempted to increase the pulmonary blood flow by creating adhesions between the lung and the chest wall, and has met with some success. This operation can be used where the above two are impracticable, as in cases of atresia or absence of the pulmonary artery.

Children with Fallot's tetralogy are usually small and under weight, slow in development and often mentally retarded. Exertion produces an increase in their cyanosis which is usually present to a certain extent from birth. Dyspnoea may limit the child to walking only a few steps without resting, often in the characteristic squatting position. Severe dyspnoea with intense cyanosis sometimes occurs in spontaneous attacks, which may end fatally.

Gross clubbing is seen in the fingers and toes, producing the characteristic "drumstick" appearance. The extremities are usually cold.

The low arterial oxygen saturation produces a compensatory polycythemia, so that red cell counts of eleven million with a haemoglobin of 180% are occasionally found.

A systolic thrill with a harsh systolic murmur maximal to the left of the sternum, is usually heard.

Chest X-ray shows a characteristically sabot-shaped heart with a blunt elevated

apex, a concave pulmonary bay and clear lung fields without visibly pulsatile vessels, due to poor vascularity. Angiocardiography showing the anatomy of the great vessels is invaluable in planning surgery, which requires the presence of both pulmonary arteries and a systemic vessel in suitable proximity for anastomosis. Cardiac catheterisation demonstrates the increased right ventricular pressure and the decreased pressure in the pulmonary trunk.

These children all deteriorate gradually, so that only one blue baby in two will attain the age of seven and less than one in ten the age of twenty-one. The operative risk has been estimated at about 12 to 16%. Great improvement takes place after operation so that children who had been able to walk only a few steps can play and walk normally; the colour becomes nearly normal, the polycythaemia disappears and the clubbing subsides. The heart enlarges a little, due to the creation of an arterio venous fistula. Not knowing the ultimate prognosis we can only say at present that many of Blalock's early cases are well six years after operation.

Margaret, Age 3.

Had spasms of difficulty in breathing, when she would become blue and often lose consciousness. Prior to admission she had been having between three and seven such attacks daily. She also became dyspnoic walking ten yards on the level. She crawled at ten weeks, walked at fourteen months, and never squatted. At the age of three months she had bronchopneumonia, when the cardiac lesion was discovered.

Margaret was an intelligent lovable child, slightly built, with cold, blue extremities and gross clubbing of her fingers and toes. She became markedly cyanosed on crying.

A systolic thrill was palpable, and a loud, high pitched systolic murmur could be heard maximally over the second and third left interspaces. Her radial and femoral pulses were equal on both sides and her blood pressure was 120/80. Chest X-ray showed a small heart and oligæmic lung fields. The E.C.G. showed right ventricular hypertrophy. Simultaneous filling of the pulmonary artery and the aorta was shown on angiocardiography, demonstrating a large ventricular septal defect, a normal left subclavian artery and adequate pulmonary arteries.

30.1.51. Theatre "C." Left subclavian pulmonary anastomosis by Mr. I. M. Hill. Anaesthesia by Dr. R. A. Bowen. Rectal

pentothal was given in the ward, followed by gas, oxygen and ether in the theatre. 150cc. dextran was given intravenously during the operation.

A left posterolateral thoracotomy was performed through the bed of the fourth rib, and the upper lobe of the lung collapsed and held back with a retractor. The morphology of the pulmonary artery was noted very carefully. The thrill was maximal at valve level, the valve cone was not felt, the artery was of low tension and without poststenotic dilatation.

The pleura was incised over the pulmonary artery and the latter mobilised carefully by blunt dissection. The subclavian artery was similarly mobilised and its terminal branches were ligated. A bulldog clip was applied to the artery proximally, which was then divided through the origin of the vertebral artery, thus giving it a wide mouth. The pulmonary artery was occluded proximally with a Blalock clamp and distally with a bulldog clip and silk sling. The subclavian artery was turned down and an end to side anastomosis performed with the pulmonary artery so that a "T" junction was produced. The arterial suture was performed with 5/0 silk thread on a fine atraumatic needle. A continuous everting suture was used, the stitches being placed 1mm apart, 1mm from the edge of the vessels. Neither arterial wall nor thread was touched with forceps. The anastomosis is the crucial part of the operation, requiring about half an hour to perform. No bleeding occurred when the occluding devices were withdrawn. A good continuous thrill was felt over the site of the anastomosis.

The lung was inflated, a basal water seal drain inserted, and the chest closed in layers with nylon.

Post-operative recovery was uneventful, the patient being nursed for the first two days in an oxygen tent in the routine manner. The patient was discharged 18 days after operation. When seen again four months later she was well, could play and run without dyspnoea, and had had no further unconscious attacks.

Coarctation of the Aorta

In the adult form of coarctation, which is the form amenable to surgery, there is an annular constriction of the aorta at the level of the ligamentum arteriosum, which latter is sometimes patent. The symptoms, signs and pathology result from the hypertension present proximally to the constriction, i.e.,

in the head and neck, and arms. Many young patients are symptom free; some, with a mild degree of coarctation, never develop symptoms. However, the average age of death is about 35 years, so that the condition must be regarded a serious danger to life. Long-term strain on the left side of the heart eventually causes cardiac failure, or the patient may die before this from cerebral hæmorrhage, rupture of the aorta or sub-acute bacterial endocarditis.

The early symptoms are those of hypertension. Examination shows prominent arterial pulsation in the neck and upper limbs in marked contrast to the feeble or absent pulsation of the femoral artery or dorsalis pedis. The blood pressure in the arms is frequently over 200 mms. of mercury. Pulsating vessels may be felt over the chest wall. The heart is often enlarged, and a systolic murmur may be heard over the aortic area.

The X-ray may show notching of the lower borders of some of the ribs due to the pulsating intercostal arteries, an enlarged heart, and an abnormal aortic arch. The constriction is usually seen on angiocardiography, but retrograde aortography may be necessary. It is preferable to visualise the coarctation before deciding on operation, as the constriction may be too long for resection without the use of an aortic graft. The operation consists of resection of the constriction with end-to-end anastomosis of the cut ends of the aorta. Part of the aorta must be mobilised in order to bring the cut ends together. This is most easily accomplished in a young child, so that this is the optimal age for operation. An aortic graft has been successfully used by Gross to bridge the gap in a few cases.

H.C. Aged 14.

The patient was completely asymptomatic. A cardiac murmur was noticed at the age of five and a diagnosis of congenital heart disease made. The patient was subsequently forbidden to play games at school. Examination showed an intelligent, well developed youth. Vigorous pulsation could be seen in the neck and could be felt medial to the scapular margins on the back. The cardiac impulse was thrusting, and the apex beat placed half an inch outside the mid-clavicular line. A loud systolic bruit could be heard over the præcordium. The blood pressure in the right arm was 160/115. The femoral pulses were not palpable.

5.3.51. Operation: Theatre "C." Resec-

tion of coarctation and aortic anastomosis by Mr. I. M. Hill.

Anæsthesia by Dr. R. A. Bowen. Pentothal, gas, oxygen and curare. 4½ pints of blood were given during the operation.

A left posterolateral thoracotomy was performed through the bed of the fourth rib. Large collateral vessels had to be tied in the chest wall. The coarctation, which was easily visible just below the origin of the subclavian artery, was dissected out, and tapes were passed round the proximal and distal ends of the aorta. As the intercostal vessels were being dissected off the chest wall to allow for further mobilisation of the aorta, one of them parted company at its origin. Torrential hæmorrhage occurred before the bleeding points could be controlled, so that although a pressure transfusion through two drips was being carried out, the heart stopped beating momentarily, to be restarted by massage. This incident illustrates well the technical difficulties of such an operation. After ligation and division of the proximal intercostal vessels and the ductus arteriosus the proximal and distal clamps on the aorta were adjusted and the coarctation was resected.

End to end anastomosis was easily carried out with a 3/0 everting mattress suture, after which the distal aortic clamp was released, followed by the very slow release of the proximal clamp. No significant leakage from the anastomosis occurred; the chest was closed in layers in the usual way, after the insertion of a basal intercostal drain.

For the first two post-operative days, due most probably to the cerebral anoxia caused by the sudden severe blood loss, the patient was semicomatose. Thereafter he improved rapidly, so that on his discharge one month later he was perfectly well. The blood pressure fell gradually, and on discharge registered 128/96 mms Hg. in the right arm. The pulses were normally palpable in the lower limbs.

I wish to thank Mr. I. M. Hill for permission to publish these cases, and for very kindly looking through the manuscript and making many helpful suggestions.

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CORRESPONDENCE

CHARTERHOUSE SQUARE
ARCHITECTURE

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

Congratulations to your critics of the New College Hall, Charterhouse Square, but just what *do* they mean by the curious phrase "The most encouraging thing about the new hostel is the ubiquitous acceptance of the forthcoming 'Scandinavian' style of our buildings, furniture, and textile patterns . . ." Surely, the most encouraging thing is not the "ubiquitous acceptance" of anything, but that the College have triumphed over countless difficulties and are at last able to give us a comfortable and convenient place in which to live. Now when this involved sentence is further examined, one cannot do otherwise than conclude that these critics consider the New Building to be in the Scandinavian style, and that this is the coming style in English architecture. This is very far from the truth.

The modern style in architecture has come about as the result of a struggle to find beauty and utility within the opportunities that the architect is given and restrictions imposed on him by needs and materials. Modern architecture verges toward functionalism owing to the new opportunities given by steel, glass and concrete in designing industrial buildings, blocks of flats, government departments, etc. The first building to exploit these possibilities was our own Crystal Palace, designed by Paxton just one hundred years ago. But in Britain we did not see fit to follow his example. It was Behrens and later Walter Gropius, in Germany, who were really the first to take the full advantage of new engineering feats, and Le Corbusier, who tried to put into architectural practice the ideals of his social Utopia. Under the influence of Gropius' *Bauhaus*, which was little more than a newly constituted concern with the same ideas in mind as our own William Morris' circle, the new movement spread to America, France, Switzerland and other European countries and finally reached Scandinavia. Here it was incorporated with the former true Scandinavian style of folk origin, and took root so firmly and so completely that only in these countries does

modern architecture exist without self-consciousness rather than appearing the choice of a sophisticated minority.

In our New Building there are none of the characteristics that one looks for in the Scandinavian style. The materials that have been used are local and typical of London, not of Scandinavia. No use has been made of the processed concrete surfaces employed in Denmark, but impossible in our climate. The pitch of the roof is not characteristic. Wood, which is so freely and effectively used for construction and decoration in Norway is here almost limited to a single stair rail. Though these critics might choose a vase of the Tang dynasty (a particularly dull phase of Chinese art) the architect has made no use of sculpture, as in Finland where it gives a goal and perspective to the corridors; or to break up and give relief to the flat walls of the stairway or the exterior, as seen in Sweden.

So far, then, there is little Scandinavian influence to be seen, so what of the furnishings and textiles? The three successful exhibitions: Malmo, Copenhagen and the culminating one at Stockholm have dubbed all subsequent efforts to return to the simple style of a folk art as being under a Scandinavian influence. Have these critics so soon forgotten the original work of John Ruskin and William Morris? Modesty has its place but our country cannot afford to allow other nations to take the credit due to herself. It is time that we brought out our own lights from under our bushels. The enormous success of the architecture of our Festival has shown the world that we can make the best use of available materials and we have the liveliest of modern architecture. These critics say that the New Building owes no inspiration to the South Bank, yet they themselves admit that they were constantly reminded of the Homes and Gardens Pavilion!

No sir, Scandinavian architecture is not "ubiquitously" accepted neither is it "forthcoming". The New Building is an example, I do not say one of the best—of the new school of British Architecture, of which we have every right to be proud.

I am, sir,
Yours, etc.

JOHN BARLEYCORN.

Abernethian Room.

STUDENTS HALF-PRICE

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

I wish to lodge a strong protest against the attitude which the organisers of many recent art exhibitions adopt towards medical students. "Students half-price" is a notice frequently displayed, but on production of my hospital card I am told that this only applies to Art students. I encountered this reaction at the Picasso exhibition, and later at the Toulouse Lautrec exhibition, both at the New Burlington Galleries, and recently at the Munch exhibition at the Tate. Such notices should be changed to bear out the facts or preferably this privilege should be extended to all students.

Yours, etc.,

LORE FELDBERG.

Abernethian Room.

STUDENT RESPONSIBILITIES

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

Although I am bound to agree with Professor Sir James Paterson Ross that there are innumerable opportunities open to the student, I do not think that the student is encouraged to do as much as he was in Mr. Hadfield's days.

It seems, from talking to my contemporaries, that dressers on the Surgical Unit are encouraged to do more, especially in the theatre and on out-patients, than on any other firm. I, personally, found, as a dresser, that it was difficult to get the nurses to leave the dressings of my own patients for me, even after I had told Sister that I would do them.

My greatest complaint, however, is about the Casualty Department in which I was only able to work for three afternoons and two evenings during my three months' dressing. In that time I managed to put in stitches twice, whilst some students had no opportunity to do it at all.

As far as I can see, the only other time the student has in that department is four mornings during his Surgical Out-patient appointment, which occurs two years before he qualifies.

I do not wish to criticise my own hospital, but I do find that students in some other London hospitals live in and are on duty in the Casualty box for at least a week or a

fortnight. This gives them a longer time in which to become used to the practical details essential for general practice, than we have in our hospital.

Now that the second surgical firm has been abolished (a measure of which I am in favour, as much time is wasted doing surgery when one can often learn more from patients on a medical firm) it does seem essential that the student should have more practical work some time during his training.

Though I feel unqualified to make such statements with only a few months' experience in the hospital and before doing my Surgical Out-patients' appointments, I do think it necessary to express my views while the subject is "being considered."

Yours faithfully,

ANTHEA BLOFELD.

Abernethian Room.

A BAKER STREET
CORRESPONDENCE

The Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

I read the article on Mr. S. Holmes, Dr. J. Watson and Bart.'s with great interest and I am sure it filled a gap in the higher criticism. Although the vital part this hospital played in the lives of these two men was ignored by the Councillors of Marylebone it is remembered by others. At a recent meeting of the Sherlock Holmes Society of London there was present an American who suggested a plaque should be erected either in the Criterion bar or in the chemistry laboratory at Bart.'s to commemorate the fateful introduction of Dr. Watson to Mr. Holmes.

I do not know if any final decision about the site of this plaque has yet been made. Undeniably this hospital has the more substantial claim as the place of the actual meeting. If we still feel pride in these former Bart.'s men we should make every effort to support our claim.

Yours faithfully,

GILLIAN FRANCE.

Abernethian Room.

I am told by the organiser of the Abbey House Exhibition and a leading Sherlockian that a plaque presented by the *Baritsu Chapter of Tokyo* is already marking that fateful meeting in the Criterion Bar.—EDITOR.

WATSON MATTHEWS DUNCAN'S DRESSER?

To the Editor.

St. Bartholomew's Hospital Journal.

Dear Sir,

I was interested in reading the article in the last number on Sherlock Holmes and Dr. Watson at Bart.'s, with some of the suggestions about his early medical career.

I cannot accept the view that Dr. Watson was H.P. to Dr. Samuel Gee. Stamford was a dresser under him, presumably while he was a house officer, and surely this implies that he was a house surgeon, or perhaps on the obstetric side? The fact that he took the M.D. (London) rather than the M.S. might fit in better with the latter, and in the lecture which I gave to your Abernethian Society—now some fifteen years ago—I suggested that he had probably been resident to your great obstetrician Matthews Duncan.

It seems to me important to settle the site of the famous meeting between Watson and Holmes in the old chemical laboratory, and I was especially interested in learning about the private pupils who were taken by Augustus Mattieson, at that time.

Yours sincerely,

MAURICE CAMPBELL.

Guy's Hospital,
London, S.E.1.

WATSON'S WAR WOUNDS

The Editor,

St. Bartholomew's Medical Hospital
Magazine.

Dear Sir,

I was glad to see the pictures I lent you came in useful for the interesting article about Mr. Holmes and the Dr. in your magazine last month. I can't say I understood it all properly but it seemed to me that you were trying to work out whether the Dr. had been wounded in the leg or in the neck. This seems queer to me for the fact is I always understood from my Aunt that the Dr. had been wounded in both places. I often heard Aunt speak about the nasty scar at the root of his neck which she often saw in the mornings when she took up his tea in the night-shirts what gentlemen wore in those days.

About the one in the leg I remember my Aunt being cross with me when a little girl because I asked what made the gentleman walk funny and Aunt told me to hush because the Dr. was a very brave gentleman that had been wounded fighting for the

Queen. Dear, oh dear, what a long time ago it seems now.

Well I hope this will give you a clue, as the saying goes.

Yours respectfully,

ELSIE HUDSON (Miss).

1B, Victoria Mansions,

Willoughby Crescent,

Euston.

To the Editor.

St. Bartholomew's Hospital Journal.

Dear Sir,

The ingenious but rather fantastic article on the career of Dr. Watson, in spite of its elaborate documentation, makes many unreasonable assumptions. There is not the slightest evidence that Watson ever underwent any operation and the assumption that a tenotomy of the tendo Achillis was performed is unjustified.

On the medical side I fear that the writer of the article can never have seen a case of typhoid fever: if he had he would know that patients suffering from that disease would never be put into the Fowler position.

I beg to remain,

Yours rather perturbedly,

ZETA.

Another Medical School.

Watson, you were indeed the perfect friend,
Unquestioning you did as you were told,
And stood your ground to see events unfold,
Not knowing what might be the bitter end;
By you it was that all those tales were
penned,

To Holmes you were well worth your weight
in gold.

Though cast in absolutely different mould
Your genius with his made perfect blend.
Yet both were children of a greater man
On whom for ever rests our benediction,
For from his fine imaginings began
That famous trinity of fact and fiction;

The world of crime together they could foil—
*John Watson, Sherlock Holmes and Conan
Doyle.* ZETA.

Watson himself, it will be remembered, was a great admirer of Petrarch's Sonnets.—Editor.
Does anyone know the whole story?

SNUFFBOX—REWARD for recovery of silver 18th century inscribed "Snuff box of Jenkyn Lloyd of Clockuan, murdered by his doctor."

—From THE TIMES personal column.

"ARSENIC AND OLD LACE"

I contend that an amateur performance is frequently more entertaining than a professional one. Personal performances are remarkable as a rule rather than an exception. When they are only moderate one can admire the actor's valour in coming on at all, but when they are really good amazement gives almost as much pleasure as the excellence of the acting.

In this year's production there was an almost

constantly high standard of personal performance, and only sufficient of the valour for one to appreciate its presence. Especially to be applauded are Miss Carice Ellison and Miss Wendy Cook, who took two long and difficult parts, assuming the mantle of years with commendable assurance. Richard Nainby-Luxmore appeared to thoroughly enjoy, as did all of us, the part of Teddy Brewster, which he played with great confidence, his ocular powers emulating those of Eddie Cantor.

Sheila Dennis as Elaine Harper and Gordon Reed as Mortimer Brewster were, as is most proper on these occasions, charming. Not being character parts, they were both difficult, and I think well played, though I think the producer should have damped down



Mr. Richard Nainby-Luxmore [Masheter]
Miss Wendy Cook Miss Carice Ellison

Mortimer Brewster's earlier enthusiasms to leave him some emotional reserve for the trials to come later. I think a more definite stand could have been taken concerning accents, which ended up as a mixture of American and English. It was good to see that we provided our own producer from Bart.'s this year.

Graham Thompson was most convincingly psychopathic as Johnathan Brewster, Bert is to be congratulated on his formidable appearance and remarkable resemblance to Mr. Karloff, the rest of the make-up continued in his tradition of excellence. Michael Perkins as his partner in crime battled valiantly with the double load of the assumption of villainy and a mid-European accent, only marred by being occasionally difficult to decipher.

Of the smaller parts all were enjoyable. Robert Roxburgh seemed at home in a dog collar. The play as a whole was a delightful affair and a sound choice for the occasion, though I for one would rejoice to see the Society undertake one of the more robust restoration plays, though I admit the difficulties of production are considerable. This will probably be the last play produced by the Society with which John Pittman is associated. After so many years' work for them I am sure the Society will be sorry to see him leave the rank and file to join the hierarchy of the profession.

I think we must congratulate all concerned for providing a most enjoyable evening's entertainment. J. A. L.



[Masheter.]

Miss Carice Ellison Mr. Robert Roxburgh

THE IMPORTANCE OF BEING UNQUALIFIED

By "FORTUNE"

GEORGE BERNARD SHAW took the utmost advantage of being unqualified. His half-knowledge of things medical allowed him to advocate all the unregistrable '-opathies', and even to sample them: a homeopath cured the Shavian hydrocele, with what even Shaw suspected of being sugar in minute doses!

In 1922 he addressed the Abernethian Society¹ on "The Advantages of being Unregistered." While, unfortunately, no complete record exists, there is no doubt that he was well, but by no means seriously, received. It seems to have been a happy affair. A similar talk at St. Mary's was spoiled for Mrs. Shaw by the Chiefs, who puffed away at their cigars throughout his talk. At Bart's we must surely have realised that this was 'bad form,' even if we forgot Shaw's views on smoking. Although this was his best known connection with Bart's, it was not the only one; and is but a drop in the sea when compared with his other medical associations.

In the 1880s Shaw was a great friend of Dr. Kingston Barton, a 'Perpetual Student' of this Medical College. (An honour—we can almost hear Shaw saying it—comparable in its stupidity with the Order of the Bath.) The originals of two poems² addressed to Dr. Barton are in the College Library; they make us wish that Shaw had tried his hand at this kind of thing more often:

'May his profits quicken
His skill find constant use,
May the neighbours sicken
Like the very deuce.'

Later in life he wrote to the Librarian here: "I have no objection to the publication of

this doggerel in the Bart's H.J., though if I were editor I should burn it."

In his medical writings Shaw shows his usual mixture of deep perception and thinly veiled folly, of seriousness and high humour.

Thus we find the strangely perceptive statements: "... he who cuts out your insides receives hundreds of guineas, except when he does it on a poor person for practice", and "Nothing is more dangerous than a poor doctor," in the same volume as this advice to the general public: "Take the utmost care to get well born and well brought up." Oh! that he were alive today to champion the all too poor General Practitioner, so meagrely provided for by the Health Scheme. As long ago as 1917 he foresaw that General Practice was destined to disintegrate into a sorting-house for the specialists; and he pleaded

"Wanted: A State Medical Service," but he did stipulate that it should be a well-paid one. In the Shavian Health Scheme a central authority would fix the figures for the incidence of disease and for mortality; should the figures be exceeded, the Doctors would be penalised. A whimsical idea? ... well, it just depends on whether you believe in payment by results.

Shaw's seemingly fantastic medical opinions are far too prolific for me to more than hint at them here; his letters to the *B.M.J.*, to *The Times*, and to many other papers have all been published⁴ and make not only amusing but highly provocative reading. The reader should not do more than bear his views in mind, he will never get a House job if he takes them to heart! One day—who knows?—Shaw may be



G. B. S. in 1881

regarded as the great prophet of medicine: some of us have even heard a lecturer at Bart's admit that although the Doctors Dilemma angered him much at the time of its publication, its truths had been increasingly brought home to him since!

In 1929 the Dramatic Club of our hospital planned to give performances of *Arms and the Man*, but they failed to get permission. When Shaw heard of this he wrote to the Clerk of the Governors:

"I do not know whether the Governors intend to offer their guests any refreshments, and, if so, whether they are asking the caterers to supply them gratuitously; but if so, they are treating me worse than the caterers because the 2,000 persons, being fed, will be as hungry as ever next day, whereas their appetite for the play may be so satisfied that the next manager who offers them a performance of it on the usual terms will offer it in vain ... next year, please turn your attention to Shakespeare. He is no

longer obliged to live by his work, as the live playwrights are."

Shaw honestly thought that he was getting a raw deal. In his medical writings he showed again and again that he felt the patient to be getting a raw deal. In the case of the play he waived his fees. The interests of the patient he would *not* waive. We should be failing in our duty as a profession if we were to ignore the views of a great and inarticulate section of the laity which found expression in Shaw's writings.

I can only conclude, as Shaw concluded a letter to his publishers in 1887, by wishing the reader the "compliments of the detestable season." Yes, Shaw, not Scrooge.

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¹Abernethian Society Minutes Book. June 8th. 1922.

²St. Bartholomew's Hospital Journal. 1947, p.26.

³Preface to the Doctors Dilemma.

⁴Doctors Delusions.

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RENAL TUMOURS

By MAURICE LUNN.

THE object of this short paper is to place on record an analysis and follow up of the cases of renal tumour which were admitted to this Hospital between the years 1932 and 1950. Those of 1935-50 were included in the large series of 2,314 cases presented to the Annual Meeting of the British Association of Urological Surgeons by Riches, Griffiths and Thackray (1951).

Only histologically proved cases whose notes have been traced are included. This means that patients classified as "Explored" or "No operation" are few in number, as only those in the former group who had a biopsy performed and only those in the latter group who died in hospital and who were examined post-mortem qualify for inclusion.

The total number of cases available is 52. These are classified histologically in Table I. The term adenocarcinoma is used to describe the parenchymal carcinoma in preference to the older term hypernephroma.

Of the 35 adenocarcinomas one is considered to have had a bilateral lesion in that after removal of a large tumour on one side he was found post-mortem to have an

equally large tumour on the other side. It is of interest to note that neither of the two pelvic squamous carcinomas was associated with a stone, although a calculus was pre-

TABLE I

Type of Growth	No. of Cases	%
1. Adenocarcinoma	35	68%
2. Transitional celled Carcinoma of Pelvis	6	
3. Squamous celled Carcinoma of Pelvis	2	
4. Papilloma of Pelvis	2	
5. Adenoma	1	
6. Wilms' Tumour	2	
7. Fibrosarcoma	3	
8. Leiomyosarcoma	1	
		32%
Total	52	

sent with one of the transitional celled carcinomas. The origin of the fibrosarcoma is not known for certain, but as the tumours were involving the kidney they presumably arose from the capsule.

Age. The two patients with a Wilm's tumour were aged 1 and 1½ years. The range of the remaining cases was from 23 to 69 years. The patient aged 23 was suffering from an adenoma. The youngest patient with an adenocarcinoma was aged 28. The incidence of adenocarcinoma rose with age to a maximum in the seventh decade whereas the incidence of the remaining lesions was practically constant in the fifth, sixth and seventh decades.

Sex. There were 36 males and 16 females.

Side Affected. Right 23, left 30. (One bilateral.)

Symptoms. Haematuria, pain and tumour were the main presenting symptoms. A number of cases had only general symptoms and these were usually inoperable patients with widespread metastases. Pain in the groin due to a recent varicocele led to the doctor discovering a mass on one occasion. Haematuria was present in 27 of the 35 adenocarcinomas, in 9 of the 10 pelvic growths, in one Wilm's tumour and in one fibrosarcoma.

I think it important to stress the fact that in a number of patients the making of a correct diagnosis was delayed because of a failure to investigate thoroughly a patient complaining of haematuria, such as attributing the bleeding to the prostate without a pyelogram being performed.

"Pelvic Growths."

Operation Deaths. There were two deaths on the table: one was found post-mortem to have malignant emboli in the pulmonary artery, the other was operated upon with a Haemoglobin of 45% and was not transfused during operation. One patient who had an inoperable lesion died the following day. The patient with a bilateral adenocarcinoma died after 17 days, having had a suprapubic cystostomy performed for repeated clot retention. The fifth patient died after three weeks.

Two patients should not have had a nephrectomy. The first was the case with the bilateral lesion already referred to. The second was a woman of 53 who had pain in the left side and haematuria. Cystoscopy and a pyelogram were normal. She was found to have an enlarged supraclavicular gland which was removed, the histological report stating that it was lymphadenoma. She received Deep X-ray therapy but she was re-admitted six months later with further haematuria. There was a mass in the left side which was thought to be spleen, but on further cystoscopy no dye was excreted from the left ureteric orifice. Left nephrectomy was performed, the kidney containing an undifferentiated carcinoma of renal tubular origin. When this section was compared with that of the gland it was realised that

TABLE II

	Nephrectomy	Exploration	No operation	Total
Adenocarcinoma ...	24 (4)	4 (1)	7	35
Pelvic Growths ...	10* (-)	(-)	—	10
Other Lesions ...	6 (-)	1 (-)	—	7
Total	40 (4)	5 (1)	7	52

The number of post-operative deaths is shown in brackets.

Operative mortality 11%.

* The two cases of papilloma of the pelvis both underwent ureterectomy, one 1 and the other 3 years after nephrectomy.

Treatment and Operative Mortality. Of the 52 cases 40 underwent nephrectomy, there being four post-operative deaths, all cases of adenocarcinoma. Five patients were explored, found inoperable and a biopsy performed. Seven proved cases died with operation.

The operations performed for the various lesions are shown in Table II. Groups 2, 3 and 4 (from Table I) are combined as

the latter was a metastasis of the former. She survived operation by two months.

Results of Nephrectomy. Deep X-ray therapy was given post-operatively to a few patients but the number is too small to allow of satisfactory analysis. In the larger series referred to above post-operative irradiation significantly improved the survival rates.

Of the 52 patients the follow up of 50 is complete. One patient was lost sight of after

discharge from hospital and one was followed for only one and a third years. Neither of these patients has been traced. All patients dead are assumed to have died of recurrence. In many instances only the date of death had been found by Somerset House.

The 3 and 5 year follow up figures for those who underwent nephrectomy are shown in Table III. Operation deaths are included.

TABLE III

	3 year follow up			5 year follow up		
	Cases	Survived	%	Cases	Survived	%
Adenocarcinoma ...	15*	6	(40%)	13	2	(15%)
Pelvic Growths ...	9	5		7	2	
Others	4	1		2	1	
Totals	28	12	(42%)	22	5	(22%)

* Counting ½ each for the cases lost sight of in the first three years.

A survival chart prepared by the life-table method shows that in the first year there is a steep fall to 65% and that after this the fall is more gradual down to 19% at 5 years. The median survival is approximately 2½ years.

It is difficult to compare these figures with other series, but reference can be made to the large series collected by the B.A.U.S. In this there were 1,746 adenocarcinomas. Of those who underwent nephrectomy the survival rates for 1, 3, 5 and 10 years were 80%, 44%, 30% and 17% respectively. For those who had post-operative irradiation the corresponding figures were 86%, 53%, 49% and 27%.

It is of interest to consider the fate of those who were explored but found inoperable. There were five such cases, four with an adenocarcinoma and who lived 6 years,

8 months, 3 months and 1 day, and one with a sarcoma who was lost sight of on discharge from hospital.

The variation in the behaviour of the adenocarcinomas is also of interest. One tumour which was known to have been present for over 16 years weighed 3,380 grams on removal, whereas another patient died of widespread metastases from a tumour only 1.8 cms. in diameter.

Summary

1. Cases of renal tumour between the years 1932-50 are analysed.

2. Of the 52 cases 40 underwent nephrectomy, the three and five year survival rates being respectively 42% and 22% for all cases, and 40% and 15% for the adenocarcinomas.

Acknowledgements. I wish to thank the members of the Medical and Surgical Staff for permission to report their cases, Mr. A. W. Badenoch for his advice on the preparation of this paper, Mr. Curwen for his help in analysing the figures, and Mrs. Perkins of the Follow-up Department for tracing the fate of many patients.

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

EXAMINATION RESULTS

UNIVERSITY OF LONDON
Third (M.B., B.S.) Examination for Medical Degrees

October, 1951

Honours

Evans, E. W. (Distinguished in Obstetrics and Gynaecology)

Pass

Albright, S. W.	Smith, D. P. Q.	McKinna, C.	Haigh, P. G.
Barnes, J.	Weston, P. A. M.	Phillips, G. D.	Johnson, R. J. R.
Chitty, W. A.	Almond, F. A.	Stanley, H. W.	May, A. G.
Gill, R. B.	Briggs, J. H.	Weston, T. E. T.	Pichall, G.
Harman, C. O. D.	Cracknell, D. D.	Bapty, A. A.	Waterhouse, J. P.
Lloyd, E. A. C.	Gobert-Jones, J. A.	Butcher, R. H. G.	Wright, A. N. H.
Morgan, D. I. R.	Jarvis, H. C. M.	Fallows, L. G.	

Part I

Arthur, B. K.	Dodge, J. S.	Lascelles, B. D.	Ross, H. B.
Blau, J. N.	Dreaper, R. E.	Lewis, B.	Rosser, E. M.
Brown, H. E.	Elliott, C. J. R.	Lockett, H. I.	Ryan, J. F.
Bruce, J. D.	Fitt, W. P.	Lodge, A. B.	Stanford, R. M.
Caplan, J.	Frears, R. E.	Lumley, P. W.	Stevensou, K. M.
Cave, J. D. H.	Girling, J. A.	Manuel, J.	Stoke, J. C. J.
Chapman, L.	Gompertz, K. M. H.	Mercer, M. H.	Tarnoky, G. E. M.
Chia, A. K.	Goode, J. H.	Morgan, D. I. G.	Thomas, B. D.
Clappen, J. A.	Grassby, G. C.	Page, A. R. W.	Thomas, H. A. J.
Cochrane, R. C.	Haggitt, R.	Palmer, C. A. I.	Todd, I. N.
Cook, J.	Hall, M. C.	Pickard, A. M.	Train, P.
Cookson, T. S.	Hill, F. A.	Poole, G. H. G.	Watts, M. B.
Davies, G.	Hill, J. J. McL.	Price, M. G.	Wilson, M. S.
Davies, H. T.	Hughes, K. R.	Randall, J.	Winser, M. A.
Davies, P. E.	Jenkins, D. G. W.	Robson, B. E. C.	Winston, F.
Dean, L. C.	Lacey, S. M.	Romanes, J. L.	Woodruff, W. A. A.
Derrington, M. M.	Lamplugh, A. N.		

Part II

Goodspeed, A. H.	Husainee, M. M.	Singer, G. E.	Watson, L. P. E.
Hazelton, S. F.	Paiker, R. B.	Waddy, G. W.	Whittard, B. R.

Part III

Beale, I. R.	Charles, H. P.	Dossetor, A. E.	Shattock, F. M.
Blake, A. S.	Cookson, T. S.	O'Reilly, P. B.	

SOCIETY OF APOTHECARIES

Final Examination

October, 1951

Medicine
Shah, M. C.

STAFF APPOINTMENTS

The following appointments to the Medical Staff have been made with effect from the dates given:—

Department of Anaesthesia

Consultant Anaesthetist ...	Mr. R. I. Ballantine from 1.1.52
Resident Senior Registrar ...	Miss L. Alexander from 1.12.51 (vice I. Matthias)

Gynaecological and Obstetrical Department

Resident Assistant Gynaecologist and Obstetrician ...	Mr. M. P. Durham from 1.1.52 (vice J. J. O'Sullivan)
---	--

Mr. Hume's firm

Junior Registrar ...	Mr. D. Rosedale from 1.1.52
Locum Junior Registrar ...	Mr. R. B. McGrigor from 15.10.51 to 31.12.51 (vice K. Lawrance)

Junior Medical Registrars

Medical Professorial Unit ...	Mr. I. E. McGee from 1.1.52 for one year only (vice R. Marshall)
Dr. Cullinan's firm ...	Mr. R. C. King from 1.1.52 (vice F. G. Campbell)

Diabetic Clinic

Part-time Assistants ...	Dr. H. W. Bunje
	Dr. L. A. Robertson

SPORT

RUGBY CLUB

1st XV v. ALDERSHOT SERVICES. Lost 9-6.
At Chislehurst, October 27th.

Bart.'s were somewhat unlucky to lose a fast open game played in perfect conditions at Chislehurst. Bart.'s attacked right from the start but it soon became evident that the Services' hard-running outsiders assisted by ineffective marking were to prove a real danger, and, in fact, after 10 minutes the Services' centre sold a large dummy to a bemused defence to score an unconverted try, 3-0. Shortly after we suffered a severe loss when scrum-half MacKay went off with an injured ankle. The pack carried on with seven men while Cohen deputised, very effectively, it may be said, at scrum-half. A few minutes later an excellent cross-kick by the Services' wing caught our defence on the wrong foot and sent the other wing over for a further try, 6-0. At this stage, the writing appeared to be on the wall, but Bart.'s rallied magnificently. The pack held its own in the tight and gradually attained ascendancy in the loose, hustling and harrying the Services completely out of their stride; so that at half-time the score was unchanged. It does seem a pity that we seem to need the stimulus of a man short to play really well.

In the second-half Bart.'s really went to town. With loose passing rushes and opportunist movements, they carried out a sustained siege into the enemy camp, both backs and forwards playing really well. Davies, Roche and Corbett each being brought down, literally, within inches of the line. At last a long run by Murphy sent Davies over for a well deserved try (unconverted), 6-3. The pressure was maintained and the score was levelled with an excellent penalty by Jones, 6-6. In the final quarter, Services came back with a terrific attack, but the defence held, only to have a penalty kicked against them in the last few minutes. So the game ended 9-6 to Services.

Nevertheless, if Bart.'s play this sort of Rugby more constructively, and with more cohesion, we should see better results in the future.

Team: J. L. M. Corbet; A. D. M. Thomas, R. D. Bailey, J. K. Murray, D. D. Lammiman; M. J. A. Davies, A. Mackay, A. J. Gray, P. Knipe, F. I. Macadam, J. M. Jones, D. W. Roche, L. Cohen, M. Graham, C. W. H. Havard (Capt.).

BOAT CLUB

UNITED HOSPITALS' REGATTA, 1951

The Annual United Hospital's Rowing Club Regatta was held at Putney on Wednesday, November 7th, and resulted in Bart.'s upholding our claim to be the leading rowing hospital. Our 1st Eight began training in mid-September at Molesey, and, although we lost one of our best oarsmen, Bryan Palmer, to Clare College, Cambridge, we received a very able replacement from Westminster School in J. F. G. Pigott. During October we had three Eights training at Chiswick, the 1st Eight being coached by Mr. H. H. M. Ward of Thames Rowing Club, and the 2nd Eight by N. Whelan. We were stimulated to fanatical efforts by reports leaking through from Putney of a mighty crew of "Blues" and "Trial Caps" assembled by St. Thomas's, and although we progressed favourably, we went down to Putney with

some doubts about our ability to overcome this formidable opposition.

Our fears, however, were ill-founded and after beating the London Hospital comfortably by four lengths, we proceeded to defeat St. Thomas's by three and a half lengths in the final. Our opponents individually were first-class oarsmen, but they were unable to combine as a fast crew in the short time available for training. We are grateful to John Currie for finding the time in his arduous duties as a house surgeon to stroke our crew for the fourth successive year.

Our Senior Four, perhaps, should have won their first race against Westminster Hospital; we were level for most of the course, but in the last 100 yards we became unsteady and allowed them to take the lead. It is doubtful if we should then have beaten Middlesex in the final, as this hospital had a fast four containing three "Blues."

The victories of our junior crews in both Junior events were particularly gratifying as they indicated a better standard of rowing throughout the club than was shown by other hospitals. The high proportion of pre-clinicals taking part is also a good omen for the future. In the Junior Eights our 2nd Eight, admirably stroked by Peter Mann, were given a hard race in the final by the London Hospital, but were better finishers and won by one length. Our 3rd Eight did not disgrace itself either and were close behind St. Thomas's II in their heat. Our Junior Four completed a successful day by beating St. Thomas's in the final of this event.

Announcing **WRIGHT'S COAL TAR**

LIQUID

SURGICAL SOAP

FOR THE SURGERY

Active Constituents: Coal Tar Derivatives & Hexachlorophene

This new WRIGHT'S preparation has been specially produced for pre-operative "scrub-ups" and satisfies the need for quick and certain destruction of infective agents.

Bacteriological tests prove that, under the usual conditions of washing the hands and arms, most pathogenic organisms are completely killed by Wright's Coal Tar Liquid Surgical Soap in less than half-a-minute. The rate of sterilization, using four common organisms of widely different types, is indicated in the accompanying table.

ANALYTICAL REPORT

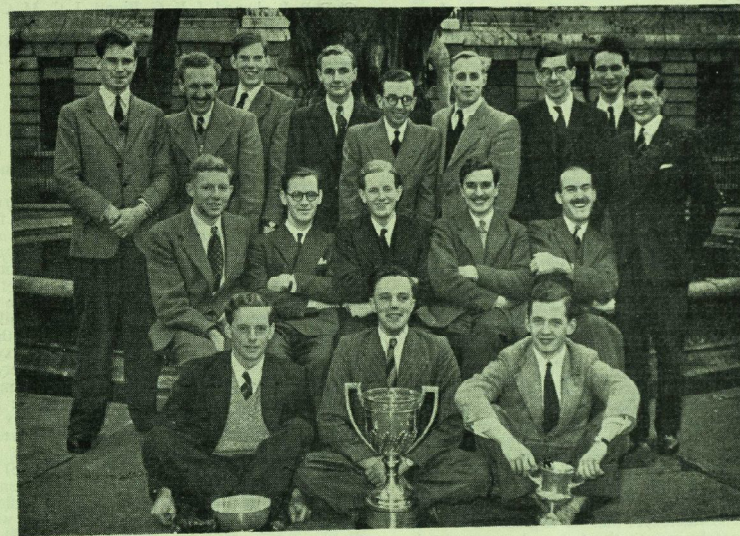
Organism	Type	Time to produce complete sterility at 37° C	
		At a dilution of 1-100	At a dilution of 1-50
Streptococcus haemolytica	Gram positive	less than ½ min.	less than ½ min.
Staphylococcus aureus	Gram positive	less than 1 min.	less than ½ min.
Salmonella typhi	Gram negative	less than ½ min.	less than ½ min.
Proteus vulgaris	Gram negative	more than 2 mins.	less than ½ min.

Hospitals are now using this new WRIGHT'S liquid surgical soap in the operating theatres. It will prove invaluable in the surgery.

Price: 14/- per ½-gallon. Free package and delivery from WRIGHT LAYMAN & UMNEY LTD., 42-50 Southwark St., London, S.E.1

Representative crews were:—
1st Eight J. M. Gray (bow), R. J. Knight, R. G. D. Newill, G. F. B. Birdwood, F. R. Spink,

D. H. Black, J. F. G. Pigott, J. C. M. Currie, R. J. Blow (cox).



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CAR & GENERAL INSURANCE CORPORATION LTD.
83 PALL MALL, LONDON, S.W.1

2nd Eight—B. P. Harrold (bow), P. G. Burton, P. Sleight, I. H. Backhouse, P. J. G. Smart, G. D. Langham, J. D. Salmon, P. E. Mann, F. J. C. Millard (cox)

3rd Eight—I. R. Simpson (bow), C. G. Taylor, W. G. Harris, A. K. Thould, J. Randall, A. H. Luscombe, C. J. W. Hunter, W. P. Fitt, M. A. R.

BOOK REVIEWS

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY, by W. A. Norman Dorland. 22nd edition, 1951. Saunders Co., pp. 1,736. Price.

A good reference book, apart from any other quality, should be a pleasure to use. I consider it an advantage and a commendation that on looking up one word you come away having read up twenty others, and forgotten the one you wanted. Such success is achieved by the Oxford Companion to Literature and Music, Chamber's and Webster's but not "Dorland's." From this point of view this dictionary does not rank amongst their company, and not from an inherent lack of interest in its subject matter but because of the dull and staid treatment of promising material. A preface in one of the previous editions explains that through shortage of space the illustrations have had to be cut down, as has some of the material; this, together with the fact that this is a dictionary not an encyclopedia, is the probable explanation. But surely in a work of this kind it is the approach of the encyclopedia with its fuller interest, illustrations and references that we require. However, this cannot be put to the test as however much its need, we have no medical encyclopedia of this type. "Dorland's Dictionary" owes its enormous popularity because it is one of the few enterprises of this kind; it may be more the lack of competition than the qualities of usefulness and accuracy that have earned it the prominent position it now occupies!

"Dorland's" is an unmistakable American production. The binding is more slick than serviceable. The preface is obscured by "blurb" about "motivation of existence," "complete coverage" and "semicentennial" celebrations. The impressive list of contributors is very American, as is the text, e.g., "*esophagus*, see *esophagus*." I looked up toothless, half-hoping to find "edentulous uncompensated." The biographical entries are so brief as to be valueless, the selection seems strange and biased. Harvey is casually mentioned under the adjectival *harveian* (with a small h). Pott is dismissed with a terseness characteristic of himself, and of St. Vitus I could discover no mention.

The Editor has applied the principle—the more obscure the word the greater its call for inclusion—with vigour. With the rapidly growing medical vocabulary, and his wish to keep the dictionary in its present handy form, he is left with only two courses of action, either fewer or shorter entries. He has chosen, wrongly I think, the latter. Wrongly, when so much can be done about the former. Let me make this clear. As long as room can be found for entries such as *strainer*, an *apparatus for straining*, and *static*, not *dynamic*, there is no excuse for the extreme brevity in other entries. Bearing in mind that the type of person who is to use this book has had an extensive education and should possess an English

Manhire (cox).

Senior Four—R. G. D. Newill (bow, steers), G. F. B. Birdwood, J. F. G. Pigott, J. C. M. Currie (stroke).

Junior Four—P. J. G. Smart (bow), G. D. Langham, J. D. Salmon, P. E. Mann, F. J. C. Millard (cox).

dictionary to look up such words, many of these non-technical words (which, like the medical ones, are often inadequately defined and discussed) could be omitted. The selectors seem to have fared better amongst botanical and veterinary terms, which are adequately covered. In the fuller discussion of words, I should like to suggest some indications on the use of words: *Megaloscope*, a large magnifying lens, is an entry of no particular merit, and calculated to encourage the use of this cumbersome word. How much more useful to suggest as an alternative—magnifying glass. Similarly, no indication is made under acidophil that this is a hybrid word and undesirable, and that oxyphil should be used. This brings me on to the etymologists and consultant classicists, mentioned on one of the fly-leaves, who do not seem to have been looking to their jobs. The derivation of calyx and calyx is confused, in fact, both are alleged to be identical and referred to under calyx. Calix—icis, m. a cup or goblet (hence the English chalice) (thus calic, plural calices, describes the subdivisions of the renal pelvis. Calyx—vcis, a whorl or flower bud, thus calyx, plural calyces, describes the whorl of the flower. Why no mention of the Medusa's Head? *Lesbianism*, *homosexuality between women*, seems a bizarre contradiction. To read from Intra-abdominal to Intravesical (five columns) is about as absorbing as a column of the S-Z telephone directory.

When a twenty-third edition of this remarkably popular book is issued, may I suggest: a stouter binding, the complete omission of the preface of publisher's "blurb," and the removal of the "Essay on the Fundamentals of Medical Etymology" which seemed to me to be not a "good foundation for the comprehension of the derivation and meaning of medical terms" but a cumbersome bore. Remove totally the Index to plates and tables, which are to be found more quickly by searching directly than by the cross reference. Then perhaps we may have room enough for fuller biographical entries, some of the old plates, references for further reading, and space to cope with the increasing hordes of words.

"Dorland's Dictionary" is a book that you want to buy the same day that you decide to be a doctor; it is a book you will use as a student, and least when you think you can most afford a copy. Congratulations on its "semicentennial." It is just reaching maturity; long may it continue. It is exceedingly reasonable in price (it may be mentioned here that Saunders have not raised their prices since the devaluation of the pound, despite the unfavourable exchange). It is on the whole accurate, though it is beginning to suffer from a natural complacency springing from a lack of competition. I may have seemed to deal a little harshly with this dictionary, but no words of mine could shake its enormous sale. At any rate, it is large enough not to mind, and I am too small for it to pay any attention.

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

Vol LVI

FEBRUARY, 1952

No. 2

UNDER THE STETHOSCOPE

We are familiar with our hospital; we know where everything is, which corridor will take us where we want to go, and what time we should arrive. We recognise the faces we pass—the doctors, the nurses, and our fellow-students. We are used to the patients, and no longer embarrassed by them. In short, we are "at home."

Remember your first few days here? You did not know the way around then, you did not recognise any of the faces, you did not feel "at home" at all. You probably did not enjoy Bart.'s then as much as you do now. When you first arrived you had to ask the way of the porter at the gate.

But consider the patient; he feels like you did when *you* first arrived, but instead of being young and fit like you were, he is *ill*. Everything is strange and new to him, he does not know where to go in—so he has to pluck up courage to ask the porter—; then when he gets inside he is asked for his doctor's letter (which he had forgotten all about), he finds it at last and is given a lot of papers and told to go and "sit over there." He feels lost, he has never been in a place like this before. He is worried, he knows there must be something seriously wrong with him or his doctor would not have sent him to the hospital. He is far less "at home" than you were, and although it may be without reason, perhaps he does not like Bart.'s too well on that first visit. To the

doctor this man is but a fraction of the day's work, and just like any other patient on any other day. Not so for the patient, it is a big and worrying day for him and may be one that will affect the whole of the rest of his life. A good nurse understands this, and every doctor and student knows it; but we are often too preoccupied with other things to be *altogether* thoughtful for the patient. On other pages we print two articles by doctors which bring out these points.

It is inevitable that some patients should be "taught on" before a large class of students. This would be an ordeal for a normal healthy person, but the embarrassment that it brings to a sick and worried one may be very great. It is up to us to help these patients; to explain to them that their presence *is* necessary (not only for our benefit as students, but for our future patients' sakes), to keep them warm, to apologise in advance if we have to keep them waiting, to give them the paper to read. Such small actions as these will be remembered with gratitude.

The smallest effort on our part can help our patients much more than we might think. We can always spare the time to stop and tell a lost looking old lady the way. We can so easily smile when we say "good morning." We must always apologise when we hurt a patient, however necessary it may be in diagnosis. A "please" here and there will

make all the difference to a worried patient, even if we do think he is neurotic. The reputation of a great hospital stands or falls not by its treatment so much as by its kindness to the patients. Most Londoners are too preoccupied with their indignation to be bothered with "good manners," but good

manners are a first essential of good medicine, and Bart.'s has a great and good reputation for its manners. Mr. Reginald Vick has said "I have never known a patient unkindly treated at Bart.'s."

We hope that it may never be otherwise.

Eighty-one

The Journal sends congratulations to Lord Horder, who celebrated his eighty-first birthday last month.

He was entertained to a dinner at the R.A.C. by his former House Physicians, to mark the occasion. Let us hope that Lord Horder's continued good health will allow this annual event to take place for many years to come.

New Year Honours

Professor R. A. Peters, F.R.S., who is Whitley Professor of Biochemistry at Oxford, and an old Bart.'s man, has been knighted. The Journal sends its congratulations.

Obituaries

Notices appear in this issue of two noteworthy former Bart.'s men, who have recently died. Lord Addison was too well-known to need an indication here. On the other hand not many at Bart.'s will have known of a fine old man, Dr. Square, who carried on in his General Practice until he was 91. A record which few indeed can hope to copy! We print a picture of Dr. Square on another page.

Journal Appointments

Adrian Griffith, who has been Editor of the Journal for the past six months, has resigned. George Birdwood has been elected Editor in his place, and I. H. Backhouse is now Assistant Editor.

R. J. Blow has been elected Assistant Manager, and F. J. C. Millard is the new Charterhouse Representative.

Sister Smithfield

Sister Smithfield, Miss M. Pridham left on January 5 to marry Dr. G. C. R. Morris, formerly house physician to Dr. Bourne and to the Skin Department.

Miss Pridham entered St. Bartholomew's Hospital on December 12, 1940, and finished her training in October, 1945. She subsequently held the appointments of district midwife at Lloyd Square, charge nurse and night sister. On September 25, 1949, she was appointed Sister Smithfield and has worked there ever since. All their friends on the medical and nursing staffs will wish her and Dr. Morris every happiness.

Students' Union Annual Ball

The Student's Union Ball was held at the Dorchester Ball Room on January 25. A full account will appear in the March issue, but meanwhile we should like to congratulate the organisers on a successful evening.

Rugger Ball

The Rugby Club are to hold their Annual Ball, as they did last year, at the Victoria Halls. Monday, February 18 is the date, and the time 8 p.m. to 1 a.m. Tickets can be got from the Secretary of the Rugby Club.

The Journal

Contributions for the Journal should reach the Editor by the first of the month for inclusion in the issue for the following month.

Subway

At Charterhouse Square a fine new tunnel is being built beneath the green, running from the New College Hall. The exact purpose of the tunnel is something of a mystery, although it will presumably keep the students dry on rainy days. Meanwhile the patients continue to travel to "X-ray" from the Wards in wheel-chaired bliss, covered with a rubber sheet when it rains or snows. *Planning*, with a capital "P," seems to be abroad again. Had a vote been taken at Charterhouse, it would surely have been unanimous for presenting the tunnel wholesale to the Hospital, to put the patients under cover. No doubt the cause of all this lies with some Ministry or other, and it would need A.P.H. to find out which!

Staff Photographs

The Library has recently been very fortunate to be presented with a book of 48 photographs of the Hospital Staff at the beginning of this century. Dr. G. S. Haynes, whose book this was, will have earned the gratitude of many old Bart.'s men, who can now admire again their former chiefs (or themselves!) besporting round the fountain.

Marriage

On January 12, at St. Nicholas' Church, Broadway, Dr. G. C. R. Morris, lately House Physician, and Miss M. R. Pridham (Sister Smithfield).

Worthy of Mark Twain

On a tombstone under the organ of Martham Church, Norfolk, is the following inscription, of considerable medical interest:—

"Here lyeth
The body of Christ BURRAWAY who
departed this life ye 18th day
of October Anno Domini 1730.
Aged 59 years.
And their lies Alice, who by her life,
Was my sister, my mistress
My mother and my wife
Dyed Feb. ye 12th 1727
aged 76 years."

Can anyone think of an innocent explanation?

Matron's Ball

This popular event, provided each year by the generosity of the Lord Mayor, was held in the Great Room of Grosvenor House on Wednesday, January 2. Many of the guests found the Ball even more enjoyable than in previous years.

Sidney Lipton's Band played music for dancing, and had added to their repertoire many of the hit tunes from the Ward shows. Two interesting sidelights on the preferences of the nurses were apparent at the Ball; one was the fact that cups of tea were served with the buffet supper, and the other, as reported by an evening paper, was that while several physicians came, there was a complete absence of their surgical colleagues.

SO TO SPEAK . . .

Decreased Frequency

Micturition: "The patient has his scrotum tapped every six weeks."
—heard in S.O.P.

A Positive Sign?

Tattooed on the abdomen of an old man who had suffered many laparotomies:
"Don't operate, I've got Tabes."

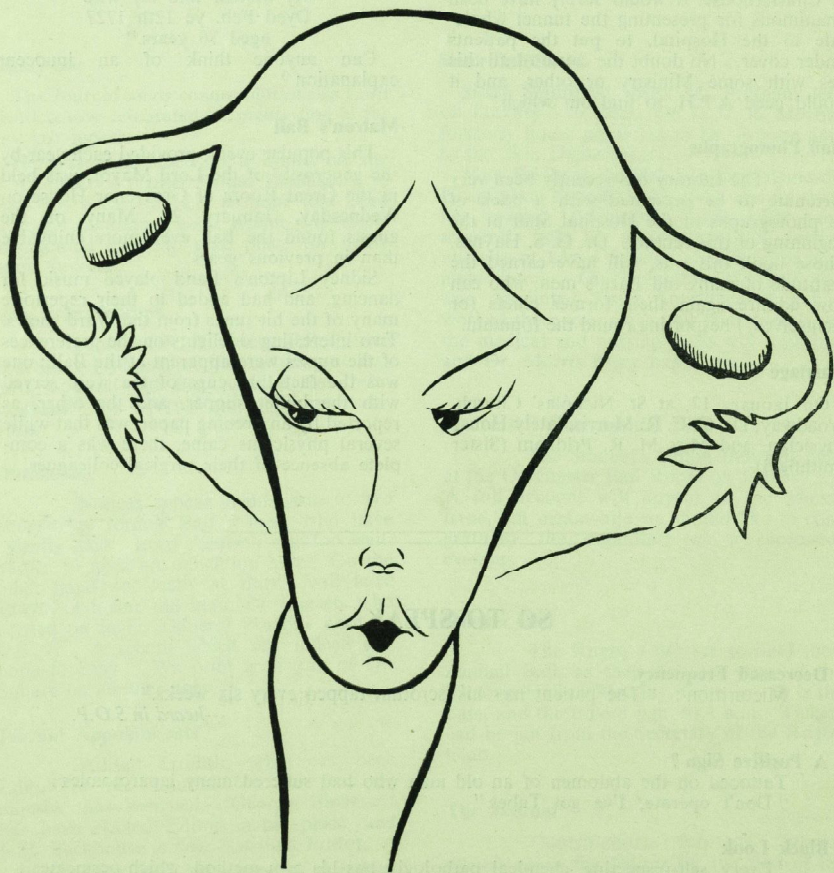
Black Look

"Every self-respecting chemical pathologist has his own method, which permeates him to posteriority."
—a lecturer.

Mr. John O'Sullivan

It is now four years since the Irish bombshell, John O'Sullivan, hit the Royal and Ancient. In those four years he has endeared himself to all, and in his time of residence in Surgery House has brought many of us into the obstetrical world without mishap, apart from infecting us with his characteristic enthusiasm.

It is with no inconsiderable regret that we have to record his departure to a higher plane, for our resident physician accoucheur has achieved consultant status and is leaving us for the distant regions of Bethnal Green and Harley Street. We offer him our hearty congratulations and also congratulate Clare, his wife, on the birth of their second son, Barnaby William.



"There's just no one to take me out now you're away."

"WORM'S EYE VIEW"

HOW THE PATIENT SEES LIFE IN HOSPITAL

by MALCOLM DONALDSON

LET me say at once, that on those occasions on which I have been in hospital or a nursing home as a patient, I have always received every possible attention; but those hospitals are among the most famous in the world, and perhaps I was in a rather privileged position. Even under these very favourable circumstances there are certain small points, about which the medical staff are too busy to worry, and the nursing staff are not in a position to alter.

It has long been my intention to form an association of "Doctor Patients" who would meet, and over a glass of port, discuss all those small unnecessary annoyances which a patient has to suffer in a hospital.

The strong and healthy consultant, as he goes round the ward, will have scant sympathy for anything that is written here, and the students, bursting with health and longing for the moment when they can down tools and take some open-air exercise, will have still less.

If, by any chance, such people see this article, they will probably say: "What is the blighter grouching about? We cured him, and under the new Act he gets it all for nothing." Very true, and most patients are profoundly grateful, but to quote my old nurse when spiteful words poured from the mouth of any one of her charges, "Is it necessary? Is it kind?"—and I repeat the same about these little annoyances. The mentality of a patient who is feeling ill in a medical ward, or who "has been made ill after entering a surgical ward" is very different from that of these healthy people, and however unselfish in ordinary life, he or she becomes self-centred to a very high degree after lying in bed day after day with nothing to occupy the mind.

At what point, then, should the Association of "D.P.s" start to discuss its tale of woe? The mattress is perhaps a good foundation on which to start our investigation into the underlying troubles. Let me be quite frank; to some extent I brought this mattress difficulty on myself because, many years ago, after some calculations involving higher mathematics, I realised that

at least one third of my life would be spent in bed, and invested an amount of capital in a mattress which seemed commensurate with that period of years. Discounting all this, however, the fact remains that the average hospital bed is JUST TERRIBLE. Somebody may remark that it is no worse than that found in the average "three-star" hotel in this country, which is the only sort at which most people can afford to stay. It is also true that the hardy Britisher seems to take a pride (when he is well) in lying on a hard mattress, in the same way that a Fakir delights in lying on nails with the business ends uppermost. But this is not the way to woo Morpheus to a patient who is feeling ill.

This brings us to the second point: "Sleep, perchance to dream"—but there is no perchance about it in a hospital bed, which is conducive to every sort of nightmare.

Sleep, the most important part of any treatment (and by sleep is meant natural sleep, which is quite different from that induced by drugs) is a terrible problem in any hospital, and the ideal conditions are practically impossible to attain. In a ward of many beds some of the patients must be attended to during the night, and possibly emergencies admitted. There is little doubt that hospitals in the future will be built with only small wards, although many arguments have been used against such construction. In spite of all this, much can be done to lessen noise, and I well remember how unpopular I became with the nursing staff when I succeeded in getting a sub-committee of the Medical Council appointed to go into the matter. My unpopularity was even greater during the first German war when I succeeded in getting the Colonel of a Casualty Clearing Station to make a rule that nobody should be washed except for therapeutic reasons before 6 a.m. Until then it was a law of the Medes and Persians that every patient must be washed before the "day staff" came on duty, with the result that if a large convoy of sick and wounded came in late, the lights were turned on at

2 a.m. and the ablutions started. When it was suggested that dirt on a normal skin never killed anybody, but that want of sleep for an ill man might, the reply was that the very sick and severely wounded were allowed to go on sleeping. What a hope! when the lightly wounded, finding themselves comparatively safe in a C.C.S., began to talk and sing like birds on a spring morning. However, the rule was passed and the nursing staff refused to speak to me for two or three weeks. "Was it necessary? Was it kind?"

Let us now pass as discreetly as possible to the "function of nature." If anybody sat down to think out the best way of unsettling the regular routine of such functions, he could not have done better than design the present receptacles provided in hospital. The healthy will say "What rot! It has been the same since the days of Rahere" and "patients get used to it." Perhaps they do if they remain in hospital many months, but "Is it necessary? Is it kind?" Firmness and depth are attributes of good character and many other things, but not least should they be applied to the above-unnamed receptacle. Such a design is simple enough and I will send a drawing free of charge to anybody who will have a prototype made.

Fortunately this daily agony has been reduced to some extent by the growing practice of allowing patients to get out of bed at an early stage in their convalescence.

The next point is post-operative movements in bed, or indeed, any type of movement in bed. Everybody will agree that such movement is beneficial except for a very few cases, then why does not every hospital provide every bed with a chain and crossbar? It is a great relief to ease the body off the mountain range running irregularly down the inside of the mattress. Is it not necessary? Is it not kind?

Finally, we come to what should perhaps be called the "Psychological Approach to the Patient." To my shame be it said I know no psychology: it is a science that has been developed since I was a student, so I prefer to head this paragraph: "Commonsense Methods of Dealing with Patients."

Let me illustrate what I want to discuss by recalling an incident that happened a few days after my arrival at my first boarding school. One night the bed occupied by the boy next to me was empty, not even a pillow (which made it look even emptier), so I summoned up courage to ask Matron what

had happened to little Tommy. The answer was, "That's nothing to do with you. Mind your own business." For several nights I found it very difficult to sleep and even shed a silent tear, not because of the mattress (such things did not worry me in those days) but because I pictured little Tommy lying in his coffin. Imagine the relief and joy when little Tommy reappeared, not from the grave but from the Sanatorium. "Was the Matron's answer necessary? Was it kind?"

There are countless patients who lie in bed worrying themselves quite unnecessarily trying to piece together scraps of information they have overheard. This has even happened to some of my medical friends, though fortunately not to me as my colleagues have always shown me everything. Indeed, I doubt if it happens to any patients in Bart's.

I fully realise that it is want of time that prevents the M.O., surrounded as he is by students and a retinue of nurses, from remedying this very real evil, but the result is that many patients have complained "They would not tell me anything in hospital."

The ideal patient is, of course, one who thinks of his doctor as a "High Priest" and does not want to know anything about the mysteries of his own disease. But the High Priest business has been a bit blown on with the spread of literacy, and many patients are more intelligent than they appear at first sight, and are not congenital idiots. This is particularly true among the "new poor" who find themselves in hospital. We cannot put back the clock so what can be done about it? The answer is simple, provided there is sufficient time, namely, to encourage questions and to answer them in lay language. The latter is easy and it is seldom necessary to depart from the truth.

When my new Association meets, our memories will not, however, be occupied only by the little inconveniences mentioned in this article, but will once more recall that infinite kindness we have received from our colleagues. Perhaps even more vivid will be our memories of the touching care and superb nursing of those women who, however tired they may be, never lose their tempers or show their resentment when we grouse. Perhaps some of us will ask ourselves: cannot we invent some labour-saving gadgets to help these angelic women, and to save their weary feet? By the way: do angels have feet?

LOOKING BACK

by O. DEMA

I SUPPOSE I am one of the few people who know what it is like both to be a doctor and a patient. I think the best thing to do is first of all to make my own position clear.

I graduated in medicine at Edinburgh University when I was twenty-three years old. I am now fifty-one and the bulk of my medical life has been spent in General Practice. General Practice, I may say, of all types—country and town—poor and well-to-do—industrial and suburban, so I have had a fairly extensive experience of a cross-section of the people. Some years ago I began to develop symptoms of unsteadiness in my gait which progressed rather rapidly so that about four years ago I had to give up work altogether.

Now I realise that you know possibly more than I do about the disease I am suffering from—Disseminated Sclerosis. But for the sake of those who don't, let me say a few words about it.

It is a curious disease. It is very crippling but the patient seldom dies from it directly. It is characterised by many periods of so-called remission, when the patient may lose some or all of his symptoms and apparently be cured. And finally, it presents many different forms, ranging from total blindness to a slight abnormality in walking, but whatever the feature which is presented the condition is generally slowly and steadily progressive so that ultimately the patient is bedridden and unable to do anything whatever for himself.

I have said that I have had this trouble for the past five years and it will be best if I give you some idea of what I am like at present. Incidentally, I have never had a remission and the disease has progressed more or less steadily.

No one would know that anything was the matter with me when I am sitting still and keeping my mouth shut, but the moment I try to get on my feet I tend to fall forward on my face. I am markedly ataxic and cannot get about unless I hold on to somebody or something. My heat regulating mechanism does the most extraordinary things so that my body may be burning hot while my hands are icy cold. I have also to be extremely careful when

taking a bath that I do not scald myself. On the other hand, I used to get a lot of undeserved kudos for bathing in the cold weather in the days when I could get about alone.

There are many other minor afflictions, amongst which the impairment of my speech and writing are prominent. I find that I have a loss of emotional control, which shows itself in some people by weeping immoderately. Luckily I do not go in for weeping but I find myself laughing unrestrainedly—a symptom which sometimes lands me in the gravest difficulties. I would also stress the fact that I get abnormally tired on slight exertion.

Lastly I have a condition which I am not sure is due to Disseminated Sclerosis at all. It is a postural hypotension and in certain positions—especially when standing—I go rapidly and invariably unconscious. This happens frequently as sometimes it is impossible to avoid the upright position. I would stress that the condition is definitely not *petit mal* and is easily put right by someone lifting one's feet in the air. On the other hand, I have been "out" as long as twenty minutes owing to my not being near anyone who knew what to do.

That is all on the debit side. What is there to put on the credit side? I eat well. I sleep well. I am not gaga (at least I do not think so). My sight is not affected and my upper limbs are in good running repair, except for fine movements.

Now this article is not meant to be a lecture on Disseminated Sclerosis. Nor is it meant to describe the joys and sorrows of that complaint. I am saying this so as to make it clear how I am affected at present and what stage the disease has reached in me. What I am setting out to do is to pass on to you some of the lessons I have learned from both ends of the stethoscope.

I think the first thing I learned after becoming a patient was at the very beginning of my illness. I had that unpleasant operation performed whereby one's ventricles are blown up with air and then X-rayed. The doctors who were looking after me thought I had got a cerebral tumour (which turned out subsequently to be a mistake). At the

operation the films were developed rapidly so that they might have a preliminary look-see. I distinctly heard one doctor say to the other "Look, there it is—just there." I must admit that the effect was rather shattering to me for no one likes to be told that he has a cerebral tumour. There should be a moral to this, but the only one I can think of is to be extra careful that your voice does not carry when the patient is in a nearby room.

Some time later I had occasion to have the same operation performed through a trephine in my skull. As every medical man knows, the operation is done under a local anaesthetic. I asked the surgeon who was doing the operation when I might expect something painful. To my astonishment he kept up a running commentary on the operation, detailing each step in advance and leaving nothing to the imagination if he did not do it absolutely correctly. The motto from this is obvious—even if you have a doctor for a patient, remember that he is basically a stricken and a frightened man—especially when he is horizontal on the operating table.

When my doctor is phoned up with the request for a visit nowadays, it is generally because I want something. He almost always gives me what I want and bucks me up as well. You see, I am not one of these people who have a bottle of medicine carefully hidden in the sideboard. When I think of the gallons and gallons of medicine I have prescribed and dispensed throughout my life, I am appalled. I do not think I have ever wholeheartedly believed in their efficacy. I remember being almost struck dumb the first day of my *materia medica* lectures at Edinburgh. I think there were about a hundred lectures of about an hour each. I have never forgotten the words of the Professor at that opening lecture. "Gentlemen, I am going to tell you about many drugs but there are only about half a dozen I can vouch for."

I gathered such an attitude is not confined to my day, as a young relative of mine, who is a medical man, invariably tries out on the dog those little samples of tonics which we all get from time to time. The dog, I am glad to say, is still vertical and as frisky as ever. Now why I mention this is because I am more and more convinced that the main effect of a doctor's visit is psychological. It is the effect of one personality on another. Do not take this to mean that all prescribing

is bunkum. The ordinary layman needs some "outward and visible sign" to hang on to and, whether we like it or not, it is at present represented by a bottle. This however, does not destroy my contention that the main effect of a doctor's visit is psychological.

One other thing the doctor must always remember is the effect of his visit on the relatives. A mother sends for the doctor because her child is covered with spots. She does not know whether it is chicken pox, measles or something entirely different. Let us imagine it is measles the child is suffering from. The doctor quite correctly says he will come back in a couple of days. Why? He cannot cure measles or alter its course, but he can say if the child is developing pneumonia or not. It is a tremendous relief to the mother.

I wonder if the average doctor realises just how much the ordinary man in the street looks up to him and respects him. He does, you know. Not only are his pronouncements in the field of medicine accepted as the last word on the subject, but his opinion on many outside things is received with respect. I wonder if the average young doctor realises what an important position he holds in the community. He can be respected and admired or dismissed with a shrug of the shoulders. The people are waiting all agog to see how he turns out.

There is one other thing that I want to say. Every patient wants to speak. He, and particularly she, wants to tell the story of their symptoms. If you are a wise man and have the time at your disposal it is not only useful to you but good to let the patient overflow like a newly opened champagne bottle, and when you are listening—or appearing to listen—don't prejudge the case. Let us imagine it is rheumatism—do not let yourself get into the state of mentally saying "aspirin, codein or sodium salicylate." I call that the aspirin-minded state and, believe me, it is very easy to fall into.

What would I do differently if I had my own life to live over again? I would try and be a real friend to everyone. Remember that everyone one sees in trouble and everyone who sits in that chair has come to you for help. And I do not think I would be so keen on chasing the almighty dollar. I remember an Irish doctor of my acquaintance saying of a man whom I knew had a large practice, "You know, Doctor X has never seen a patient in his life." "Go on," I re-

plied, "he's seen thousands." "You're wrong," replied the Irishman, "he's only seen five shillings sitting on the chair in front of him." After all, none of us will make a lot of money off medicine. We make enough to keep ourselves from want, and possibly our dependents, but it is highly improbable that medicine will make us really wealthy. After all, our real monument is not a few lines in the obituary notices of the B.M.J. or a short notice in the "Telegraph" or even the few thousands which some inquisitive

spinster will see in the papers. Rather a real and lasting memorial is in the memories and affections of the people we have attended. I am not advocating the type of doctor who pats the children on the head and their mothers on the back and who utters platitudes out of a vacuum of intelligence and knowledge. Be good at your job. Be thorough and painstaking, but go that extra bit further which people look for. So often we repulse them with a stone when they come looking for a piece of bread.

A CASE OF SPONTANEOUS ATLANTO-AXIAL DISLOCATION

By R. S. HENDERSON

A LITTLE girl aged eleven was putting her dress over her head when she felt a sudden pain and developed a wry neck. Her general health was good at the time. Radiographs at her local hospital and examination under anaesthesia did not lead to a diagnosis of cervical dislocation, though this was suspected. Her pain disappeared in a few days, but the deformity persisted. In the months that followed, she was given energetic courses of remedial exercises and neck stretching, without any obvious improvement. At one stage she received treatment from a psychiatrist.

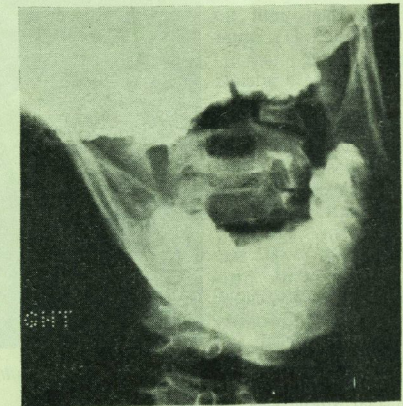
After ten months she was seen in the Orthopaedic Department at St. Bartholomew's Hospital under the care of Mr. W. D. Coltart. Tomograms confirmed beyond doubt an atlanto-axial dislocation on the right side only. Views taken at 6 cms. and 7 cms. respectively from the back of the head, showed the forward displacement of the right lateral mass of the atlas, the atlanto-occipital joints being symmetrical.

Comment

Watson-Jones and Roberts (1934) recorded twenty-one cases of spontaneous atlanto-axial displacement all associated with some local infection, ranging from cervical adenitis to mastoiditis and the common cold. They held the view that infection caused hyperaemic decalcification of the axis and consequent loosening of its transverse ligament. This child remembered nothing that would suggest local infection.

Bone-grafting operations for the upper cervical spine as described by Cone and Turner (1937) are occasionally performed in cases of fracture dislocation, treated early by closed reduction, if recurrence is likely.

Clearly the major procedure of very late open reduction, as a preliminary to bone grafting, was not justified in this case, where the problem was mainly cosmetic. Considerable improvement did in fact take place with prolonged head traction, and both the patient herself and her parents decided they did not wish any more drastic treatment.



My thanks are due to Mr. W. D. Coltart for permission to publish this case and to Dr. G. Du Boulay for his help with the radiographic findings.

References

- CONE, W. AND TURNER, W. G. (1937). *Journal of Bone and Joint Surgery*, **XIX**, 584.
 WATSON-JONES, R. AND ROBERTS, R. (1934). *British Journal of Surgery*, **XXI**, 476.
 * A case shown in May, 1951 to the Orthopaedic Section of the Royal Society of Medicine.

OBITUARIES

LORD ADDISON

WE record with deep regret the death, on December 11 last, of Lord Addison at the age of 82. Few men distinguished themselves in one profession: Lord Addison was eminent in two—anatomy and politics.

He was born on a Lincolnshire farm in 1869 and was educated at Trinity College, Harrogate, and then as a medical student at Bart.'s, qualifying in 1891. He was a demonstrator in anatomy here and was then appointed professor of anatomy at Sheffield at the early age of 25. From then until he was 41 he was a figure of growing importance in the academic world of anatomy, returning to London in 1901 where he held posts at Charing Cross Hospital and Bart.'s and was Hunterian Professor at the R.C.S. He was Secretary of the Anatomical Society, editor of the Quarterly Medical Journal and a frequent contributor to many more. His

special study was the relative position of the abdominal viscera and the older surgeons still know the transpyloric plane as Addison's line.

In 1910 he entered Parliament as a Liberal and soon showed his ability by helping Lloyd George pilot the National Insurance Acts through the Commons. During the first World War he succeeded Lloyd George at the Ministry of Munitions in 1916 and was later Minister of Reconstruction. In 1919 he was appointed the first Minister of Health

and his tenure of office was characterised by its emphasis upon preventive medicine and educating the public in health matters. However his treatment of the housing problem was not generally acceptable and he resigned his office. In 1929 he was back in the

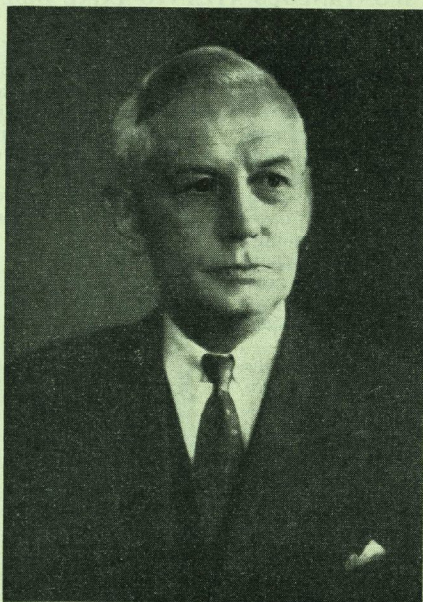
Commons as a Labour member and was Ramsay MacDonald's Minister of Agriculture in 1930. In 1937 he entered the House of Lords with a barony.

In 1945 he began the most important stage of his life's work. He was in succession Secretary of State for the Dominions, and then for Commonwealth Relations, Lord Privy Seal and Lord President of the Council. As Leader of the House of Lords he achieved great success. Under his firm and tolerant guidance many controversial problems were discussed with a freedom from acrimony which was a standing example to the Lower

House. He was made a Knight of the Garter in 1946. On December 17, during Evensong at St. George's Chapel, Windsor, the banner of Lord Addison, as a Knight of the Garter, was presented at the high altar.

His services to medicine were emphasised in the year of his death by his election, by a special bye-law, to the Fellowship of the Royal College of Physicians.

We offer our deepest sympathy to his wife and to his children.



Viscount Addison Vandyck

Dr. MERVYN GORDON writes—

Christopher, Viscount Addison of Stalingsborough, Knight of the most noble Order of the Garter, was the greatest and most successful medical statesman that this country has hitherto produced. As Leader of the House of Lords, Lord President of the Council, Lord Privy Seal, Minister of Agriculture, First Minister of Health—in all of these high and responsible offices of State he performed worthy and devoted service.

He has told the story of his political activities between 1911 and 1918 in a book "Politics from Within" which is most candid and illuminating and should be read by all who remember those thrilling days.

My own acquaintance with Addison began in 1905 when he won the seat of Hoxton in the Liberal cause while still continuing to lecture on anatomy at the Hospital. We both used to lunch early in the then new restaurant under the Out-patients' Department and then proceed to the House of Commons where he went in by the front door, while I went in by the back one under the Victoria Tower, as I was making an investigation of the effect of the ventilation on the spread of droplet infection through the air. There were complaints that the air of the Chamber made people sleepy and tired—but the chief trouble had been influenza there which got so bad at one time that there were no ministers to answer questions. A committee of Members took the matter in hand under Sir Michael Foster as chairman and it was for them that I was working. I remember Addison asking me if I got any pay, and when I answered "No—only my expenses," he was furious and I heard him mutter "I'll see that they do some day." The application of bacteriology for the purpose of limiting the spread of infection through air was then, and still is, at an early stage. As droplets given off by ministers speaking at the box on the table by the Treasury Bench went direct to a certain shaft over the Speakers Gallery (as proved by an experimental orator there who had gargled with B. prodigious first) it was possible to get specimens of salivary streptococci from each minister in turn when they had to introduce the estimates of their departments. The report was eventually published as a White Paper, with a blue book Appendix with illustrations.

It was declared by Addison when he entered Parliament that he was out for the

good of the greatest number, and thus it was natural for him to continue in the service of the Labour Party when the Liberals lost power. His personal charm and reasonableness, with every now and then a touch of humour or sarcasm made a useful contribution to debates. Although, as he confesses in his book, no orator, he had a quick and accurate grasp of detail—the legacy no doubt from the early anatomy lectures.

The Hansard account of the House of Lords debate on April 28, 1950, reveals Addison at his best in introducing the new Medical Act. He brightens it up for their Lordships by telling them that he himself qualified at the age of 21, and had a painful struggle with poverty until he got a junior job which then was unpaid. It may be added that in one of his last letters Addison expressed his affectionate pride in St. Bartholomew's, and his grateful appreciation of the skill of Sir James Paterson Ross.

Up to the end of his official duties he retained full vigour of mind and body, and at the last State Opening of Parliament as Lord Privy Seal he held up the Sword of State for 50 minutes without movement, to the astonishment of his colleagues.

VISCOUNT ASTOR writes—

I was Chairman of a Committee on Tuberculosis from 1912 for nearly two years. Addison was a member of this Committee. We reported on the organisation that should be visualised for dealing with Tuberculosis Dispensaries, sanatoria, etc. We also recommended that a sum of money should be set aside to create a Research Committee and Institute.

Our recommendations were adopted: Lord Moulton was the first Chairman of the M.R.C. and Fletcher its secretary, later I became Chairman. When the Ministry of Health was set up, Lord Addison was the first Minister, I was his Parliamentary Secretary, and on receiving this appointment I resigned from the M.R.C. in order to establish a precedent that no Minister connected with the Department for Health should be in a position to control the doings of the M.R.C.

Mr. FOSTER MOORE writes—

Viscount Addison was the first anatomist to be in charge as such of the Anatomical Department; others, Sir Holburt Waring, Cozens Bailey, Battie Rawling, Sydney Scott and others had occupied the post, but as a stepping stone to a surgical career.

He came from Sheffield where he had edited Ellis' Anatomy, and had defined the transyloric plane to which his name became attached.

He was an excellent teacher and lecturer limiting himself strictly to topographical anatomy, on the grounds that embryology and comparative anatomy had little practical application: he once confessed that he could not describe the lobes of the cerebellum. But it soon became clear that he was intent on a political career, and Harold Wilson and I, who were demonstrators, began to receive messages, asking us, at short notice, to take a lecture or demonstration for him.

The anatomy room factotum was something of a character: he had unsuccessfully applied for the post of public hangman. He had a way of disappearing without leave, and returning, his breath redolent of peppermint—or was it cloves—saying he had been to the Post Office.

This happened so often that Addison, smelling a rat as well as the peppermint, asked him if they sold peppermint at the Post Office: he mended his ways.

Addison's appearance at the lunch table often started a political discussion, especially if Cozens Bailey, who was often more than a match for him, was present.

During his election campaign, when he was engaged in what he naively called "Exporting Hay from Hoxton"—Hay was the sitting Member—we demonstrators, Harold Wilson, D'Oyly Grange and myself did what we could

to help him, regardless of our own political leanings.

I remember being sent to substitute for him at a boxing evening at the Hoxton Baths: my function, no doubt, was to act as a sort of cover in case of an accident.

I went laden with a stethoscope and, I think, more to justify my presence than anything else, refused to let one of the fellows box; the decision was not well received by one of the promoters as, it seemed, it upset the pairings: I'm not sure that my presence advanced the cause.

For some time before Addison left Bart.'s there had been difficulty in obtaining bodies for dissection, and one of his early acts when he attained office, was to institute an Inspector to look into and remedy the shortage: he elected his successor and friend, Alex Macphail, to the post and the difficulty was overcome.

What a charming man he was, with a Lancashire brogue and a whimsical smile.

So far as I remember he took no particular interest in sport of any kind, but one time, when he and Lady Addison were spending a weekend with us I introduced him to the mysteries of casting a fly.

I found him next morning, before breakfast, flogging the stream with great power, and a cast from which he had cracked the fly, I suspect, quite early in the proceedings: he seemed dejected.

When next will Bart.'s produce a K.G. and a Leader of the House of Lords?

DR. W. H. SQUARE

William Halberton Square was born on November 29, 1860, at Kingsbridge, South Devon, where his father practised as a solicitor. He loved the Devon countryside and as a boy explored his native county on a "penny farthing bicycle." He was educated at Sherbourne and at Bart.'s where he dissected with D'Arcy Power. His recollection of those days included tales of surgeons who still operated in old frock coats and many anecdotes of Tom Smith and Matthews Duncan.

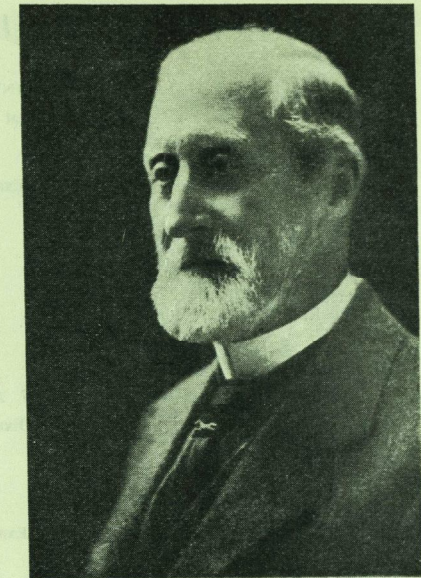
He went into practice at Newton le Willows in Suffolk and soon moved to Sunder-

land where a busy general practice included over 150 "milder" cases a year. Here he married and a breakdown in his wife's health made necessary a move to the south. He came to Leighton Buzzard in 1898 and continued to practice there until just after his 91st birthday. In the early days most of his visiting was done on horse back with a cycle for night work. For a time an American Buggy was in favour but in 1907 a small car was acquired. Horses were not discarded for he was very keen on hunting and at that time had three days a week with stag hounds, there were *no* regular surgery hours! After

the first world war the stag hounds were no more and he contrived to get two days a week with the Whaddon Chase and an occasional day with the West Herts until he was 73, when, after a nasty fall, he contented himself with "hacking" round to a few patients in the afternoon having done the more serious work by car in the morning.

Dr. Square was for many years chairman of the Bench, and until its break up by the second world war was chairman of the local Dramatic and Operatic Society. He attained high honours in Freemasonry, in the Grand Lodge of England he was Past Grand Deacon, in the Provincial Lodge of Bedfordshire he was Past Provincial Grand Warden and in the Chapter of the Province of Bedford late Second Principal.

In his prime a sound general practitioner Dr. Square was an institution to generations of patients and as he passed from being THE doctor to being the OLD doctor he retained their loyalty and affection and the older ones when told recently he was ill and could not attend said, "If I can't 'ave 'im I won't 'ave nobody." He was never ill, but ten days ago he was too tired to get up. He slept peacefully to his end—on December 18.



Dr. W. H. Square

HOUSE APPOINTMENTS

January 1st to July 31st, 1952

At St. Bartholomew's Hospital

Dr. Bourne	I. A. Horton
Dr. Bodley Scott	M. W. Sweet-Escott
Dr. Cullinan	J. A. Parrish
Dr. Black	D. D. Cracknell
Dr. Spence	H. J. Wyatt
Dr. Oswald	G. Haysey
Dr. Scowen	A. E. Dörmer
Dr. Gibb	G. P. Greenhalgh
Prof. Christie	R. G. Huntsman
Dr. Hayward	J. H. Briggs
Mr. J. B. Hume	B. St. J. Brown
Mr. A. H. Hunt	B. R. Whittard
Mr. R. S. Corbett	J. A. Williams
Mr. A. W. Badenoch	G. S. Banwell
Mr. J. P. Hosford	P. Venables
Mr. E. G. Tuckwell	R. V. Fiddian
Mr. Naunton Morgan	R. F. Jones
Mr. D. F. E. Nash	P. D. Matthews
Prof. Sir J. Paterson	M. Braimbridge
Ross	E. W. Evans
Mr. J. B. Kinmonth	
Casualty House Physician	J. F. Andrewes
Children's Dept.	
Dr. C. F. Harris	Miss E. S. Tomlinson
Dr. A. W. Franklin	Mrs. E. C. Shore
E. N. T. Dept.	
Mr. Capps	Mr. Jory
Mr. Hogg	Mr. Cope
	J. G. Wallace

Skin and V.D. Depts.

Dr. MacKenna Dr. Nicol C. C. Molloy

Eye Dept.

Mr. Philips Mr. Stallard D. W. Hill

Gynae. and Obst. Depts.

Mr. Shaw Mr. Beattie
Mr. Hawkins Mr. Fraser

Interns

C. P. Wendell-Smith (Midwifery)
H. Horwitz (Gynaecology)

Junior H/S

D. K. Williams

Anaesthetists

N. E. Winstone (S.R.A.)
P. H. Simmons
D. F. A. Aubin
P. H. S. Hooper
J. Barnes

Dental Department

Orthopaedic Dept.

(Accident Service)

At Hill End Hospital

E. N. T. Department

Orthopaedic Dept.

J. C. Pittman
F. A. Almond
J. P. Waterhouse
G. H. Aphorpe
G. C. Jenkins

Thoracic Dept.

Neuro-Surgical Dept.

Anaesthetists

J. C. M. Currie
R. S. Atkinson
M. Wise

At Alexandra Hospital

S. W. Albright

R.M.O.

EXAMINATION RESULTS

CONJOINT BOARD

Pre-Medical Examination

Chemistry
Simpson, J. R.

December, 1951

First Examination

Anatomy
Canning, W. C.

Greenwood, R. A.

Lloyd, A. G.

Physiology
Batterham, E. J.

Lloyd, A. G.

Farrar, J. F.

Menage, J. A.

Pharmacology
Adam, R. M.
Caldwell, A. M.
Hodgson, M. J.

Jones, B. S.

Pugh, M. A.

Storey, V. C.

Knipe, P.

Ryan, H. S. S.

Walker, L.

Lindop, P. J.

Southgate, B. A.

Gibbs, J. T.

SOCIETY OF APOTHECARIES

Final Examination

Pathology
Portelly, J. E.

November, 1951

Midwifery
Shah, M.C.

Final Examination

Pathology
Cookson, T. S.

Stanton, T. J.

December, 1951

Medicine
Cookson, T. S.

Stanton, T. J.

Midwifery
Mehra, P. C.

UNIVERSITY OF OXFORD

2nd M.B. Examination

Medicine, Surgery and Midwifery
Carlisle, I. O.

Eaton, D. H.

Haysey, G. T.

Michaelmas Term, 1951

Sweet-Escott, M. W.

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination

Part I (New Regulations)

Baddoo, M. A.
Cannicott, S. M.
Dallas, S. H.
Griffith, A. N.
Phillips, J. M.

Shimmin, H. J.
Verney, G. I.
Caiger, V. G.
Channon, C. E.
Fiddian, R. V.

Keil, A. McL.
Preece, J. F.
Simister, J. M.
Campbell, D.
Chapman, W. H.

Michaelmas Term, 1951

Newcombe, J. F.
Rowson, K. E. K.
Underwood, K. M.
Goldsmith, R.

Part II (New Regulations)

Andrewes, J. F.
Fiddian, R. V.

Phillips, J. M.
Banwell, G. S.

Greenhalgh, G. P.
Sarma, V.

Clarke-Williams, M. J.
Maxwell, C. M.

ROYAL COLLEGE OF SURGEONS

Subject to the approval of the Council of the R.C.S. at a meeting on December 13, 1951, the following are entitled to the Diploma of Fellow:—

Bartlett, D. J.
Desai, A. P.
Elphick, G. D.
El-Wakil, I.

Griffin, S. G.
Jacobs, H. B.
Macrae, D. E.
Masou, E. I. H.

McNeill, K. A.
Motawi, A. A. K.
Pyper, J. B.
Ratcliff, A. H. C.

Shulman, I. M.
Stack, H. G.

CORRESPONDENCE

DOUBLE CONDUCTORS

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

Mrs. Cooper's letter about Boyd Neil is very interesting, but the experience she relates is not quite unique, as I and my twin sister were brought into the world by Dr. Tamm (at present making his practice in Dortmund) not two hours before he conducted the University Operatic Society in the première of Adrian Leverkühn's opera "Love's Labour Lost" (April 1, 1927). We are both alive and well and testify to the many-sided nature of the medical mind.

Yours honourably,

ULRICH N. MOGLICH (D. Phil.)
Kaisergärtenstrasse, 107,
Celle, Germany.

Dr. Boyd Neel's case of a delivery after his first concert is well capped by this case of twins before a première.

Should any of our readers know of a similar case (dare we suggest one of triplets?) we should like to hear of it.

EDITOR.

POT POURRI

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

We would like to express through your Journal our thanks to all those connected with the Christmas shows, and especially the magnificent co-operation we received from all concerned with the "Pot Pourri."

The services of members of shows which had not been included in the "Pot Pourri" and who volunteered for menial off stage duties is something that we feel should not go unnoticed.

Yours, etc.,

J. LATHAM,
Registrar Anaesthetist to the
Facio Maxillary Unit, Hill
End.

N. E. WINSTONE,
Senior Resident Anaesthetist,
St. Bartholomew's Hospital.

C. TODD,
Demonstrator of Physiology,
St. Bart's Hosp. Med. Coll.

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

I hesitate before attempting to tilt at so old-established an institution as the "Pot Pourri," but I feel I must offer some criticisms. Under the present system, when faced with the awful prospect of writing a ward show, one has to consider three audiences. Your show is primarily designed for the patients, secondly for the staff and finally for that indefinable but quite unique audience, "the Cripple-gate."

What is the result of this division of loyalties? About one firm every year succeeds in producing a show which is good entertainment for everyone. The majority, however, have not this adaptability and more often than not, the patients being quite rightly put first, it is the Cripple-gate audience who suffer. The only compromise that can be adopted is to work into the script a short passage designed to catch the eye of the selectors. This is in itself a bad thing as it immediately limits one's scope with regard to the remainder of the script.

I have yet two more criticisms to offer. One is that the uncertainty as to whether or not you will be asked to be in the Pot Pourri makes the organisation of holidays (however unofficial) quite impossible; the other is that never is it possible to rehearse the show fully before the first night. This year the stage management was little short of miraculous, but frequently the lack of co-ordination is all too apparent.

Nobody can say that the Pot Pourri is not enjoyable, but it is not the best we have to offer. All too frequently it is an under-rehearsed hotch-potch of extracts from shows designed for an entirely different audience. I suggest that the only remedy is to divorce the Cripple-gate entirely from the ward shows. Put on a revue, well rehearsed, and designed to suit the audience. The talent is quite plainly present, why should we waste it as we are doing now? If anyone doubts the feasibility of the scheme they need only take a short walk to the other side of the Thames where they will see it working with conspicuous success.

Yours faithfully,

MARTIN CROSFILL.

Littleholme,
Oxted.

CAMBRIDGE GRADUATES CLUB

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

The Sixty-second Dinner of St. Bartholomew's Hospital Cambridge Graduates' Club will be held at Frascati's Restaurant on Friday, March 14, 1952, at 7 for 7.30 p.m., with Mr. Geoffrey Keynes in the Chair. Notices will be sent out to members of the Club early this month, and the Secretaries would be

most grateful to hear from any Bart.'s Cambridge graduate who may have been overlooked. All Bart.'s Cambridge graduates are automatically members of the Club, which was founded in 1876.

Yours faithfully,
H. JACKSON BURROWS,
R. A. SHOOTER,
Hon. Secretaries.

25, Upper Wimpole Street,
London, W.1.

POT POURRI

From our Cripplegate correspondent.

"Everyone knows that a girl who is prudent
Would never go out with a medical student."

--Old Chinese Proverb.

In case the reader is an old Bart.'s man busy in his practice it will be said at once that the Pot Pourri was as enjoyable as ever, and thus he will be saved the trouble of reading on. In case he is not, an account of the show must be given.

It began with the opening chorus and a scene from "High Drops Foetalis." The old cleaner was particularly enjoyable and so, in a different way, was Angeline, whose approaches to her chief were embarrassingly life-like. Followed two short pieces from Dr. Cullinan's firm, and sandwiched between them was a delightful rendering of "When Father Papered the Parlour," which is still ringing in your correspondent's ears.

Next we heard the "theatre thirds" from Hill End, and many of the audience must have wondered why they had been wasting their time at Bart.'s when a mere twenty miles away were such a . . . also from Hill End we had two gentlemen masquerading as theatre sisters—until one of them let her hair down—and they gave us a beautifully timed mime version of "Anything you can do";—one of the highlights of the evening.

Concluding the second half was "Bar None," which had so polished and finished a cast that we were carried away in the realms of phantasy to the Wild West Bar, where Bart.'s men go when they leave the Register. The many songs were most cleverly arranged and performed. The part singing of "Rhubarb and Senna," with its falling refrain of ". . . two beautiful flowers" richly deserved

its apt comment "a mighty *moving* song, boys." Altogether, a mighty fine show.

The compère's job is ever an unenviable one, but Mr. Douglas Robertson played the part with such engaging style that he bettered many a professional; and particularly so when he told a story that really was funny. The accompanist (or was he several) did not appear on the programme, but deserves a good word for his subdued and balanced contribution. In fact, he remained accompanist, and never once drowned the singers—a rare achievement.

We had "Corn in Egypt," and with it came Farouk, whom your correspondent had been half expecting all the evening. There was much Sullivan (off licence), and some Gilbert (still on), but at a private show, there was no danger, in its own words, "Of landing in the D'Oyly Carte."

From "Djin and Tonic" we had two short excerpts, one of them from a highly talented snake charmer. These were followed by Mr. Maurice Chevalier who amazed us with his personal knowledge of the Bart.'s staff, which was so intimate that it enabled him to imitate them with remarkable accuracy.

As ever, to end up, the Residents—this time in "Malice in Wonderland." We had some delightful moments from this show, and Beadle Dum and Beadle Dee were something of an inspiration. "Just half a cup," said Alice. "Certainly," replied the Mad Hatter.

"LOUISE"

from "BAR-NONE"

Every little breeze seems to whisper Louise,
The birds and the bees, make you think of Louise,
Spring's in the air—better beware
She'll haunt you! Taunt you!

You will find Louise, is just like a disease.
All others one sees, can resemble Louise,
Think she is yaws, make sure, because,
She may be Louise.

Christopher Columbus,
Knew her through a friend,
He could not avoid her,
She caught him in the end.

So remember please, when you think it's Louise
That only Louise, makes you weak at the knees,
Walking on air, never a care
When you've met Louise.

You can not escape her,
Since when you lose touch,
Grandiose delusions,
Show you're in her clutch.

Get her on the brain and she'll drive you insane,
She'll touch your heart, with her own special art,
A light in your eyes, and we realise,
You've met our Louise.

M. G. P.
R. V. F.

CLINICAL CASEBOOK

Mr. W. B., aged 36.

Occupation. Aircraft operator for B.O.A.C.
Complaining of pains in the right leg and loss of powers of concentration.

History of present condition. Eleven years ago syphilis was diagnosed from the scrapings of a primary chancre. A course of arsenic injections was started, but these were very irregular as he was at sea much of the time. Ten years ago he got a shore job and had a complete course of injections. When the course finished he was told that his blood W.R. was negative. He has been quite well until one year ago when his wife noticed slurring of his speech. Nine months ago, he had an attack of severe pricking pains behind the right knee, and at this time he noticed that he was losing his powers of concentration. Since then his wife has noticed that he has been getting more irritable. Till one month ago he was working, then he was sent to hospital by his M.O. because of his symptoms. The performance of certain of his

radio tests was unsatisfactory, and he forgets the names of people with whom he works.

Systems. C.N.S. sleeps well, has bad frontal headaches. A.S. Appetite good, no indigestion. Other systems normal.

Past history. In 1942 he contracted malaria in the Belgian Congo. He has had four attacks, the last four years ago, and about 20 rigors in all.

Social history. His wife has a negative W.R. Six years ago one child died after birth. There are two children of eight and four whose W.R. is not known.

On examination. The patient was pale and his speech slurred. In the eyes the conjunctivae and fundi were normal, and movements full and normal. Pupils were irregular, with sluggish reaction to light, and normal accommodation. No abnormality was found in the chest and abdomen. The arms were normal. There was some loss of power in the legs, and no quadriceps jerk on the right. Ankle jerks were absent on both sides. The

plantar response was flexor. There was no wasting and normal vibration sense, co-ordination and response to pin prick. The Rhomberg and Kernig signs were negative. He was unable to repeat test sentences, even after the tenth try. Fresh errors kept coming in. He could only remember the names of prominent men in Parliament with prompting. A slight loss of intellectual power was observed. This would not matter perhaps, in most people, but in a man with his responsibility it was important, and it is improbable that he will continue his job.

Diagnosis. Tabo-paresis. This was diagnosed rather than uncomplicated G.P.I. because of the absence of the right knee jerk and ankle jerks and the lightning pains in the right popliteal fossa.

Special Investigations. Blood W.R. strongly positive. Chest X-ray, heart and aorta appear normal. Lumbar puncture, pressure 125 m.m., varied with pressure on jugular vein. C.S.F. clear, W.R. strongly positive,

cells 200/cu.m.m., lymphocytes. Protein 40 m.g./100 c.c. Lange curve 5 5 5 4 3 2 1 0.

Treatment. He had 10 mega units of penicillin I.M. over two weeks. Repeat lumbar puncture showed, cells 100/cu.m.m. protein, 30 m.g./100 c.c. A further lumbar puncture will be done in three months and if necessary penicillin given again.

Discussion. We are told that if penicillin fails benign tertian malaria or other methods of inducing pyrexia must be used in cases of G.P.I. The interest in this case lies in the fact that the patient had had four severe attacks of malaria and about 20 rigors in all. This far exceeds the therapeutic allowance of 6 to 12 rigors. Yet about three years after the last attack the insidious symptoms of tabo-paresis began.

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

J. H. Stevens.

SPORT

RUGGER CLUB

Saturday, December 1st, v. Old Alleynians

Result: Lost 6-11.

Bart's lost to the Old Alleynians 6-11 on December 1 at Dulwich. The game started off at a great pace on this notoriously heavy ground and it wasn't long before Lammiman scored on the right after a quick heel and a good cut through by Taylor. Jones failed with the kick but ten minutes later succeeded with a penalty—Bart's thus leading 6-0. The Old Alleynians woke up considerably after this reverse and with their backs getting plenty of the ball, their fly-half ran through several half-hearted tackles to score under the posts. This try was converted and so our lead was reduced to one point. In the second half the Old Alleynians' forwards continued to have the upper hand of ours in the loose and their backs were given plenty of the ball, and only hard tackling by Murphy and Taylor in the centre stopped them from scoring earlier. This they did with a penalty followed soon after by a try as a result of a fumble on our line. Thus our brilliant start was not repeated, and this was really due to the fact that our backs, more than equals to their opponents, were given too few chances from the loose scrums and lineouts. In the set-scrum Jewell, the hooker, did extremely well against an experienced front row, and Gawne was the outstanding forward in both packs.

Team: J. L. M. Corbet, A. D. M. Thomas, J. K. Murphy, M. G. Taylor, D. A. Lammiman, K. A. Clare, B. Grant, A. J. Gray, H. M. Jewell, A. J. Third, D. W. Roche, J. Jones, D. M. Cuthbert, E. D. F. Gawne, C. W. H. Havard (Capt.).

Saturday, December 15th, v. Old Millhillians at Chislehurst

Result: Won 28-14.

In spite of the recent rains, the ground was surprisingly firm. As the game progressed worn patches appeared in midfield. The ball, which became very wet, was handled skilfully by both teams. Bart's started well and a good combined movement by forwards and backs carried the ball well into the O.M.'s half. Almost immediately O.M.'s recovered and carried the ball back to the halfway mark. These movements sum up the tempo of the game throughout. Bart's were playing excellent football showing far more dash and initiative than in recent games. Both forwards and backs were handling well. The pack were keeping the ball "close" to their feet and carrying out some most effective forward rushes. The backs were chucking the ball about and keeping it moving with great effect. O.M.'s seemed bewildered by the vicious attacks and were kept on the defence perpetually.

Early in the first half Lammiman opened the scoring with a clever cut through. The try was not converted. O.M.'s scored the next try. A good movement put their fastest player away in midfield to score in the corner. Bart's were playing good and confident football, taking advantage of their opponents' mistakes. Two penalty goals and an excellent opportunist try by Havard put the score to 12-3 in Bart's favour at half-time.

The second half opened with determined attacks by O.M.'s but Bart's defence proved to be as good as her attack. Two more tries for Bart's scored by Taylor and Third were converted and it was apparent that the early part of the second half

had tired the opponents. However, carelessness in passing and ineffective tackling allowed O.M.'s to score two quick tries. Another penalty goal and a good try by Clare after some more good football put the final score to 28-14 to Bart's.

It was a fine game with much good football by Bart's. In set and loose scrums Bart's obtained over 60 per cent. of the ball. The half-backs played well considering the conditions, although some erratic passing in the first half prevented the stand off taking the ball flat out. The backs played an excellent game marred only by the occasional careless actions in the second half for which the team paid heavily. The full-back played a good game and shows much promise.

Team: G. Scott-Brown, D. A. Lammiman, M. G. Taylor, M. J. A. Davies, J. K. Murphy, K. A. Clare, A. Mackay, A. J. Third, P. Knipe, A. J. Gray, J. M. Jones, D. W. Roche, D. M. Cuthbert, E. D. M. Gawne, C. W. H. Havard (Capt.).

December 29th, v. Civil Service.

Result: Won 9-3.

Under ideal conditions at Chiswick, Bart's won an uneventful game, by two tries, one dropped goal to one try.

The team suffering from Christmas after-effects did not appear to be playing all out, and it is possible that the score could have been more decisive.

The forwards, although playing against heavier opponents, secured more than their fair share of the ball, beating their opposition convincingly in the loose and in the lineouts. J. P. Stephens made a welcome return to the side and proved to be an invaluable asset in the lineup, doing much as he pleased with the ball to our advantage.

Although the backs showed improved penetration, many opportunities were thrown away through lack of finish and speed, which upon this occasion could fairly be said to be due to lack of fitness.

Tries were scored by J. K. Murphy, and J. Jones. M. J. A. Davies dropped a goal.

Team: G. Scott Brown, J. K. Murphy, N. G. Taylor, M. J. A. Davies, J. L. M. Corbet, K. A. Clare, A. Mackay, A. J. Gray, H. Cowper Johnson, W. B. Castle, O. W. Roche, J. Jones, P. Weston, J. P. Stephens, C. W. H. Havard (Capt.).

WOMEN'S HOCKEY CLUB

The 1st XI went on tour to Cambridge for the week-end November 9th to November 12th. Three matches were played, of which one was won and two were lost.

RESULTS

v. Cambridge University W.H.C. Lost 1-8.
v. Homerton College. Won 6-2.
v. Pembroke College. Lost 0-5.

In the first round of the Hospitals' Cup. Barts won against Middlesex Hospital 12-0.

OTHER RESULTS

1st XI
Won—Guy's Hospital 10-0; Dickinson's Ladies 4-3; Westfield College 5-3.
Lost—Lansbury 2-8.
Drawn—King's College Hospital 3-3.

2nd XI

Won—St. Ebba's Hospital 2-1.
Lost—St. Bernard's Hospital 2-3; Guy's Hospital 0-6.

SOCCER CLUB

Despite anything the Hockey team may say to the contrary, the club's first match of the season resulted in a convincing 8-0 win over the Architectural Association. The responsibility of having to maintain an unbeaten record unsettled the team slightly, but a hard fought and fluctuating game against the Royal Dental and Charing Cross Hospitals resulted eventually in a 4-3 win for Bart's. Bromley School proved a match severer test. The game was fast and even; Bart's defence was sure, but poor finishing in the forward line allowed the school to win 2-1. This being an away match, there still remained the consolation of an unbeaten home record.

The match on their ground against St. Mary's was another close and enjoyable one, resulting in a 2-2 draw. A memorable feature was a totally impossible goal by Wright, who was facing in the wrong direction at the time. The team showed good understanding against the Civil Service Strollers, winning by six goals to nil, but only managed to draw against the London Hospital despite a determined attack in the closing minutes. That fragile record was finally shattered by Westminster Hospital, the team lacking cohesion and Tom Duffy.

The "A" team has beaten the Swiss Mercantile College and lost to St. George's.

The 2nd XI lost to Normandy Company, Sandhurst, and beat Old Cholmeleians and Oxted, in which match Shere notched five goals.

RESULTS

1st XI v. Architectural Association. Won 8-0.
1st XI v. Roy, Dental and Charing X. Won 4-3.
1st XI v. Bromley School. Lost 1-2.
1st XI v. St. Mary's Hospital. Draw 2-2.
1st XI v. Civil Service Strollers. Won 6-0.
1st XI v. London Hospital. Draw 2-2.
1st XI v. Westminster Hospital. Lost 2-5.
1st XI v. School of Oriental and African Studies. Won 10-3.
1st XI v. Old Cholmeleians 2nd XI.

FENCING CLUB

The numbers of the Fencing Club have increased considerably this season, and we have been honoured by the acceptance of the Presidency of the Club by Dr. E. R. Cullinan.

The standard of fencing has improved steadily at our weekly meetings under the able instruction of Professor Fortunato Delzi who has devoted much of his time to those new members, in particular, who are learning to fence for the first time.

Regular matches have been fought, and include those against Guy's, Westminster and King's College Hospital; all three weapons have been used. Several members of the club were entered for the University Trials, and both individual members and a team are being entered for the Fildes Cup and Intercollegiate Trophies, which will be awarded early this year. Much room for improvement exists in the standard of the team's fencing, and this will be largely achieved by more determination on the part of the foilists.

Great keenness has been shown by all club members both in their attendance and in their individual performance.

BOOK REVIEWS

A TEXT BOOK OF MEDICINE, edited by E. Noble Chamberlain. Published by John Wright & Sons, Ltd., pp. 962 + xii, illustrations 266. Price 50s.

Dr. Noble Chamberlain's new Text-book of Medicine has been produced in the same attractive style as his well-known Symptoms and Signs in Clinical Medicine. More than half of the seventeen contributors are Liverpool men and only two are from London schools, among them Dr. F. H. Young who is co-author of the excellent section on diseases of the respiratory system, which may be read with profit by all Bart's students whether they possess the book or not. The standard throughout the other sections is high and it is hard to single out any for special mention. Professor Clifford Wilson writes well on diseases of the urinary system, his description of nephritis being particularly good and free from the inconsistencies and obsolete terminology which so often obscure accounts of this subject.

Diseases of the skin are not included and there is no section for disorders of metabolism. Though the chief metabolic disorders are dealt with under other headings, it is a pity that room was not found for such important topics as dehydration, salt depletion, and disturbance of the acid-base equilibrium. Nevertheless, the difficult task of selecting material for a volume of this size has been carefully and well done, with emphasis on the commoner diseases and their commoner symptoms rather than on the rarities. The result is a book of just under 1,000 pages which should prove useful as a background to clinical work in the wards and out-patient department. The text is well arranged with bold headings and many excellent photographs.

Kenneth Black.

MUIR'S TEXTBOOK OF PATHOLOGY, 6th Edition, 1951. Revised by D. F. Cappell. Edward Arnold, pp. 1,090. Price 50s.

The outstanding virtue of this textbook is I think the excellence of its photographs and photomicrographs. There are over six hundred of these in a book, which, by present-day standards, is of moderate size. Each one is beautifully reproduced and unlike many such illustrations is informative.

The book is divided into two parts. The first chapters deal with general pathological principles, the second part with the special pathology of the individual organs and systems. The emphasis throughout the book is on the morbid anatomy and histology of disease. As Professor Cappell says, "The importance of the necropsy in the teaching of pathology can hardly be over-emphasised and there is no substitute for experience gained in the post mortem room."

Parasitology, Tropical Diseases and Special Bacteriology are omitted. Immunity and Serology have been dealt with more fully. One tends to hear less of this side of medicine in these days of antibiotics and chemotherapy.

The text is well and clearly written and is not so encyclopaedic as to give the aspiring student the impression (all too common today) that his task is hopeless.

CHRONIC BRONCHITIS by Trevor Howell. 1st Edition, 1951. Butterworth, pp. 110. Price 17s. 6d.

A satisfactory definition of chronic bronchitis has not yet been devised. Dr. Trevor Howell, in his interesting and entertaining book, fights shy of this difficulty and alludes to "the triad of cough, dyspnoea and wheezing, on which the diagnosis of bronchitis usually rests," which is doubtless true. He sensibly divides bronchitis into acute and chronic, pyrexial and apyrexial, with and without bronchospasm; perhaps wheeziness would be better than bronchospasm. He has studied many bronchitis patients himself, including Chelsea Pensioners and others at a military hospital in Poona. His views, guided by a thorough search of the literature, are clearly expressed upon the aetiological, clinical and therapeutic aspects, many of which would perhaps carry more weight if they were based upon larger series of patients. In treatment, he found the usual expectorants to be of doubtful value, but aminophylline by mouth often relieved wheeziness and acute exacerbations could frequently be prevented or cured by antibiotics. His physiotherapeutic recommendations are somewhat unorthodox and include short wave diathermy and shaking the chest with an electric vibrator.

The chronic respiratory catarrhs of children and young adults and the relationship of bronchitis to asthma are barely mentioned, but Dr. Trevor Howell is known to many of us as a geriatrician and his book is concerned largely with bronchitis in elderly men. It should find a place as a valued contribution to our understanding of geriatrics.

NEVILLE OSWALD.

EXERCISES BEFORE CHILDBIRTH. By Kathleen Vaughan, pp. 48. 1st Edition, 1951. Price 6s.

This is an attractive and interesting little book; describing the exercises that a normal woman should do, to maintain and increase mobility of the lumbar and pelvic joints, in preparation for labour. The reasons for doing them are clearly explained.

It is perhaps a pity that the other details of training for childbirth are not covered as fully. The value of relaxation is stressed—but the subject could, with advantage, have been discussed even further.

Controlled breathing is not mentioned, nor is sufficient explanation given as to the active co-operation which the mother may give, in the first and second stages.

TRUDA WAREHAM.

BIOLOGY STAINING SCHEDULES FOR FIRST-YEAR STUDENTS, by R. R. Fowell. 4th edition. Lewis, 1951, pp. 27. Illustrations 3. Price 2s. 6d.

This little booklet contains, in very clear style, all the information which is required for the first M.B. exam, on staining biological specimens. In addition the constituents of the various stains are listed.



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manufacturers of new drugs are of considerable value. Our Medical Information Division is at all times glad to receive requests for information from medical students. When writing it is essential to give particulars of your medical school and status (i.e. whether clinical or pre-clinical).

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THE APPROACH TO CARDIOLOGY by J. Crighton Bramwell. 1st Edition, 1951. Oxford, pp. 116. Price 17s. 6d.

The Author says in his Preface: "My experience as an examiner has led me to believe that there is a danger of students being so overburdened with detailed factual knowledge that they can no longer see the wood for the trees." Dr. Bramwell has therefore addressed this book to the clinical students of the Introductory Course, for whom he has drawn a wood of delightful clarity on the firmest of foundation, but with the absolute minimum of trees. This is not a Textbook on Diseases of the Heart, and should not be judged as such. The first chapter—"The Clinical Approach"—is concerned with the Doctor-Patient relationship, and gives a clear and noteworthy introduction to clinical medicine. The succeeding chapters deal each with an aspect of cardiology. No attempt is made at completeness for this would disguise the basic principles which the book contains in such abundance. Each subject is taken far enough to lay a firm foundation on which clinical experience may later be built up.

This book is so well produced that I suspected it at first of being an American production. The print is large, clear, and easily readable; the paper of a now rare quality. The text is in the main a clear and scholarly exposition, aptly described in the Preface as a "Monograph." If the facts or even the principles are forgotten, and this would not seem likely, the reader retains the almost incalculable benefit of reading a hundred pages of logical thought by an expert in his subject. In the matter of the illustrations, by contrast, the book goes strangely astray.

In at least seven cases (over 10 per cent.) they contain mistakes or are misleading: Tables II, III, and V contain detailed figures of no possible value to the intended reader, and which could be summarised in each case in a single sentence; the caption to Fig. 28 refers to Car-carotid, and radial, car. and rad. do not appear in the figure; Fig. 32 is labelled Carotid Sphygmogram, but sphygmograms are defined (wrongly) in the text as of the radial artery only; in Fig. 34 the wave form moves from right to left, instead of the conventional way, and this is not pointed out; in Fig. 36 four "phases" have crept in, which are not previously explained—possibly because they are inexplicable; in Figs. 42 and 43 normal and absolute sphygmograms are compared, but one is drawn as traced and the other geometrically; the beginner for whom this book is written would naturally assume this to be an important point of difference; in Fig. 43 a hypertensive sphygmogram is labelled "Hyperpiesis"—a word not used in the text, and one which four fifth year students chosen at random failed to understand. This is really too much. The Author can perhaps be excused criticism on the grounds of over acquaintance with the material, and of relying on his proof-reader and publisher for corrections. But why were the corrections not made? It is to be hoped that this carelessness will not become a characteristic of so excellent a book in its later editions.

All students, and—dare I suggest?—not a few doctors, should read this book, and read it not once but regularly; whenever their view becomes obstructed with trees, Dr. Bramwell can be relied upon to refocus attention on the wood.

A SHORT TEXTBOOK OF MIDWIFERY, by G. F. Gibberd. Fifth edition, 1951. J. & A. Churchill, Ltd., pp. viii + 576 + 199 illustrations. Price 25s.

"Gibberd's Midwifery" is the standard obstetrical textbook at most medical schools in this country, and justifiably so. It is well and clearly expressed. The writing is easy to follow, and it seems to stick in the mind. The first edition was produced in 1938, and since then the publishers have issued five editions to keep it up to date. Twelve years are a long time in a rapidly growing subject, and some sections have called for considerable revision; for example, the sections on the treatment of Placenta Prævia and Pthisis in pregnancy. Although a place in the index has been conceded to physical exercises in antenatal care, a place in the text would have seemed more useful. The section on puerperal infections is large, but it is justified in the author's preface. This book is reasonable in price, it is clearly printed, adequately illustrated and well bound. To be strongly recommended.

THE GREAT PLAGUE IN LONDON, 1665, by Walter G. Bell. Second edition, 1951, pp. 361 + 40 illustrations, maps and folding plans. The Bodley Head. Price 25s.

Daniel Defoe was a remarkable man, if for no other reason because of his ability to create characters and situations whose possibility was made plausible and indeed probable by his attaching and weaving into his tales some established facts. For example, the "Yorkshire Sailor," "Robinson Crusoe" and "Moll Flanders." With these one must class the "Journal of the Plague Year." After this report of doubtful value as fact, we have had to wait nearly two hundred years for an accurate and scholarly record of the Plague. It has been well worth the wait. Who better could there have been than Mr. Bell, that lover and chronicler of the city, to write such a history. It is a well-written and carefully documented study; this latter quality will be very much appreciated. This book describes the part played by our own Hospital in the Plague Year. He describes how many of the Staff left, apparently each one, like Thomas Turpin, found "the business was to hot for him to act therein." The apothecary, Francis Bernard, did stay, however, and he performed the work of both surgeon and physician. Though Mr. Bell does say that he received a Fellowship of the Royal College of Physicians, he does not relate that he received his reward from the Hospital, too. For those whose interest in the city and its history lies beyond the Hospital, here is a fascinating book, which will be worth your getting. We are very grateful to the Bodley Press for bringing out a second edition of this excellent work, which has been unobtainable in the shops for many years.

ANATOMY AND PHYSIOLOGY FOR NURSES by W. Gordon Sears, M.D. 2nd Edition, 1951, pp. 395. Edward Arnold and Co. Price 10s.

Dr. Gordon Sears' book is too well known and popular to need recommendation, and has always been good value for money. It should on no account get any larger; descriptions of the Rhesus factor mean nothing to the new entrant who reads this book, and the senior nurse looks for such things in her medical text-book.

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

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No. 3

SIR ARTHUR CONAN DOYLE, M.D.

ON another page of this issue a correspondent makes a plea to Sherlockians to turn their admiration from Holmes to Sir Arthur Conan Doyle. We do not foresee a great success for such a plea, but we agree with the writer that Conan Doyle is indeed pitifully neglected. Without disparaging Holmes and Watson, why should we not admire "That famous trinity of fact and fiction; The world of crime together they could foil—*John Watson, Sherlock Holmes and*

Conan Doyle."

as did Zeta in our January issue? There is little new to say of Holmes and Watson, so let us concentrate for once on their creator.

Although one might imagine that the placing of the first meeting in our Chemistry Laboratory was a tribute to the author's old hospital, this is not so. Doyle did his medical training at Edinburgh, and there is little evidence that he ever set foot within the walls of Bart.'s. We do not know of any direct evidence, in fact we have found none even so concrete as that for Holmes' presence here. Indeed we are reduced to the vague presumption that Doyle must have chosen Bart.'s for *some* reason—and perhaps the most likely is that he once came here himself.

The Professors at Edinburgh provided Conan Doyle with ideas for many of the characters which were to appear later in his books. Dr. Joseph Bell—a surgeon at the Edinburgh Infirmary—was, according to the author, the prototype of Sherlock Holmes. Dr. Bell himself confessed that Doyle "owes much less than he thinks to me"; but there

is no doubt that Bell was the first inspiration and that Doyle enlarged on it as the Holmes saga developed. Other possible sources, one of which Doyle himself acknowledged, were pointed out by Bernard Shaw when he said: "As I was brought up on Dickens' Inspector Bucket, Wilkie Collins' Sergeant Cuff and Poe's Dupin, I thought nothing of Sherlock Holmes." Hesketh Pearson, in *Conan Doyle—His Life and Art*, suggests that Holmes' precise method first appeared in Voltaire's *Zadig*. All these have something of Holmes; but what author can now create a character which is altogether new? New names may owe a debt to their counterparts in the older fiction, or the similarity may be quite fortuitous. The best evidence we can hope for is an honest author's word that it is to so-and-so, or such-and-such an author, that he is indebted. In Conan Doyle there existed a writer who was unusually frank about such matters, and it was Dr. Bell and Poe's Dupin that he mentioned as the sources of Sherlock Holmes.

Doyle records an example of Bell's diagnostic powers that shouts "Holmes" from the rooftops:

A new patient was brought before Dr. Bell:

"Well, I see you've served in the Army."

"Aye, Sir."

"Not long discharged?"

"No, Sir."

"In a Highland Regiment?"

"Aye, Sir."

"A non-com. officer?"

"Aye, Sir."

"And stationed at Barbados?"

"You see, Gentlemen," said Bell to his students—among whom was Doyle—"the man was a respectful man but did not remove his hat. They do not in the Army, but he would have learned civilian ways had he been long discharged. He has an air of authority and is obviously Scottish. As to Barbados, his complaint is Elephantiasis, which is West Indian—"

This precision of thought is the part of Holmes that Dr. Bell inspired; the moods, the tobacco, and many other facets of Holmes' private life are much more like Dupin. If they were also like the private life of Bell we should hardly expect Doyle to have known it.

The character of Conan Doyle himself has been many times pointed out as that of Dr. Watson. The character of Holmes is remarkably consistent throughout the stories, but Watson's displays variations—as if Doyle were writing of himself in one story, and of Watson in another. Both Doyle and Watson were under fire in the Boer War. It is tempting to explain the inconsistencies of Watson's wound as being one of Conan Doyle himself and the other of Dr. Watson. Unfortunately there is no record that Doyle was in fact wounded at all! But apart from such idle speculations, the writing reveals real inconsistencies in Watson's character. Thus in "The Red Circle" Holmes addresses Watson, "Ah, yes, Watson—severely practical as usual!"—it might almost be Lady Conan Doyle addressing her husband!—and has little similarity with the following opinion of Watson: "Your fatal habit of looking at everything from the point of view of a story, instead of as a scientific exercise," says Holmes, "has ruined what might have been an instructive and even classical series of demonstrations." Yes, John Watson was indeed a variable character, "severely practical" in one tale and quite unscientific in another. He undoubtedly has something of Conan Doyle as his friends knew him, and perhaps the rest is Doyle as he saw himself; but the identification cannot be complete—

"So please grip this fact with your cerebral tentacle.

The doll and its maker are never identical."—as Doyle wrote of another matter.

So it is that Dr. Watson has a nebulous character and one which inspires no single picture in the reader's imagination, while Holmes' face and figure are as well known to us as those of the current Prime Minister.

So much for a brief outline of the origins of Sherlock Holmes and Dr. Watson. Not everyone will agree with everything that has been written, nor with all the views which have been expressed.

Although Dr. Bell said that he always regarded Doyle as one of the best students he ever had, Doyle's medical career was not a great success. His first post was as a ship's doctor in 1881, at a salary of £150 a year. After several other jobs, including one in West Africa, and another in partnership with his friend George Budd (who ran a very strange General Practice), he went into practice on his own. He was popular but never succeeded in earning more than a bare living for himself, and later, for his wife. One of his income tax returns showed such a small figure that the inspector wrote "Most unsatisfactory" on it and sent it back to Doyle, who added "I entirely agree" and returned it! His first writings date from this period in General Practice, and as his writing became more and more accepted his medical interest waned. He made one brief attempt at a medical revival, as an ophthalmologist. He trained for a month or two in Vienna, and on his return set up as a consultant. But, in his own words, he had "—a waiting room and a consulting room, where I waited in the consulting room and no one waited in the waiting room." With this light thought he passed from medicine to Sherlock Holmes and Brigadier Gerard. "Not even the Corpus Hippocraticum," said the *Lancet* at the time of Doyle's death, "with over two thousand years start, has been sold in such profusion as the various volumes in which Sherlock Holmes appears." A worthy tribute to a man who deserves to be remembered as something more than "The Editor of Watson's manuscripts."

The Dorchester Ball

The annual Ball is always an interesting as well as an entertaining event in the necessarily somewhat meagre social life at Bart's—its social life is restricted because there is nowhere in the Hospital to hold the smallest hop until the new Charterhouse Square building is open. The entertainment lies in firmly ignoring one's attenuated bank account and for once in a while enjoying the life of the fat and the wealthy and the belimousined. The interest is twofold. It lies partly in seeing who one's friends' partners are. This special occasion, thought of for months and planned for weeks, calls for special partners, and it is indeed interesting to note how the barometer of friendships has changed at short notice and to see that Mavis, an odds-on favourite a few weeks ago, has now relinquished pride of place to Lulubelle. Interest also lies in seeing one's chiefs in new rôles, laying aside the white coats of authority, putting on the tailed jackets of *bonhomie*, and gyrating—some of them very badly—round a smooth, polished floor. The senior staff were by no means prominent, but two professors, a well-known physician, an eminent surgeon and a tame psychiatrist were all seen with their hair at least loosened, if not actually down.

Some 300 people enjoyed the Ball very much—your correspondent takes it upon himself to speak for so many. The ballroom at the Dorchester is beautifully furnished,

the dance floor is good, the carpets are of thick plush, and the waiters are obsequious. Bill Savill's orchestra played popular hit tunes almost non-stop from 8.30 till 2, and the floor, though full, was never overcrowded. The buffet supper was well up to the high standards of Dorchester cuisine.

But there are also one or two criticisms to make. About three-quarters of all the dances were quick-steps, and after one has danced about five of these, even to tunes taken from "Kiss me, Kate" and "South Pacific," they become a bore. Neither tango nor rhumba was heard the whole night, and there were no more than four slow waltzes. The elimination dance was a farce—surely a little forethought could have found a more amusing way of eliminating couples than hiving them off by corners!

The other criticism is the lack of a cabaret. There is plenty of room for one in a Ball that lasts five and a half hours and costs the price of this one. A cabaret does not mean a costly chorus, but only a little organisation and not much expense. A few unusual songs well sung, one or two comedians, and a sketch suitable to the tone of the evening would provide a most welcome interlude and make the annual Ball a first-class event. It should not be difficult to find the talent necessary for this either in the hospital or among the large number of people connected with, treated at, or interested in Bart's.

Vice-President

Mr. F. C. W. Capps has been appointed Vice-President of the British Association of Otolaryngologists for 1952. The *Journal* sends its congratulations to him.

Students' Union

We congratulate Professor Garrod upon his election as the new President of the Students' Union. He takes the place of Dr. Strauss.

Professor Garrod's election created a vacancy for a new Treasurer, to which Professor Blacklock has been elected. The other two treasurers are Professor Cave and Mr. Alan Hunt.

Notice

Mr. C. Naunton Morgan is standing for election to the Council of the Royal College of Surgeons.

Publication

We congratulate Philip Gosse on the publication of his biography of Philip Thicknesse entitled "Dr. Viper—The querulous life of Philip Thicknesse." *Journal* readers will remember that Mr. Gosse was the author of the article in the January issue entitled "Four Humorous Writers from Bart's." A review of his book—for which we wish him every success—appears on another page.

Bart's Bombsite Garden

Not many people at the Hospital realise that outside the Bart.'s Workshops is a bomb-site garden, which must be one of the first of such gardens to be built in London, since it was started well before the war. The death of the workshop cat, Minnie, inspired the original garden, which was planned as a small area of crazy paving but grew to include a birdbath, flower beds and a large rockery. In 1938 the garden was already so famous (such things were rare in the pre-war City) that C. H. Middleton trespassed in a nearby building to get a view of it.

In 1939, with war threatening, some 450 tons of sand (lest sandbags should be needed to protect the Hospital) was stored on the land immediately adjoining the garden. A hoarding was erected to prevent the garden from being quite submerged in sand. In August, 1939, all the sand was put into bags in record time—barrels of beer were provided for the workers—and the garden returned to normal.

During the big air raid of May, 1942, the adjacent buildings were destroyed by a land mine, and most of the wreckage was deposited on the garden. For the remainder of the war no one had time to clear up the mess, and the garden ceased to be.

In 1948 the workshops were to be repaired and it was necessary to put up scaffolding. To do this the debris had to be cleared away, and it became possible to reclaim what was to become our *bombsite* garden. A colossal amount of work had to be done to move and support the debris, and a very ingenious wall of bricks (but no cement) is holding back over six hundred tons of it.

The garden now has a rockery with a pool, an ornamental stand made from an old flower-pot and a dustbin lid, flower beds, and cinder paths, and is on four different levels. Many of the plants have been rescued from the Hospital dustbins, and others have been given by the Hospital gardeners and by the offices which overlook the site.

The whole garden has been built, and is kept up, by three members of the Bart.'s workshop staff, and all the work has been done in their lunch hours. If any of our readers have some of their lunch hour to spare they should go and see this attractive garden; they can be sure of a warm welcome from the Bart.'s Bombsite Gardeners.

College Hall

The new College Hall at Charterhouse Square is now fully open. It was much admired when it was on view last month; and, looking round the building, one received an impression of "style" which has been sadly lacking from post-war Britain. Everything has really been *designed*, and there is no evidence of "We couldn't do that, we hadn't got a licence." One was reminded, not so much of the Festival—for here is something solid and lasting—as of seeing round a great new liner before her maiden voyage. However much the *Journal's* correspondents may disagree about it, *Scandinavian* is the word which will convey the right impression of this building to old Bart.'s men, who have not yet seen it. We say "not yet" because we hope that all Bart.'s doctors will come and see this fine new building. They will not be disappointed.

On behalf of the present and future students here we say thank you to the Medical College for a building which will be the pride of Bart.'s for many years to come.

Medical Spelling

It has been pointed out that the word humorous was twice mis-spelt "humerous" in our January issue. This seems to be an occupational condition, even if it does not quite amount to a disease; the link with humerus must prove too strong for many medical men. No doubt there are numerous examples; for instance, oarsmen often spell the cranium—"scull," while anatomists give scull a "k." Nevertheless we apologise for the mistake.

Wessex Rahere Society

The list of old Bart.'s men living in this area is now sadly out of date. Dr. Charles Wroth has a meeting arranged in Exeter for April 19, and would be glad if any old Bart.'s doctor who now lives in Wessex would communicate with Mr. Daunt Bateman, 3, The Circus, Bath.

BIRTH

JEPSON. On January 16, 1952 at Invercargill, New Zealand, to Joan (nee BLACK-LOCK) and Frank—a son, Charles Robert. Both well.

"ON FARING FOREIGN"

by SIR PHILIP MANSON-BAHR, C.M.G., D.S.O., M.D., F.R.C.P.

IT IS difficult for those who have not had any first-hand experience of life in the Colonies to understand what an enormous task confronts the endeavour to raise the standards of health in illiterate native peoples. Civilization spreads very slowly, slower than the stay-at-homes can realise; doctors have to fight famine, drought, poverty, diseases and malnutrition. The majority of natives are, under the best circumstances, living on inadequate and ill-balanced diet, and it is a matter of opinion, whether this does not constitute the background to most tropical infections and render their efficient treatment more difficult to achieve. It must not for one minute be thought that the so-called tropical diseases always dominate the scene, because tuberculosis, venereal disease, helminthic infections, fungus skin diseases, pediculosis and scabies are widespread.

In spite of this statement much progress has been made during the last 25 years. Yellow fever, once the scourge of West Africa, has been fully controlled, and in many places eliminated, whilst malaria has been virtually eradicated from most of its ancient strongholds, so much so that the West Coast of Africa which was formerly known as the "white man's grave" is now regarded by some actually as a health resort.

At present there are in the Colonial Medical Service some 800 administrative, public health and clinical posts for officers holding a registrable medical qualification. Of these some 50 posts are available for women medical officers. There is also a large auxiliary force of locally-trained doctors and medical orderlies.

There are opportunities for men with higher qualifications which have been approved for the purpose of qualifying for appointment as Special Grade Medical Officers such as F.R.C.S., M.R.C.P., M.R.C.O.G., and for those with diplomas in ophthalmology, psychology, bacteriology, clinical pathology, medical radiology, public health, and anaesthetics.

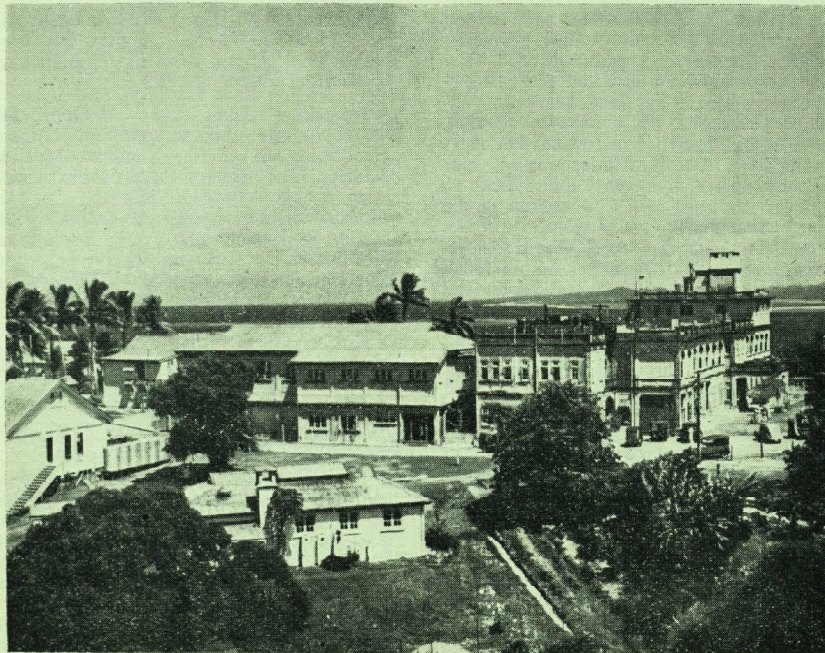
Successful candidates would enter the Medical Officers' salary scale with £1,050 per annum rising to £1,590 per annum in East, or £1,060 to £1,600 in West Africa and, in addition, they receive increments in respect of war service and approved professional experience. The salary scale in Malaya is from £1,120 to £1,652. In most countries higher salaries than these are paid to men on short-term appointments.

Recently a scheme has been drawn up for the employment of doctors from the National Health Service in the Colonial Medical Service. The primary object of this scheme is to enable doctors to join the Colonial Medical Service for temporary periods without loss of pension rights within the National Health Service superannuation regulations. The scheme applies especially to those Medical Officers who, within 12 months of ceasing to be employed by a Regional Hospital or Board of Governors of a Teaching Hospital, should seek to join the Colonial Medical Service. The doctor who accepts this will be required to serve for such period as may be arranged for one, two or three tours up to a maximum of six years in all.

For superannuation purposes he would continue to participate in the National Health Service Superannuation Scheme. The contributions payable are based upon his Colonial salary, whilst the Colonial government would pay the employer's share of contribution, i.e. 8 per cent. of Colonial salary. The doctor so employed will be eligible to transfer permanently to the Colonial Medical Service, on transfer to the service payment of contributions under the National Health Service would cease. Service which is pensionable under the N.H.S. Superannuation regulations would be regarded as qualifying for Colonial Pension. If the Medical Officer elects to re-enter the National Health Service on expiration of his period of service in the Colonial Medical Service for which he is engaged, he will be granted 20 per cent. of the aggregate of his salary during his period of service to the Colonies.

In spite of our somewhat over-generous Colonial policy of the last few years there

still remain a number of countries which require the services of British Medical Officers. In the Mediterranean, where the climate is salubrious and there are many historic and cultural attractions, there is Gibraltar and Cyprus where you can always eat oranges and lemons to your heart's content. The climate is in the main temperate; in summer the maximum temperatures range from 83° F. to 85°; but from



Colonial War Memorial Hospital at Suva, Fiji Islands.

June to August it is practically rainless. There is little indigenous disease and no malaria or typhoid.

Cyprus is still one of the cheapest resorts in the world. The climate is ideal so that women and children can remain permanently on the island. There are very numerous opportunities for sport, for shooting, fishing, and even for skiing. As the result of the recent anopheles eradication campaign there is no danger any longer of being infected with malaria.

Africa is hot, in parts dry and dusty; in others steamy, soggy and wet. You cannot expect otherwise. You can be very hot indeed in Central Africa; you can just be cool, but also you may freeze. With such a range, in such a vast continent, we have much to choose from. Aden guards the gateway to Africa and Arabia. It is, it is true, hot, dry and dusty. Camels and

smells abound. There are those who actually enjoy them.

East Africa is a white man's country and in times like these is the focus of attraction for many. The climate is, of course, tropical, but is modified in many ways. It differs according to the elevation between the coast and the Central Plateau.

The highland area (5,000 to 10,000 feet) with cold nights, and occasional frosts, provides a bracing climate, ideal for Europeans.

For those who like the wide open spaces, let me recommend N. Rhodesia. Although it lies between 8-18° south of the Equator, its elevation robs it of the unpleasant high temperatures and humidity usually associated with the tropics.

During the winter months—May to August—fair, cool weather is the rule and ground frost is not infrequent.

Nyasaland—a land of lake and mountain—where tea and coffee grow, has been a bit of a Cinderella amongst its larger neighbours; but it has its attractions and medicine there is varied and interesting. The climate is similar to that already described above.

West Africa has certainly had a bad reputation and this it consistently maintained, until some 40 years ago. Now as the result of the newer antimalarial drugs and antimalarial measures, together with improved hygienic conditions and a more sensible outlook on the part of Europeans—the discarding of antiquated notions about sunhelmets and clothing—and most of all, by the introduction of the motor car and the frigidaire, the outlook has improved beyond recognition. Now European women and children reside in the Gold Coast as well as in Nigeria and Sierra Leone for a year and even longer without any recognisable deterioration of health, but children should not remain after reaching the age of six or seven. Opportunities for sport naturally vary in different stations, but tennis is usually available and there is excellent bathing in some resorts on the coast.

Mauritius is an island in the Indian Ocean, the ancestral home of Paul and Virginia and the Dodo, though situated within the tropics, it has a particularly even temperature, but is subject from time to time to tropical cyclones. Mauritius is the typical example of the ideal healthy tropical paradise which was ruined by the introduction of malaria from the mainland of Africa nearly 100 years ago. Now the island is rapidly regaining its reputation as a tropical health resort as the result of the application of D.D.T. on a large scale.

Further north lie the Seychelles which are seldom visited by the tourist, but which are extremely beautiful and healthy and, considering their proximity to the Equator, enjoy an agreeable climate. In the South Atlantic lies the Island of St. Helena, where lay the tomb of Napoleon and which was so

tragically connected with the closing years of this historic phenomenon. The climate there is mild and healthy with temperatures ranging between 46°F. and 86°F.

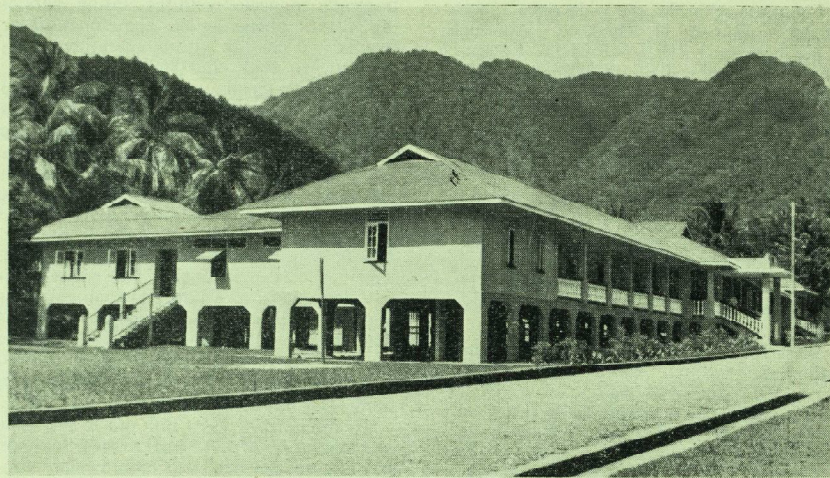
In the vast Pacific a number of islands are staffed by British Medical Officers. The most important are the Fiji group and these are in the Western Pacific where the climate is healthy and there are no anopheles mosquitoes and, consequently, no malaria. The rainfall is heavy, averaging 120 ins. in the wet zones and about half of this in the dry. The Polynesians are a fine, upstanding race, who have taken to cricket and rugby football, like ducks to water, and their relations with the British have always been co-operative and friendly. The climate is suitable for most Europeans. The average maximum temperature is 82.5°F. and the average minimum 71.5°F.

To the north-west of Fiji and in the same administrative area lie the British Solomon Islands, but the heat and humidity are considerably greater and exert an enervating effect upon most. These islands are fortunate in lying outside the hurricane belt and the coconuts flourish on a large scale. For those who enjoy a Crusoe existence amongst coral reefs, palm trees and lagoons surrounded by friendly and attractive people the Gilbert and Ellice Islands can be recommended.

Far in the South Atlantic, bordering the Antarctic seas lie the Falkland Islands where conditions are very different indeed. This is the land of seals and penguins and the temperature is low, ranging from 40°F. to 65°F. in summer, and from 30°F. to 50°F. in winter.

In the West Indies the climate is, of course, tropical but very favourable on account of the cooling effects of the N.E. trade winds, so that even in the hot season the temperature rarely rises above 93°F. The rainy season sets in about June and lasts till the end of the year. In the Bahamas malaria is practically non-existent. In these islands which make an ideal winter resort, the climate is delightful with an average of 70°F. Barbados has a reputation for health and the climate is equable and cooler than its proximity to the Equator would suggest.

Beautiful Bermuda is well-known as a millionaire's playground. The climate is healthy: malaria is absent and it is particularly agreeable without extremes of cold or heat. The summer season—July to September—is enervating.



Souffriere Hospital and Health Centre at St. Lucia, Windward Islands.

Up till the last few years British Guiana, where the sugar comes from, had an unenviable reputation for malaria, but this has receded almost to the point of extinction, by spraying with D.D.T. The heat on the coastal plain is tempered by sea breezes and the maximum shade temperature rarely exceeds 85°F. or falls below 73°F. on the coast. Nearby lies British Honduras, the forgotten colony, the headquarters of Chicle from which the chewing gum of the Americas springs and the home of mahogany. There the conditions are similar to the West Indies.

Jamaica possesses, apart from the occasional hurricane, an ideal climate, for it is hilly and in parts mountainous. The mean temperature of Kingston is 78.7°F. rising to 87.6°F., but falling to 71°F. in the early mornings. The Leeward Islands comprise Antigua, St. Christopher and Nevis, Montserrat, Trinidad and Tobago. Here, too, the climate is delightful from the end of November to May. After this the trade winds peter out and the rains set in, Trinidad, the home of asphalt, has a slightly warmer climate and the night temperatures average 74°F. In the Windward Islands—Dominica, Grenada, St. Lucia and St. Vincent, the climate is pleasant from December to May. From July to the end of October

there is greater humidity. Malaria still exists, but is minimal.

On the other side of the world there is fertile, prosperous Malaya where the climate is particularly healthy for a tropical country, though the range of temperature is small, varying between 86.8°F. to 74.3°F. In most parts there are no marked rainy or dry seasons, but in some there are a couple of dry months. The average rainfall is about 100 ins., so that the vegetation maintains an intense green colour. European children do well up to the age of six. The saving grace are hill stations situated from 2,000 to 4,000 feet.

Hong Kong, that busy and most important emporium, is favourable to Europeans, for there is a cool, dry winter and a well-marked seasonable change, though the summer is trying on account of the humidity, the temperature rarely exceeds 98°F. From November to March the climate is well-nigh perfect with temperatures from 35°F. to 80°F. Children can remain in the colony until they are eight or nine years old.

The climate of North Borneo is tropical and equable, varying from 70°F. in early morning to 88°F. at midday. The nights are cool—about 70°F. Typhoons are unknown. Malaria, until recently, was widespread.

Sarawak is now controlled by the Colonial Office. The climate is healthy and resembles that of North Borneo. It has also the advantage of cool nights which induce blessed sleep. The annual rainfall in Kuching, the capital, is 130 ins. The N.E. Monsoon blows from October to March.

You may want to know in what directions you could make yourself more useful and how you could undertake any original work. For the clinical observer there is still an immense field in what is best known as "geographical" pathology—that is the incidence of various diseases and their apparent predilection for certain races of mankind. In this category we can place pernicious anaemia, nutritional anaemia, chlorosis, Cooley's anaemia, sicklaemia and the various forms of leukaemia. Then there is the influence of diet and habits on various races on the incidence of peptic ulcer, appendicitis, diverticulitis and carcinoma. Why is coronary thrombosis so rare among native races living under primitive conditions, and why is primary hepatic carcinoma relatively so common in Africans? What is the true etiology of cirrhosis of the liver in Mohammedan races, and in whom alcohol

can play no part? What are the various types of steatorrhoea in tropical races?

A new disease of childhood—malignant malnutrition (*Kwashiokor* of Cicely Williams) appears to be extremely common, is there a peculiar distribution which might shed some light on its essential cause?

A comparatively new entity is tropical eosinophilia or pulmonary eosinophilosis. What is its incidence and distribution?

In the field of cardiology, there is an immense amount to be done.

These are some of the questions which might attract the general clinician. But to make a contribution to scientific tropical medicine entails the special study of the triad, protozoology, entomology, and helminthology, and all of them immense subjects in themselves. That this special training is bearing fruit is shown by the number of really fundamental discoveries that have been made in recent years.

And so in this strain it would be possible to continue *ad infinitum*. To the wayfarer to tropical lands I wish "good hunting" with the hope that his steps may lead him down as many pleasant and interesting pathways as those of the writer of this article.

EXAMINATION RESULTS

CONJOINT BOARD Final Examination

January 1952

Pathology

Bartley, R. H.
Dickman, H. R.

Harriss, E. H. L.
Middleton, G. W.

Ryan, J. F.
Sarma, V.

Waddy, G. W.
Watkins, D.

Medicine

Batey, I. S.
Blake, A. S.
Channon, C. E.

Goode, J. H.
Goodspeed, A. H.
Husainee, M. M.

Parker, R. B.
Power, G. H. D'A.
Stoke, J. C. J.

Todd, I. N.

Surgery

Beale, I. R.
Channon, C. E.
Cookson, T. S.

Hall, M. C.
Heckford, J.
Ladell, R. C. H.

O'Reilly, P. B.
Parker, R. B.
Rosser, E. M.

Wynne-Jones, A. P. J.

Midwifery

Dodge, J. S.

Ladell, R. C. H.

Lewis, J. A.

Parker, R. B.

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:—
Blake, A. S. Husainee, M. M. Parker, R. B. Rosser, E. M.
Channon, C. E. O'Reilly, P. B. Power, G. H. D'A. Waddy, G. W.
Goodspeed, A. H.

UNIVERSITY OF LONDON

December, 1951

Special First Examination for Medical Degrees.

Grassett-Molloy, G. J. M.

Thomas, A. D. M.

The following External Candidate has completed the Internal First Medical Examination.
Ramsden, R. A.

The following Higher School and General Certificate of Education Candidates have qualified for exemption from First Medical.

Barfoot, P. W.
Thom, B. T.

Butler, A. C.

Costley, S. R.

Freestone, D. S.

DEATHS

DR. W. H. SQUARE

A Correspondent writes:—

Shortly before last Christmas and a few weeks after his ninety-first birthday, Dr. W. H. Square died at his home in Bedfordshire. It is believed that he was the oldest practising doctor in the country and two years ago he had said that he was the oldest Bart's man in practice. He was born in 1860, qualified in 1884 and spent sixty-seven years in general practice—over fifty of them in Leighton—ceasing to work only a few days before his death.

A stranger meeting him some months before he died was at once arrested by the alertness of mind and activity of body of a man of obviously great age. His tall thin figure, erect carriage, trim beard and Edwardian dress made an unforgettable picture. A visit with him to the cottage of a widow of the first world war whose daughter was seriously ill revealed clearly his important place in the life of the community which he served as well as a depth of feeling which a long and intimate experience of suffering could not diminish. It seemed, too, that he had remained a student throughout his life, for he had a good knowledge of relatively recent advances in medicine.

In meeting such a very old Bart's man it is natural to wonder about the Hospital as he knew it. Among the physicians of those days were Drs. Southey and Gee; the surgeons included Messrs. Holden, Smith and Willett; Dr. Matthews Duncan was physician accoucheur and Mr. Harrison Cripps the surgical registrar. Outstanding among Dr. Square's student contemporaries were W.

Herringham, T. W. Shore, F. W. Andrews, A. Garrod, A. Bowlby and J. Berry. Several of these have by their labours added to the reputation of their hospital. It must surely be that the long life of service of their less well-known contemporary has done likewise. In addition his life indicates with particular clarity the importance of the general practitioner's contribution; his personal relationship with perhaps several generations of his patients gives an insight into their complaints which others will frequently lack; his ever-growing experience of illness in all its forms and in the home is a basis for true medical wisdom; and in addition with the coming of old age his value to the community may remain undiminished.

J. E. A. O'C.

LT.-COL. HUGO

Lt.-Col. Edward Victor Hugo died recently after a short illness. He was a medical student at Bart's in the eighties and graduated M.B., B.S., in 1890, with Honours and Gold Medal. He left Bart's for the Indian Medical Service in 1892. He was mentioned in dispatches for his work on the North-West Frontier in 1898, and was appointed Professor of Surgery at King Edward's Medical College at Lahore, in 1908. This post he held until 1922, with a break for the first World War during which he resumed his military duties, and was made a C.M.G. in 1917. Col. Hugo married in 1909 and his widow survives him. We offer her our deepest sympathy.

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

THE TREATMENT OF ACUTE APPENDICITIS

by HARRY KARN

Dunedin Hospital, New Zealand.

THE object of this article is to recapitulate briefly the clinico-pathological features of Acute Appendicitis, to demonstrate the lines of treatment, and to outline certain points in the technique of Appendicectomy that may prove of value to those to whose lot the operation falls but occasionally; those practising in outlying areas inaccessible to major surgical centres, the Ship's Surgeon, and finally to House Surgeons embarking on the operation during the early stages of their career.

Appendicitis, as a disease, will continue to tax the ability of the Medical Profession. It shows no abatement in its case incidence and continues to exact an annual mortality rate in New Zealand of about 50 persons. It is now apparent that, after 50 years of skilled surgical intervention, there has been a sustained fall in the mortality rate—the figure has been nearly halved since 1940.

In any hospital serving a population of 50,000 and over, it is rare not to have a case admitted within the 24 hours of any one day: few nights pass without the resources of a busy operating theatre staff, and already tired surgeons and residents, being called upon to perform an emergency Appendicectomy.

Operation follows diagnosis—

Age is no contra-indication to operation. concurrent pregnancy makes operation imperative. The object to be achieved is Appendicectomy; the removal of an intact organ before either bacterial seepage or perforation have given rise to Peritonitis. It is by no means a minor procedure, and those embarking on it must be prepared to encounter and possibly deal with any of the conditions in the "Acute Abdomen." The successful extrication of an intact organ may demand a great amount of skill and careful judgment, yet for the small amount of trauma the result in most cases is the most gratifying of any abdominal operation.

In the long run it does not matter who performs the operation, figures collected from different centres appear to equalise out all round; what does matter is the individual diagnosing the acute abdominal condition as Acute Appendicitis WITHIN THE FIRST

24 HOURS—be he patient, relative, friend, general practitioner, physician or surgeon—admission to hospital must follow without delay.

Hour by hour, day, by day, the mortality rises with the march of pathological processes. Experience shows that general peritonitis is rare within 24 hours of the onset of symptoms, eradicate therefore all cases of 24 hours duration and over and the mortality rate should then fall to that of the surgeon's capabilities.

The symptoms are fairly clear-cut: yet, for the delay, the pitfalls are many; the mode of onset can give no clue as to the probable state of affairs 24 or 48 hours hence. *Delay, purges and enemata court disaster.* How often has the surgeon castigated the dose of Castor Oil traced as the cause of the perforated Appendix; yet he also suffers the humiliation of removing an intact and normal organ when he has embarked on, what is colloquially termed, a "true bill" case. In spite of this, there must be no exception to the rule, that all cases admitted to hospital and then diagnosed by the surgeon as Acute Appendicitis, be subjected to operation as soon as possible, even though the symptoms are six hours from the onset and the hour is midnight. The disease is possibly still confined to the organ, peritoneal disturbance is minimal, and the outcome will be one of full recovery with a smooth convalescent period.

To quote from page 60, "The Statistical Study of Appendicitis," by Young and Russell, a pamphlet published in 1939 by the Medical Research Council (Special Report Series No. 233):—

"Figures need great scrutiny, but for Peritonitis it (the mortality rate) goes up to 30 per cent. or more depending on the time interval elapsing between the onset of symptoms and either admission to hospital or operation. Although the real advantage to be gained from early operation is probably not represented accurately by these fatality rates, because the comparability of the groups at different intervals is doubtless impaired in some degree by circumstances that result in the selection of cases, there is convincing evidence that early admission to hos-

pital is one of the most potent factors in reducing the mortality of Appendicitis. Bowers in 1934 made an overall study of 15,000 cases:—

In 24 hours the mortality rate is 2%

In 72 hours the mortality rate is 9%

It would appear that the only hopeful method of further reducing the fatality of the disease is to encourage, by the education of the public, earlier entry to Hospital and avoidance of purgatives and laxatives."

Based on an intensive analysis of all cases of Appendicitis admitted to the Dunedin Hospital over a continuous period of twelve months, I came to the conclusion that there are three major sources of delay in the operative treatment of the cases.

Sources of delay in diagnosis.

(a) THE PATIENT. He misdiagnoses the condition and delays the request for medical aid.

(b) THE GENERAL PRACTITIONER. Misdiagnoses the condition and fails to send the case to hospital for operation.

(c) THE SURGEON. Misdiagnoses the case after admission to hospital and delays operative intervention.

(a) The Patient.

This is the largest group, and it is dependent upon several factors, among them being the fear of operations, and the human tendency to procrastination. Intestinal upsets are common, the "gastric flu" is a satisfying household diagnosis, and the calls of everyday duty or the pressure of urgent business cannot be delayed by sudden illness. Some dietary indiscretion is blamed: as the day progresses the full classical syndrome appears; the severity of the pain and vomiting depending on the underlying progressive pathology in the two groups (a) Catarrhal, or (b) Obstructive. The day's work is done, night draws nigh, and after the household retires the patient appears to become more conscious of the severity of the pain. In an estimation there is a delay of up to eighteen hours, in the majority of cases, before a doctor is called in for consultation. Some hope to avert the disease by starvation, hot fomentations and bed. Others take a purge—the dangers increase with each hour of delay. On close examination of statistics the highest overall mortality figures lie between the ages of 5—15 years. The child either delays reporting the illness, or is helpless against the parents' or guardians' administra-

tion of purgatives—the "cure-all" for any intestinal colic. The liability resting on persons in such cases is high. Professionally we are powerless to prevent this, and can only hope to avert these disasters by continued propaganda.

Fatalities to children due to vehicular accidents are headline news, those due to purgatives warrant no comment.

(b) The Medical Practitioner.

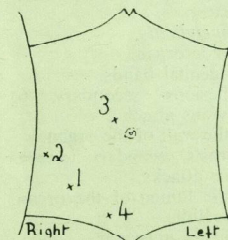
Appendicitis, as a disease, varies both clinically and pathologically. fallacies appear in diagnosis; the same case seen hours later may present different signs. If, then, Appendicitis enters into the differential diagnosis, admission to hospital for observation is the only rational treatment.

The Early Symptoms and Signs

If these were clarified, from the point of view of the individual making the FIRST examination and diagnosis, there should ultimately be no mortality rate.

The casual reader may think that all this is unnecessary. The literature on the disease, recorded by the greatest and most competent of surgeons, is readily available in all the standard textbooks. In spite of all the accessories to investigation, a thorough history and careful clinical examination are the first essentials in diagnosis. I would apologise for recapitulating and stressing certain points.

A careful HISTORY is an absolute necessity. Time spent in eliciting a chronologically correct story is time well spent. It can be taken as a safe guiding rule that in a FIRST attack the pain never commences in the R.I.F. Recurrent attacks are common.



1. Pre-Ileal. R.I.F. The classical McBurney point.
2. Retro - Caecal. Right Loin.
3. Sub - Hepatic. Para-Umbilical.
4. Pelvic. Suprapubic and Rectal.

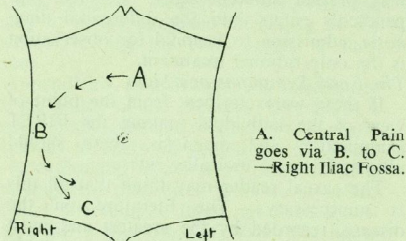
The Anatomical Positions of the Appendix.

In a first attack of the disease the pain is usually sudden in onset. One may accept the "bolt from the blue" description of a generalised central abdominal pain in an

otherwise healthy individual, often waking him from his sleep in the early hours of the morning. Vomiting usually accompanies this heralding attack of pain. There may be no rise in temperature or pulse rate.

As the disease progresses the pain travels to reach, and remains fixed, in the R.I.F. with certain variations depending on the anatomical situation of the inflamed organ.

Evidence of toxæmia—rising Pulse Rate and Pyrexia are apparent within 24 hours. Increase in vomiting and persistence of pain complete the clinical syndrome.



The Radiation of Pain in Appendicitis.

Three Clinico-Pathological Entities can be Recognised.

1. *Catarrhal Appendicitis.*

Causation. Dietetic.
Secondary to Gastro-Enteritis.
Metastatic selective bacterial action in Specific Diseases—Tonsillitis, Influenza, and the Exanthemata.

Clinically the pain is generalised, localising later. Toxaemia and constitutional symptoms appear early.

2. *Obstructive Appendicitis.*

Causation. (a) Outside organ.
Congenital bands.
Adhesions secondary to previous attacks.
(b) In the wall of the organ.
Fibrosis secondary to previous attacks.
(c) In the lumen of the organ.
Faecoliths.
Neuro-muscular inco-ordination.

Clinically the pain is more colicky and associated with vomiting. At first no marked constitutional reaction, but the condition may pass rapidly on to Catarrhal inflammation, Perforation with sudden relief of pain,

progresses after a dangerous silent period to the stage of Peritonitis.

3. *Peritonitis.*

Perforated Appendix.
Localising Abscess formation.
Generalised Peritonitis.

Clinically the Constitutional picture is one of increasing Toxaemia. Pyrexia, rising pulse rate and vomiting.

The differential Diagnosis.

A detailed discussion on the differential diagnosis is not within the scope of this article. A short list of the COMMONER conditions is added:—

IN CHILDREN

Mesenteric Adenitis.
Gastro-Enteritis.
Right-sided Pyelitis.
Right-sided Basal Pneumonia.
Prodromal stage of Exanthemata and Poliomyelitis.

IN ADULTS

Gastro-Enteritis.
Right-sided Pyelitis, Ureteric and Renal Colic.
Cholecystitis.
Perforated Duodenal Ulcer.

IN FEMALES

Ectopic Gestation.
Torsion of Ovarian Cyst.
Salpingitis.

It may be noted how often

(a) The RETROCAECAL Appendix is misdiagnosed as Pyelitis or Ureteric Calculus, in adults.

(b) The PELVIC Appendix is misdiagnosed in children as Gastro-Enteritis. The diagnosis is decided by eliciting Rectal tenderness. Delay in operating on children is fraught with danger, if there is the slightest suspicion, then laparotomy is the safest procedure.

(c) *The Surgeon.*

Some cases may reach Hospital with a doctor's letter specifically mentioning pain and tenderness; this may not be elicited on examination. It occasionally happens that the case is being seen in a "silent" stage, commoner with the Obstructive types of Appendicitis. In uncertain cases the outside doctor should be contacted personally for further confirmatory information; if there is abdominal tenderness the case should be admitted for at least 24 hours close observation. One "Appendix for Observation" admission is preferable to one perforated Appendix misdiagnosed.

Some Operative Details.

The cause of a death resulting from Appendicitis should lead to serious enquiry as to the exact causation, for in spite of everything gaps appear in case diagnosis and the final fall in mortality rests with surgical technique. It is a duty to watch, observe and criticise our own figures.

Our primary aim is the removal of an intact organ without the soiling of the general peritoneal cavity. In cases of established Peritonitis, efficient drainage and toilette of the peritoneal cavity, followed by procedures to combat Paralytic Ileus, and prevent the formation of Residual Abscesses—Pelvic and Subphrenic.

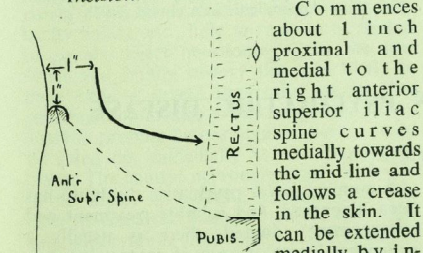
In "Bad Risk" toxic cases with extensive Peritonitis, drainage under local anaesthesia is the only possible line of operative therapy.

1. *The use of supplementary LOCAL ANAESTHESIA.*

After induction with general anaesthesia, the Ilio-inguinal, and Ilio-hypogastric nerves, are infiltrated with a 1% solution of novocaine. The lateral sheath of the right Rectus Abdominis muscle is infiltrated from the level of the Symphysis Pubis to the Umbilicus.

Part of the procedure can be performed through the muscle layers once the incision has been made. This greatly facilitates the muscle retraction in the Gridiron incision and aids in the delivery of an intact Appendix.

2. *The use of the modified McBurney Incision.*



The Modified McBurney Incision.

Commences about 1 inch proximal and medial to the right anterior superior iliac spine curves medially towards the mid line and follows a crease in the skin. It can be extended medially by incising the lateral edge of the Rectus sheath for the exposure of a pelvic appendix; it can with ease be extended proximally into the loin to expose a Retrocaecal appendix. In the hands of many surgeons this incision has never failed them in locating and removing an in-

tact appendix, in any of the anatomical dispositions.

3. *The importance of adequate exposure.*

Where the appendix is tense, bound down by adhesions, or the extremities ill-defined, as in the retrocaecal or deep pelvic positions, there should be no hesitation in extending the incision to gain adequate exposure. A long scar, through which an appendix is removed, is preferable to a small one through which an appendix is removed in pieces, or burst during manipulations. It is often technically simpler to remove a deep pelvic, or long retrocaecal appendix by the Retrograde method. Neither clamps nor direct tension should ever be applied directly to the walls of the Appendix: it is surprising and annoying to find how readily the tense organ can burst during manipulations.

4. *The whole Appendix is delivered.*

Lane's forceps hold up the ileocaecal angle and the mid-appendix, a mosquito or small artery forceps is applied to the tip of the free end of the Meso-appendix.

Two moist small packs are insinuated carefully between the parietal peritoneal edges and the fully exposed meso-appendix, caecum and terminal ileum, so as to isolate the inflamed appendix by means of a pack "barrage" from the general peritoneal cavity.

The vessels in the meso-appendix can often be visualised by the reflected light in the operating area; they are clamped off in pairs so that in cutting across them a minimum of blood, likely to contain bacteria, is shed into the open wound. In cases with a thick, fatty mesentery it is advisable to grasp the vessels in toothed Kocher forceps and transect them with catgut on a round-bodied needle.

As the inflamed organ is progressively delivered it is wrapped around in a moist swab, should it then perforate during the manipulation, the contents would spill extra-peritoneally into the protective swab "barrage." A sucker should always be available.

5. *Drainage.*

"If in doubt Drain," remains a wise axiom. If not intra-peritoneally, then at least down to the peritoneum.

Avoid the use of thick drains. Penrose tubing, oiled silk, or glove-rubber dam loosely packed with a wick gauze ("cigarette" type of drain) are most efficient, they do not press on coils of bowel, and are readily removed. In cases with extensive Peritonitis it

is well worth adopting the Mickulicz-Gibson pack drainage. The wound is left wide open, except for some holding tension sutures, and secondary suture is performed later.

It is advisable to subject swabs of the pus to examination for the presence of both anaerobic and aerobic organisms. Tests should be done for their sensitivity to Penicillin, and the Sulphonamide group of antibiotics. There is much work yet to be done on the bacteriology of appendicitis; in some severely toxic cases there is obviously a mixed bacteriological flora, the newer antibiotics of the Streptomycin group might prove valuable adjuncts to chemotherapy.

6. Peritonitis.

Cases presenting clinically with peritonitis may be given a prophylactic dose of Penicillin pre-operatively; it may be noted that such cases bleed readily, this may be secondary to the haemolytic action of the organisms responsible for the disease: the administration of Vitamins C and K may diminish this action.

Prophylactic measures in the form of continuous Gastric syphonage by the Wangenstein technique, and intravenous replacement of fluid should be established at the time of operation, to prevent and treat the complication of Paralytic Ileus. These procedures, combined with the post-operative administration of Penicillin and the Sulphonamide group of drugs have noticeably halved the mortality rate in the last 10 years.

7. In uncomplicated cases the patient is allowed up on the day following operation.

INTERCURRENT ILLNESS IN PSYCHIATRIC DISEASE

by DR. LOUISE ROSE

THE term psychosomatic is now a commonplace, although the name itself may actually obscure the simple fact that no person mentally ill can avoid some somatic manifestation, and vice versa.

In the treatment of psychiatric illness, but more particularly in the day-to-day management of milder forms of neurosis, one becomes familiar with the general personality-picture of the individual concerned and relates clinically the sign—and symptom—complex to the personality presented.

Pulmonary Embolism as a post-operative complication is a rarity.

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 Hays (1947), Surg., Vol. 21, p. 297, "Treatment of Acute Appendicitis in a closed city."

Assuming that a psychiatric disability has been diagnosed, and suitable treatment and management adopted, there is usually a somewhat lengthy period of contact between the patient and doctor, during which time new signs and symptoms may appear and old ones may alter or disappear. It is this impact of new symptoms against which one must constantly be on guard, because there is no reason why a patient with a psychiatric illness should not suffer from a new intercurrent disease. One need not stress the

undesirability, in the pressure of a clinic or consulting room, of reassuring, without adequate consideration, the sufferer that his new visual disturbance or unsteadiness or headache or such-like, is "just another part of the nerve trouble." It is not simply that one must be a reasonably competent clinician, but rather that one must have the attitude towards clinical assessment which will make it possible for doubt to enter into one's mind as to whether the new symptom or sign presented may not, in fact, herald a new disease-entity. One must be able to ask whether the new symptom is compatible not only with the original diagnosis, but with the personality of the subject. In any case, one must be prepared not to waive the complaint aside on the assumption, without due examination of the facts, that it "belongs" to the original illness. A few cases in point:—

Mr. B., aged 54, an engineer, suffered from a mild anxiety state for a number of years; the symptoms included the usual various and variable tremors. At first interview he complained of recent faulty balance, unsteady gait, slurred speech, difficulty with writing, etc. Examination of the central nervous system revealed positive evidence of cerebellar degeneration which has steadily progressed while the psychiatric condition has improved.

Mr. F., aged 53, an architect, had had two depressive episodes about the ages of twenty and thirty (one severe) and was first seen in hospital, semi-comatose with secondary impairment of all intellectual function, apathy, faulty habits, etc., able to reply in a whisper to simple direct questioning. On the personal and family history this was likely to have been a severe depressive stupor, but confirmatory evidence was sought by narco-analytic probing before organic disease could be ruled out sufficiently to warrant electroplexy. The central nervous system was found to be intact on routine examination. No clear psychiatric diagnosis could be made and observation continued. Death supervened in a few days, revealing *post mortem* a large frontal tumour.

Mr. B., aged 72, a retired violinist of somewhat hypochondriacal personality, a frequent attender at his doctor's rooms. He complained of weakness in the legs and some unsteadiness of gait in addition to his usual symptoms of "rheumatism" in the back and joints. Although not actually examined for

many months, he was referred to a Rheumatism Clinic for physiotherapy, where a nurse (if you please) suggested that he obtain further advice. He was by that time severely handicapped by the progress of sub-acute combined degeneration of the cord, but now, three years later, is maintained in good general health by routine monthly treatment.

Mr. T., aged 38, labourer, was referred for opinion concerning the poor response to rehabilitation (active and passive) of the right hand following injury at work. His complaint of inability to use the hand, and of weakness in the arms and shoulders was thought to be hysterical, motivated by the compensation factor.

Examination (*with his shirt off*) revealed typical wasting and fibrillary tremors in the muscles of the shoulder girdle, indicative of progressive muscular atrophy.

Miss N., aged 30. A recurrent depressive suffering from episodic palatal phonation thought to be an hysterical superaddition although in no way compatible with the depressive illness, which responded satisfactorily to electroplexy. The vocal disability remained and proved to be the first symptom of myasthenia gravis, episodic ptosis and dysphagia having supervened.

This is not a matter of diagnostic acumen because it is assumed that the competent physician will always be able to reach an adequate diagnosis when he has investigated the problem. The secret lies in the *attitude* which will allow of the necessary orientation towards examination and understanding of the personality and symptom-picture as a whole, so that if the new symptom does not fit in comfortably and obviously, the patient, *as a whole* should be re-examined with a view to deciding the correct place of the new picture in the old frame. This is not to say, of course, that hysterical symptoms should be reinforced by frequent unnecessary examination; on the contrary. The examination should be conclusive—but the conclusion must follow logically on the facts. New illnesses will not in this way be missed and mistakes of diagnosis and treatment will be avoided.

This subject was presented at a clinical discussion of the Bart's Department of Psychological Medicine under the title of "Multiple Pathology in Psychiatric Illness." The present title was suggested by Dr. E. B. Strauss, Head of the Department.

THE WIND-SPRITE

by E. A. J. ALMENT

It is a good and constant thing,
The friendliness of weather ;
Like meeting at the little inn
When reminiscences begin,
And strangers talk together.

Of all the ways that come to mind
Old memory's soft pretences,
The sudden motion of a breeze
Among the great slow-growing trees
Most strongly wakes the senses.

At midnight when the city's dead
An empty, fretful flutter
Strays idly round my ringing feet
And stirs the litter in the street,
And dies along the gutter.

High on a barren Wiltshire down
Where often I'd go ranging
The steady singing rhythm flows,
In waves across the grass it goes,
With light and shadow changing.

It whispers through a Cotswold vale
When summer's day is sleeping ;
Steals where a cottage chimney smokes
And flat among the nearby oaks
It sends the vapour creeping.

The wind that sits upon my sail
Along the Beaulieu river
Makes water-patterns all afloat
Like fingers of an acry giant,
And mast and rigging shiver.

The wild blast of the Norfolk coast
Of all my friends is dearest ;
Across the marsh their cry is borne
As duck come high and fast at dawn,
And I shall miss the nearest.

CORRESPONDENCE

CHARTERHOUSE SQUARE
ARCHITECTURE

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

Dear Sir.

May we reply to the strictures on our architectural knowledge implied in Mr. Barleycorn's courteous letter. He is indeed a veritable Argus—he has a hundred eyes—but should beware soothing music, particularly that of his own eloquence.

It is especially strange that Mr. Barleycorn sees fit to dispute our appraisal of textile patterns, particularly as we were given

a private view of samples and not the finished products, which are still being made. It also seems obvious even to a minor intelligence that a building conceived four or five years ago could not possibly owe any allegiance to last year's South Bank exhibition. As for "local materials" we need only instance the extensive use of Italian marble, which was imported together with native craftsmen who alone have the art of revealing its peculiar lustre.

The fact is, of course, that the origin of modern architectural style, which is your correspondent's main bone of contention, was "multifocal"; in Chicago, where Frank

Lloyd Wright built several private houses in the new idiom in the 'nineties, in Dessau in 1907 where Gropius founded his famous *Bauhaus*, in Vienna just after the first world war, and from this point of view the adjective "Scandinavian" is slightly misleading. But it was in the latter countries that the seed firmly took root, was adapted to local climatic conditions (hence the minor differences in the new College Hall, retailed with such beckmesserian delight by your correspondent) and, most important of all, was recognised and encouraged by National and Municipal Authorities in their housing schemes. No doubt all countries can point to isolated examples of modern architecture built for discriminating private patrons, but they can hardly exist anywhere in such officially sponsored profusion and good taste as in Scandinavia.

No one would gainsay the beauty and importance for *this country* of the Festival of Britain Exhibitions, but as a style it is at least forty years old, as many of our Continental friends were quick to remind us last summer. To deny honour where it is due is to reveal the impenetrable ha-has of an artistic chauvinism, conspicuously out of joint with a time when the salving of European culture is vital to our further existence.

We are, Sir.

Yours, etc.,

BURBANK AND BLEISTEIN.
Abernethian Room.

ALPINE CLUB

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

On reading your contributor's account, one wonders whether in fact, the climbers were in Cumberland or Wales. Even Cherterton could not make the A.6, however much it curled and twisted, reach the mountains of North Wales. The following names and mountains mentioned are not known in the Snowdon region. There is a Bettws-y-Coed, so descriptive of the wooded hollows in which the village shelters; Bettws-y-Loed conveys only the image of the populated clefts of the South Wales mining valleys. The difference is as great as Motherwell and

Glencoe. And where is Llewedd, Lliwedd, Crib goch, Glyder, Siabod, Tryfan, Carneddau. Get them right and learn their meanings so that in the comfort of Pen-y-Gwryd or Pen-y-Pass your members may mix the music of chimneys, couloirs and seracs with the ancient mountain and place names of Eryri.

Yours sincerely,

I. G. WILLIAMS.

Radiotherapy Dept.

A BAKER STREET
CORRESPONDENCE

The Editor,

St. Bartholomew's Hospital Journal.

Dear Sir.

Your article on "Sherlock Holmes and Dr. Watson at Bart's" in the December *Journal* makes a point which gives supporting evidence to a theory which I have long held and which I was able to put forward in a recent B.B.C. Broadcast discussion of the Sherlock Holmes Society of London on "Problems Connected with the Two Retirements of Sherlock Holmes."

What was Sherlock Holmes in fact doing during his two years travelling in Tibet under the name of Sigerson after his supposed death fall over the Reichenbach Falls, and what was his real reason for concealing his escape? Your contributor's article gives substantial grounds for believing that Holmes was connected with Augustus Matthieson, a well-known Bart's figure in the 1870's, in research into Opium and its alkaloids. The probability is that during his two years disappearance Holmes was making further investigations along the lines of this early interest.

The very fact of his secrecy would give weight to this opinion. Holmes told Watson that he kept secret his escape after the deadly encounter with Moriarty because he wished to foil the pursuit of Moriarty's followers. But, in fact, they were the only men who knew that he was still alive, for one of them actually witnessed the encounter and endeavoured to complete the attempted murder of Holmes by dropping rocks on him from above as he lay on a ledge above the Falls. Furthermore, his rooms were watched constantly for his return.

From whom, then, did Holmes really wish to conceal the fact that he was alive as opposed to merely concealing the position of his hiding place? I would suggest that it was from Watson himself. The only point on which these two excellent friends had any real divergence of opinion was Holmes' use of drugs. Watson disapproved strongly of this vicious habit and, diffident as he usually was in Holmes' presence, he made his feelings perfectly clear on that score, trying again and again to break Holmes of their hold. But in spite of all, Holmes continued to use both morphine and cocaine. May not the "Bar of Gold" have been an habitual haunt of his? The awkward encounter with Watson recorded in "The Man with the Twisted Lip," which interrupted one of his sessions of addiction, Holmes cleverly accounted for by explaining that he was pursuing a line of enquiry in connection with a case in hand. Holmes could not risk a recurrence of such an embarrassing rencontre. The "Bar of Gold" was becoming too hot for him. What more natural than that he should seize the opportunity once offered of taking up again his former search into the drug and dallying, perhaps, with the possibility of transplanting the Opium Poppy to England? For it was opium he was after. Cocaine does not occur in Tibet but the Opium Poppy grows in profusion. This obviously was the quest which employed the master-mind during those two years.

Again, what of his activities at Montpellier, supposedly in connection with coal-tar derivatives? This seems to be a far-fetched story of Holmes. Why coal-tar derivatives? Such an occupation would have little connection with Holmes' other pursuits as we know them. No, at Montpellier, he was amassing and sifting the knowledge he had acquired in Tibet, and pursuing his opium research. We know now that the synthesis of opium is a costly and unremunerative process—but may not that knowledge be due to the pioneer work of Holmes, probably under an assumed name and characteristically claiming no share of any glory to which his experiments may have entitled him. Regrettably, as with so much of his academic research work, Holmes has left us no records of his findings.

PAT COULSON.

Sherlock Holmes Society of London,
W.1.

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

In recent issues of the *Journal* we have read of two entirely imaginary (and now almost *legendary*) characters, who, it is pretended, once graced this Hospital. The enthusiasm of the pretenders is such that they now want to put up *plaques* to their heroic couple. It is to be hoped that the Powers-that-be will prevent the rash of such emblems—which has already broken out in Baker Street and at the Criterion from spreading to the Royal and Ancient. Perhaps the most surprising thing about this "speckled band" of pretenders is that they appear, in other respects, quite normal. When questioned about the latest cures promised by the press (or even about the Loch Ness Monster) they display a suitable incredulity. They are not astounded when told that two and two make four. But their faith in two mythical members of the genus "Private Detective" has no limit.

I write to suggest that it is time to call a halt, and to give honour where honour is due. It is to *one* man that we should raise our plaque at Bart.'s (if raise a plaque we must) and his name is Conan Doyle.

Yours hopefully,

FIAT JUSTITIA.

Abernethian Room.

A REVIEW REVIEWED

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

I write because, like the Rector of Huckley, I am a lover of accuracy. Readers of the *Journal* expect to be helped in their choice of textbooks by the reviews published; the January issue, by devoting all the available space to one book, hardly does this. Your reviewer tells us that we must buy this book, but he forgets to tell us whether it fulfils the purpose of its conception. He has a lot to say, but he does not tell us whether we can expect to find any word (as long as we know the correct spelling) in the new edition of *The American Illustrated Medical Dictionary*, as we could in the older editions. I take it that it is still so, for I found St. Vitus, lost to sight according to your reviewer, in 30 seconds, under

"DANCE, St. Vitus', Chorea," where anyone who has taken the trouble to learn to use a dictionary might expect to find the entry. Your reviewer, who is learned enough to know the difference between Calix and Calyx, which I am not, is obviously a Public School man, for he has allowed the surprising mis-statement: "LESBIANISM. Homosexuality between women." A bizarre contradiction, to appear in print without bothering to look up Homosexuality (which is NOT derived by any means from the Latin word *Hominius*). These two mistakes would have been avoided if your reviewer had taken more trouble; it is unfortunate that he did not.

It is not for an English review to poke fun at the spelling of a book designed for the

American market; let us be thankful for the inclusion of the English spelling, and for the fact that the book is still available on this side of the Atlantic, and at the original price. The biographical entries may be short (they consist merely of dates and nationality) but surely that is all the space that a *DIC-TIONARY* can afford to give them; after all there are larger reference books, but doubtless the innate sloth of your reviewer would discourage their use.

The review would have been more effective if only the last paragraph had been printed. So, I beg you, sir: keep them short and sweet.

I remain, your humble servant,

CEREBUS.

Wimbledon, S.W.19.

ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE STUDENTS' UNION

Income and Expenditure Account—year ended July 31, 1951.

INCOME		£	s.	d.
Members' Subscriptions	...	2848	3	10
Interest on Investments £172 14s. 8d.; Sundry Receipts, e.g., S.U. Ball	£11 19s. 7d.;	343	0	7
Sale of Refreshments £11; Stationery £141	...	646	4	2
Contribution by College towards Expenses of Foxbury	...			
Total Income		3837	8	7

EXPENDITURE		£	s.	d.
(1) Foxbury Athletic Ground:				
Wages £879 14s. 1d.; Rates £231 9s. 4d.; Telephone £20 18s. 2d.; Water, Gas, Elect. £76 1s. 11d.; Coal £36 4s. 2d.; Sundries £52 5s. 8d.; Maintenance	£198 7s. 6d.; Renewals £237 7s. 11d.;	1732	8	9
(2) Hospital and Charterhouse:—				
Newspapers £79 17s. 8d.; Accountancy £52 12s. 6d.; Wages £22 10s.; Sundries	£40 3s. 7d.; Printing and Stationery £203 12s. 7d.; Administrative Salary	498	16	4
(3) Clubs and Societies:				
Abernethian Society	...	29	12	6
Athletic Club	...	118	6	4
Association Football C.	...	82	15	6
Boat Club	...	129	19	3
Boxing Club	...	24	5	1
Chess Club	...	2	10	0
Cricket Club	...	177	12	1
Dramatic Society	...	12	18	3
Fencing Club	...	24	13	0
Golf Club	...	24	16	4
Men's Hockey Club	...	116	6	4
Ladies' Hockey Club	...	54	5	3
Men's Lawn Tennis C.	...	8	6	3
Ladies' Lawn Tennis C.	...	9	5	11
Photographic Society	...	5	12	6
Physiological Society	...	10	0	0
Rifle Club	...	35	10	0
Rugby Football Club	...	401	13	0
Sailing Club	...	30	0	0
Squash Club	...	5	0	0
Swimming Club	...	27	17	3
U.L.A.U. Affiliation	...			
Fees	...	47	15	6
Table Tennis Club	...	7	2	6
		1336	2	10
(4) Grant to Journal £14 0s. 1d. (less £11 13s. 5d. recoverable from Medical College)	...	2	6	8
(5) Depreciation £10; Reserve Fund for Equipment £150	...	160	0	0
Total Expenditure		3779	14	7

Surplus of Income over Expenditure

£57 14 0
The Students' Union Income and Expenditure Account shows a small surplus of £57 for last year. The *Journal* made a loss of £14, this being covered by grants from the Medical College and Students' Union. "Round the Fountain" was reprinted during the year and a large stock of copies is now held by the *Journal*. Costs have continued to rise and income has increased slightly with the increased income from the raised S.U. subscription. This increase is not likely to be maintained if there is a smaller entry to the Medical College. Club grants for 1951-52 have been kept at approximately the same amount as last year.

SPORT

GOLF CLUB

In a match played at Sundridge Park G.C., the club beat St. George's Hospital by three matches to one.

The Annual Meeting was held at Sundridge Park G.C. Fiddian and Sleight tied for Dr. Graham's Cup (best scratch score), each with 82. Elliott was third with 84. In the play-off R. V. Fiddian won the cup with a round of 77.

P. Sleight won the Girling Ball Trophy with a 66 (82-16) and the Hospital challenge cup (three up against Bogey). Twelve students competed.

Honours for 1951 have been awarded to R. E. Dreaper and C. J. R. Elliott. Colours were awarded to J. Bowman, B. Deering, J. Dodge, R. E. Dreaper, C. J. R. Elliott, R. V. Fiddian, A. Lodge, P. Sleight, and J. P. Waterhouse.

RUGGER CLUB

January 2, v. Leeds Medicals at Chislehurst. Won 19-8.

Played on a cold, wet day with a very greasy ball, Bart.'s did well to beat this lively touring side, who made up for what they lacked in weight and experience by sheer enthusiasm.

The first half was dull and chiefly notable for the number of chances which Bart.'s missed, largely due to bad handling of the difficult ball. After ten minutes a passing movement along the three-quarter line resulted in Fitzgerald going over in the corner. The kick was missed.

Then the Leeds' right wing, with a fine burst of speed, completely outstripped the home defence to score in the centre. This was converted and with no further scoring the sides changed over with the visitors leading by five points to three.

Soon after the restart Jones kicked a penalty goal to give Bart.'s the lead again. They were not to hold this for long, however, for a determined run along the touchline by the Leeds left wing enabled him to score in the corner. The difficult kick was missed, and with Bart.'s once again two points down the whole side suddenly woke up. They attacked immediately and a break-away by Davies was well backed up by Third, who, showing a turn of speed remarkable for one so heavy, crashed over for a fine try which he promptly converted. Next, a rush by the whole pack resulted in one of them touching down. The kick was missed. Finally, Davies, with a neat kick ahead, beat the full back to score a grand try which Third converted. Bart.'s kept up the pressure until the whistle went for no side.

Outstanding in the pack were Gawne, Third and Havard, while Mackay and Davies were the pick of the backs.

This second half display was most encouraging. After losing the lead twice, the team fought back and it is this spirit which will be so much needed for the stern battles which lie ahead.

January 12, v. Cheltenham. Lost 0-3.

Cheltenham scored a very quick try near the corner flag from one of the few three-quarter movements seen during the afternoon. The game soon developed into a very hard forward battle and remained as such until the final whistle. The

visitors were loath to open up the game, and were able to dictate the play by preventing the Bart.'s forwards from feeding their backs. Consequently, the home three-quarter line had few opportunities and were not able to penetrate the Cheltenham defence.

Davies very nearly equalised in the second half with a drop shot which rebounded from the crossbar. The defensive, spoiling play of the Bart.'s back row was excellent, and unfortunately necessary when lack of possession became the rule.

Team: B. N. Foy, A. D. M. Thomas, J. M. Kneebone, M. J. A. Davies, J. K. Murphy, G. Scott Brown, B. Grant, A. J. Gray, P. Knipe, A. J. Third, J. Jones, W. B. Castle, I. Cohen, E. Gawne, C. W. H. Havard (Capt.).

SWIMMING CLUB

Although one of the hospital's smallest clubs, the Swimming Club has been one of its most successful in its matches over the past twelve months. Nine matches have been won, three drawn, and four lost; goals for being 76 and goals against 59. Scorers were: Low, 8; Cohen, 20; Bliss, 39.

In the Inter-Collegiate League for 1951 Bart.'s finished second to L.S.E. in their league; an appreciable achievement, as the only practice available was in the matches themselves. At the end of the season colours were awarded to: F. Low, L. Cohen, M. H. Graham, and P. Bliss.

During the late summer water polo activity subsided with the Charterhouse recess, but it brought news of the award of University of London colours for water polo to L. Cohen and P. Bliss. October saw the beginning of the first post-war Inter-Hospitals league. After a shaky start Bart.'s played more decisive polo and, after losing to St. Thomas's and twice to St. Mary's, won all their other matches to finish second to St. Mary's.

We congratulate Lester Cohen on being elected Captain of the United Hospitals' Swimming Club for 1952—the first captain since 1938 to come from Bart.'s.

Finally, once again the appeal goes out for new players and swimmers, for the club cannot hope to increase their successes relying only on the eight faithfuls!

WOMEN'S LAWN TENNIS CLUB

At the Annual General Meeting held on November 6th the following Officers were elected for the coming season:—

Captain—Margaret Robinson;

Vice-Captain—Jean Cree;

Hon. Sec. and Treas.—Marguerite Smith;

Pre-clinical representative—Sheila Balhatchet.

It was decided to arrange fixtures for two teams to play matches next summer, and it is hoped that there will be increased support for the club during the season. Practice games will be held during April, probably at Paddington Recreation ground.

A silver cup has been bought, to be awarded annually for the winner of the Women's Open Singles tournament. This was won last year by M. Robinson.

SO TO SPEAK . . .

Making it clear:

"Physical signs in the chest were regarded as having cleared when either (1) there were no residual physical signs. . . ."

. . . or (2) they had cleared?"

"All appointments are effective from July 1st each year . . . other appointments are not on any specified date."

—a hospital prospectus.

A final year student was overheard to say that he was not trying to fill the gaps in his knowledge, but to create a few in his ignorance.

" . . . it is normally necessary to kill a mouse since it can be identified by its ability—

1. To ferment Inulin;
2. It is soluble in Bile."

—A Candidate.

BOOK REVIEWS

SIXTEENTH-CENTURY SURGERY

Ambroise Paré is a name unknown, heard of, and well known by members of the medical profession. His works come mostly in the second of these categories. The Falcon Educational Books are to be congratulated for their attempt to remedy this situation by the publication of "The Apologie and Treatise of Ambroise Paré, containing the voyages made into Divers Places" a volume which includes many of Paré's other writings upon surgery.*

Paré was a French surgeon who lived from 1510 to 1590, and achieved great distinction, being for many years the "premier Chirurgien du Roy." His writings contained in this book are taken from two separate sources: one—the Apologie and Treatise—is complete; the other, from his surgical writings, is a selection made especially for this edition. The English text here used is that of an edition of Paré's collected works published in London in 1634. A prospective buyer should by no means be put off by this period English, for the translation is admirable, and often lends colour to Paré's forthright style.



* The Apologie and Treatise of Ambroise Paré, edited, and Introduction, by Geoffrey Keynes. First edition, 1951. Falcon Educational Books, Ltd., pp. 220. Illustrated. Index. Price 15s.

The present edition opens with the Apologie and Treatise, which comprises a little less than half the book. This part was written by Paré at the age of seventy-five. Far from being an old man's reminiscences, it is an enthralling and detailed account of his many journeys with the French Army and of his capture by the Spaniards, and opens with the Apologie—the author's defence of his own surgical methods. This defence is especially of his use of the ligature in staunching bleeding. His adversary in the matter—one Gourmelen—advocates the use of the traditional cautery. Paré scarcely mentions Gourmelen by name, but scornfully addresses him as "mon petit maitre," and denounces his methods as those of the bookworm with no practical experience. For—

"To talke's not all in Chirurgion's Art,
But working with the hands."

—as Paré reminds him. Paré has no hesitation in telling the reader of his own wide experience, but does so in such highly diverting prose that he seems not egotistical at all. Only once in the Treatise of his experiences does he give us a glimpse of the age of the writer. He gives a description of how he obtained a receipt from a surgeon of Turin "by gifts and presents," but in one of his earlier writings (later in this volume) he describes the same incident slightly differently; he got the prescription because he was returning to Paris where he could not be a rival in practice.

The writings upon surgery have not quite the immediate attraction of the Apologie and Treatise, but they contain much of interest, and are not to be decried for they are the thoughtful writings of a man of intelligence and wide experience. The basis of so much modern surgical thought is contained in Paré's writings that it is not surprising that he could cure when his colleagues could not. "Yet none," wrote Paré, "must thinke to attaine to any great perfection in this Art, without the help of the other two parts of Physicke; I say

of Diet and Pharmacie. . . ." Advice which is sometimes forgotten even to-day.

Paré shows throughout the book that he is a cultured man, and one of a becoming humility (except where Gourmelen is concerned). He mixes freely with the nobility of France and is so highly thought of that he is sent from one nobleman to another to execute their cures. This humility is well shown by his oft-repeated remark, "I dressed him, and God healed him." How much of the humour that may be found in these pages is unintentional is difficult to judge. Some may be Paré's, some the translator's, and other the reader's. To whichever it is due, the humour of ascribing congenital malformations to the "imbecility of the forming facultie" cannot be denied.

Some of the terms used in the translation (few are Latin) need explanation, and in most cases this is given in footnotes. In two places the footnote does not correspond with the first use of a word, but this is a minor criticism. It is excellent that these notes have been kept so brief and few in number. Footnotes climbing half up the page can so easily spoil a book of this type.

This book is the first of a new Series, it is exceptionally well produced, and the price is low. Paré is a neglected subject, but does not deserve to be so. This is a book to read, and keep, and read again.

DR. VIPER, THE QUERULOUS LIFE OF DR. PHILIP THICKNESSE, by Philip Gosse. Cassell & Co., 1951, pp. 332 + 7 half-tone illustrations. Price 21s.

In his biography of the querulous life of Philip Thicknesse, Dr. Gosse has discovered not only the curious character of his eccentric eighteenth-century hero, but he has also dug up a gallimaufry of dross, gossip and skulduggery. Promising material? No! But in Dr. Gosse's hands, hands that are experienced with travellers' tales and pirate yarns, he spins a fascinating tale. Browsing through the D.N.B., Dr. Gosse comes across "that most gentle, lovable poet and physician, and inventor of the famous biscuit, Dr. William Oliver of Bath," who had a quarrel but once, and that with Philip Thicknesse. Turning up Thicknesse and finding him, between Teach and Tollett, described as the "Lieutenant-Governor of Languard Fort," Dr. Gosse has gone on to unravel for us the whole life story of this adventurer, writer, snob, leech, columnist, laudanum addict, rustic gardener—a Shirley Hibberd of an earlier age—who travelled widely and met with everyone who was anyone, and quarrelled with each in turn. But a surfeit of scandal cloy, and gossip about those for whom we bear no respect is tedious, and it is perhaps a pity that Dr. Gosse has not told us more of Thicknesse's contemporaries and how such an eccentric managed to find a place in the orthodox eighteenth century we know. This is a book which must have been fun to write—it is certainly entertaining to read.

ANAESTHETICS FOR MEDICAL STUDENTS. Gordon Ostlere, 2nd Edition. Churchill, pp. 108. Price 8s. 6d.

This is a textbook for the pocket of every medical student, for in a very clear and readable manner Dr. Ostlere gives a practical approach to the commoner anaesthetics and how to give them.

There are some changes from the first edition, but the joys of the Author's conversational style remain. This is a book without frills, there are no long explanations of the mode of action of the various drugs, that is for a larger book; the aim of this book is to enable the student to approach anaesthetics knowing the essentials of how to give a safe anaesthetic, and its possible dangers; in this it succeeds admirably.

THE PRACTICE OF ENDOCRINOLOGY.

Edited by Raymond Greene. Revised Edition. *The Practitioner Series.* Eyre and Spottiswoode, 1951. (Pages 389 + xxiii. 56 illustrations). Price 65s.

This book is one of the most successful in *The Practitioner Series.* It is written for the General Practitioner and therefore wisely concerns itself more with the practical matters of diagnosis and treatment than the theoretical aspect. The revised edition has taken this a step further, and the more academic chapters have been pruned, though not completely, and there are one or two (one could wish for more) illustrations of historical dwarfs and adrenogenital saints, but why is there no reference to these in the text? A fruitless visit to St. Paul's and an afternoon in the B.M. Reading Room were necessary to discover the full and interesting story of St. Uncumber. Dr. Greene writes clearly and the reading is so easy as to be a pleasure; it is beautifully produced and authoritative, but is unfortunately marred by a number of misprints or mistakes, though an Errata is now available.

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GYNAECOLOGICAL ENDOCRINOLOGY FOR THE PRACTITIONER, by P. M. F. Bishop. 2nd Edition, 1951, Livingstone, pp. ix + 132, figs. 16. Price 12s.

This excellent little book is meant primarily for the general practitioner. It seeks to give him a clear and up-to-date picture of endocrine physiology as it affects the female subject and to point out how the normal processes may be disturbed. Its aim is essentially practical and controversial theorising has no place in the book. Practitioners will be especially grateful to Dr. Bishop for his clear exposition of modern hormone therapy. He gives a fair assessment of the place of such therapy and does not minimise its limitations or the dangers of its misuse. He condemns random empirical therapy.

The book is well arranged and easy of reference. Although intended for the practitioner it will be welcomed too by students, both pre- and post-graduate, as a successful attempt to extract the essentials from a complex subject and to present them in a lucid, even if somewhat dogmatic manner.

In this edition the text has been revised and a new self-contained chapter on steroid chemistry has been added for the benefit of those readers who wish to know a little more about these substances which he usually finds cloaked in such a multitude of names.

TREATMENT BY MANIPULATION, by H. Jackson Burrows and W. D. Coltart. Enlarged Edition, *The Practitioner Series.* Eyre and Spottiswoode, 1951, pp. 80.

This book, which follows the first edition by eleven years, like the first is well produced, being reminiscent of a slim volume of privately printed poems. It is divided into two sections; the first describes selection, diagnosis, and management together with some warnings; the second describes with numerous illustrations, in which appear a pair of powerful and vaguely familiar arms, the technique of the manipulations. This is a timely book and one that makes the better aspects of the bonesetters' craft respectable.

CLINICAL PATHOLOGY DATA by C. J. Dickinson. Blackwell, 1951, pp. 32. Price 4s. 6d.

Sitting in the front row of M.O.P.'s and at a loss for the normal blood urea, any student would be very grateful for this booklet—his house job would be assured. All the normal figures of body fluid constituents are clearly listed, the diseases causing variations are noted, and even some of the tests are explained. This information takes time to disentangle from a text-book, but is here most easily—and accurately—obtainable.

Any student who approached the final examination without this booklet would be seriously failing in his duty to himself—and possibly his examiners!

AN INTRODUCTION TO MEDICINE FOR NURSES. 2nd Edition, 1951. By Patria Asher, M.D., M.R.C.P., pp. 354. William Heinemann. Price 25s.

This new edition is actually sixty pages shorter than its predecessor, in spite of the addition of a great deal of new material. This is achieved by abandoning the wide margins of the old edition and by judicious pruning. Some more illustra-

tions are added, and those in the new chapter on children's diseases are especially good. One of the attractions of Dr. Asher's book is its presentation of cases as patients, and its conversational style. This unfortunately leads to such lapses as "The liver recklessly adds to the confusion by breaking down protein. . . ." The glossary might well be dispensed with; the nurse who reads this book knows the meaning of nerve, fever, fracture and tumour. The price must now be at the limit of what the student nurse can afford, but it is the most modern medical text-book she can get, and can be well recommended.

SELECTED WRITINGS OF SIR WILLIAM OSLER, with an introduction by Geoffrey Keynes (pp. 279 + 5 illustrations), Oxford University Press, Price 15s.

This selection of writings, which has been made by a committee of the Osler Club, was published to celebrate the fiftieth anniversary of Osler's birth. They have made a good choice from such a wide field. There are several biographical essays, philosophical writings and letters, together with *Illustrations of the Bookworm.* No hospital in Britain had closer associations with Osler than did Bart.'s. He was frequently invited to the Hospital, he addressed the Abernethian Society, and has had a considerable influence on various members of the staff. It is pleasant, therefore, to find Dr. Franklin as the editor and Mr. Geoffrey Keynes writing the introduction, which, for many, will be the most enjoyable and profitable part of the book.

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Seventeenth Edition, revised by H. W. C. Vinas, M.D. Pp. viii+1,216, with 12 plates and 730 other illustrations. Postage 1s. 4d. 42s.

OPERATIVE OBSTETRICS

Fifth Edition, by J. M. Munro Kerr, M.D., F.R.C.O.G., and J. Chassar Moir, D.M., F.R.C.S., F.R.C.O.G. Pp. viii+960, with 370 illustrations. Postage 1s. 6d. 63s.

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7-8 Henrietta Street, London, W.C.2

MODERN DIETARY TREATMENT by M. Abrahams and E. M. Widdowson, pp. viii, 356. Baillere Tindall and Cox, 3rd edition. Price 21s.

The third edition of this well-known book is well up to the standard of the first two, and is in many ways better. The old scheme of dividing the diets, which the second half of the book contains, by price, into separate grades has been abandoned. One can almost hear the late Minister of Health chuckling over this evidence of Socialism at work, while he fills up his Super Tax returns. The simplicity which has been gained is greatly to the advantage of the book, and the multifarious diets are more readily understood. The first half of the book is concerned with the general principles of both the normal and special diets—this part may be recommended to the student—the remainder is a detailed account of the constitution of special diets and can only be recommended to those dieticians, nurses and doctors who have actually to arrange the details of a diet; and to them this book will be, as always, invaluable.

THE BAILY FAMILY of Thatcham and later of Speen and Newbury all in the County of Berkshire, by L. G. H. Horton-Smith, W. Thornley & Sons, 1951, pp. 385. Price £2 2s.

This privately printed genealogical study of the Baily family is lavishly produced, and contains a wealth of material for those interested in the family history. Much personal information of an irritating nature is included, and the final paginated leaves advertise the compiler's other writings.

The work is of interest to us for several reasons. The story of the Baily family commences with Dr. Walter Baily (1529-1592), Physician to Queen Elizabeth, and several of the persons mentioned were medical men. Among these is Sir Percival Horton-Smith Hartley, Consulting Physician to this Hospital, and brother of the compiler of this volume. The book is conspicuous for the generous detail presented, for a lengthy pedigree, and a host of blank pages, presumably for annotations.

MARRIAGE, by Kenneth Walker, pp. 136 + XII. Martin Secker and Warburg, Ltd., 8s. 6d.

WOMAN: HER CHANGE OF LIFE, by Miriam Lincoln, pp. 116. Williams and Norgate, Ltd., 6s.

ADVICE TO THE EXPECTANT MOTHER ON THE CARE OF HER HEALTH, pp. 50. E. and S. Livingstone, Ltd., 9th Edition.

Under review are three books which the medical practitioner may care to recommend to patients—each admirably dealing with a particular problem.

Kenneth Walker's book is intended for the "married and the about to be married." This latter important group has been rather neglected as far as ethical literature is concerned, though there is a profusion of pseudo-scientific works dealing with their problems. The author considers the place of marriage and sexuality in modern society before discussing marriage preparation, reproduction, family planning and—most important—"contributory causes to failure in marriage." No one will be in complete agreement with all that the author says—the final chapter on premarital chastity will be the most controversial—but throughout one is struck by the logical

approach and cannot fail to admire the insight which this accords. The practitioner will do well to read this book himself.

Miriam Lincoln has written a little gem of a book which may well be recommended to those many women who are worried about the approaching menopause. She has a happy knack of presentation which in itself allays the fear complex so often present. Perhaps the most important chapter is entitled "Warning Signals Suggestive of Cancer"—Cancer Education as it should be.

F. J. Browne's little pamphlet is in its ninth edition—a fact which speaks for itself. For it we have little but praise, but what a pity that it still reads: "The following is a modified list of baby clothes suitable for use during war-time restrictions. The number of coupons required is given."

QUININE, QUINIDINE and other Cinchona alkaloids in Clinical Practice. The London Cinchona Bureau. Director, Sir Philip Manson-Bahr.

This 28-page pamphlet summarises the use of the cinchona alkaloids, together with routes of administration and dosage. The subjects covered range from malaria and auricular fibrillation to the treatment of hydrocele. In this latter condition, treated by sclerosing agents, not all would agree that "the results of this treatment are at least as good as, and probably superior to, the results of operation." A list of references are given. Copies are available on request at 10, Princes Street, S.W.1.

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HOSPITAL JOURNAL

Vol. LVI

APRIL, 1952

No. 4

LAMENT

Five roads ran out from Sandringham
When George our King was home;
But only four that we may know
Where trees and heath and bracken blow
And driven birds would come.

The road that runs to Ammer
Is true and clear and wide;
Yet straighter still his journey lay
And steadfast in his honest way
He never turned aside.

The road down into Dersingham
Comes winding from above;
So did he to his family,
To grandson playing at his knee,
Enfold them with his love.

A road runs out through Wolferton
Among the village neighbours;
So would he stretch a greeting hand
To all the peoples of his land
And join them in their labours.

An ancient window on the world,
The road that leads to Lynn;
As he looked out with failing health
The nations of the Commonwealth
Kept faithful watch within.

Then through the sweet pine-laden air,
The short road up to God,
One beckoned softly at the end
And like some long familiar friend
He knew the path he trod.

THE ASSAULT ON EVEREST

THE failure of past expeditions to reach the summit of Mount Everest is associated in many minds with the intense cold and the technical climbing difficulties of the last thousand feet of the mountain. Prof. Matthews, writing in this issue, shows that great though these difficulties are, they may be surmounted if more attention is paid to supplying oxygen to the climber. Some of the previous expeditions carried oxygen, but none carried such highly specialised equipment as could be made today. With the aid of a reliable source of oxygen it may not be long before Everest is finally conquered. Now that Mr. Eric Shipton's reconnaissance expedition has shown the possibility of a fresh line of approach (from the South-West and through Nepal), and fresh expeditions to the summit are planned, it is appropriate to look back at some of the fine achievements of past climbers.

Everest was first surveyed—by triangulation—by Sir George Everest in the early nineteenth century, and the mountain was named in his honour. Everest-climbing is, however, a sport of comparatively recent origin. Recent not so much because there was any lack of climbers in the past, but because the mountain is surrounded by countries which refused permission for Europeans to approach it. Not until 1920 did the Dalai Lama give his permission for a climb to be made from Tibetan territory. Two earlier expeditions, planned in 1893 and in 1906, had to be abandoned because permission to approach the mountain was refused.

The 1920 expedition, under Col. Howard Bury, which was intended for reconnaissance only, discovered the approach to the North Col up the East Rongbuk Glacier. Subsequent expeditions have used this approach to the North Col, from which all the attempts on the North Peak (the highest point) have been started.

The first expedition which aimed to climb to the summit was that of 1922 under the

Hon. Charles Granville Bruce. The maximum height reached was 27,235 feet and although oxygen equipment was carried it was so heavy as partly to outweigh its advantages. In 1924, Bruce planned a second expedition, but he was now not far short of sixty, and he had the misfortune to fall sick in the early stages. Lt.-Col. Norton took over command, and on June 4, 1924, he and Dr. Somervell climbed to 28,200 feet (the height of Mount Everest is generally recognised as being 29,002 feet), before being forced to return. Four days later Mallory and Irvine—of the same expedition—set out from a camp at 27,000 feet for the summit, and were never seen again. A thorough search was carried out but no trace was found until, in the 1933 expedition, an ice-axe was found in the same area which may well have belonged to Mallory or Irvine. No further expeditions were carried out for nine years after this tragedy.

In 1933 the first flight over Everest was financed by Lady Houston as part of a combined land and air expedition. Air Commodore Fellowes and Lord Clydesdale both flew over the summit in mid-April, and they took many photographs of the approaches. In May and June, Mr. Hugh Ruttledge commanded the land expedition, among the members of which was Mr. Eric Shipton who led last year's reconnaissance. The highest point reached was 28,100 feet, first by Wyn Harris and Wager (when they found the ice-axe already mentioned), and secondly by Smythe who climbed alone to the same point, where his way was barred by a fresh fall of snow. A few days later the expedition was abandoned for a reason that appears a little surprising; the monsoon broke. Associating the word monsoon, as one does, with a heavy and continuous downfall bringing a brief respite from great heat, it is difficult to imagine also as driving snow in an already frozen climate.

Mr. Eric Shipton led a reconnaissance expedition in 1935, and Ruttledge an assault on the summit in 1936, which latter was dogged by bad weather and no height above 21,000

feet was reached. Shipton was also a member of the most recent climb, in 1938, under the command of W. H. Tilman. Despite both bad weather and illness in the party a magnificent climb to 27,200 feet was made in the worst of the monsoon. Since that date no expedition has set out for the peak, but Mr. Shipton's reconnaissance of last year has opened up the possibility of a fresh approach from Nepal, and it seems reasonable to hope that this new route,

though perhaps more treacherous in the early stages, will provide an easier climb to the summit. The approach is from the South Col and promises to be less steep than the old route from the North.

It is noteworthy that British names are foremost in the history of the Everest expeditions. We can but hope that it will be one of Her Majesty's subjects who will first stand upon the summit.

Retirement

Mr. Geoffrey Keynes—Emeritus Surgeon to the Hospital—retired at the end of March. Mr. Keynes is renowned both in literature and surgery, and we trust that his retirement from the latter will allow him to spend even more time with his books. In the surgical world he has been responsible for innovations in the surgical treatment of goitres and carcinoma of the breast, but his best known work has been in pioneering the operation for removal of the thymus in cases of Myasthenia Gravis. Mr. Keynes has been the holder of many distinguished positions: among them are those of Hunterian Professor at the Royal College of Surgeons in three separate years, Air Vice-Marshal in the R.A.F.V.R., and Linacre lecturer at Cambridge in 1949.

Many at the hospital will miss Mr. Keynes, and with the departure of his fine head-dress from the operating theatre we shall have nothing left but a drab green uniformity of cap and mask.

We wish him and Mrs. Keynes a long and happy retirement at their country home near Cambridge.

Notice

Mr. C. Naunton Morgan is standing for election to the Council of the Royal College of Surgeons.

Harvey Prizewinner

The Harvey Prize for 1952 has been awarded to T. A. Boxall. *The Journal* sends its congratulations.

Dinners

Eleventh Decennial Club

The Seventeenth Annual Dinner of the Eleventh Decennial Club is to be held at Simpson's-in-the-Strand on Friday, April 25, at Seven o'clock for 7.30 p.m. Dr. A. W. Spence will be in the Chair.

The Hon. Secretaries of the Club are Mr. Wilfred Shaw, 109, Harley Street, W.1, and Mr. F. C. W. Capps, 16, Park Square East, N.W.1.

Wessex Rahere Club

The Spring Dinner of the above Club will take place at the Royal Clarence Hotel, Exeter, on Saturday, April 19.

Mr. C. Naunton Morgan, F.R.C.S., has kindly accepted the invitation to be present as Guest of Honour.

Membership of the Club is open to all Bart's men practising in the West Country, and the Spring Dinner is being held at Exeter for the second year in succession because of the very strong demand from members living still further to the West. Further details will be sent to members, and to any eligible Bart's man if he will write to the Hon. Secretary, Mr. A. Daunt Bateman of 3, The Circus, Bath.

MARRIAGE

The marriage took place between R. J. Blow and Miss N. Lewis at the Church of St. Bartholomew - the - Less on Saturday, February 16, 1952.

Contributor

Professor B. H. C. Matthews, C.B.E., Sc.D., F.R.S., has recently been appointed Professor of Physiology in the University of Cambridge. He succeeded Dr. Adrian, who retired upon his appointment as Master of Trinity College. Professor Matthews graduated from King's College in 1927, with first-class honours in Physiology. In 1932 he was appointed assistant director of research in Physiology at Cambridge, and in 1935 he was a member of The International High Altitude Expedition for Physiological Research. In the war Professor Matthews joined the R.A.F. and was director of the R.A.F. Physiological Research Unit, and later—in 1944—director of the Institute of Aviation Medicine. In 1947, he returned to Cambridge as the first Reader in Experimental Physiology. He was elected Fellow of the Royal Society in 1940, and made a C.B.E. in 1944.

We wish Professor Matthews every success in his new appointment.

Psychology

The study of the id by the odd.

The New Vicarage

The New Vicarage was opened at an unofficial ceremony (can such a thing exist?) on Monday, February 4. The first two pints of Bitter were drawn by the Dean, and quaffed by the two Vice-Presidents of the Students' Union.

The opening hours are:—

Weekdays
12.00—2.00.
6.00—10.30.
Sundays
Christmas Day
Good Friday
12.30—2.00.
7.00—10.00.

Bravery?

There seems little doubt that some of the reckless courage of the American troops in the late war was stimulated by the knowledge that in front of them were only the Germans, but behind them were the assembled surgeons of America, with sleeves rolled up.

HANS ZINSSER. (Rats, Lice, and History.)

Could the author be a physician?

Charterhouse

The Spring Term, 1952, at Charterhouse has produced a phenomenal number of Squash players. The fees collected by Mr. Kelly have broken all records, and a Squash teaching syndicate has been set up. The reasons for the recent enthusiasm are not obvious, but the majority agree that it is a good thing. Many, who like myself, had never played before, and who were cajoled into learning, were surprised to find how much fun and good exercise could be had inside a Squash Court. The women students have been particularly enthusiastic, and some of their Squash "fashions" have been truly amazing. One young leader of fashion has been seen on the Squash Court wearing one of her father's shirts, and a pair of shorts, which were described as: "not brief, but instantaneous!" In spite of such minor distractions, Squash this term has given pleasure to many students. It is hoped that the shades of approaching examinations will not cool the present ardour.

The Manager

We congratulate John Blow—the Manager of the *Journal*—upon his marriage to Miss Lewis, of the nursing staff of this Hospital. We wish them every happiness.

Men's Tennis Club

St. Bartholomew's Hospital Men's Lawn Tennis Club have pleasure in inviting entries for a men's doubles Challenge Cup Competition to be held in May and June 1952. The competition is open to all members of the Students' Union and present members of the Medical and Surgical staffs. The closing date for entries will be Wednesday, 30th April. The semi-finals and finals will be played on the grass courts at Chislehurst on Saturday, 21st June, 1952. Other details of the competition may be obtained from notices posted with the entry lists in the Abernethian Rooms and on the staff notice boards, or from the Club Secretary.

Change of Name

Mr. R. V. Pierson has changed his name by deed-poll to the above form. His previous name was R. V. Pearson.

The Journal

All matter should be handed in by the first of the month for publication in the issue for the following month. Please let us have matter typed, and as far in advance as possible—not on the first.

THE PHYSIOLOGICAL PROBLEM OF MOUNT EVEREST

by PROFESSOR B. H. C. MATTHEWS.

It is impossible to consider life at great heights without thinking of Mt. Everest where, for over a quarter of a century, mountaineers have carried out what must be one of the most heroic experiments in human endurance of all time. Mr. Eric Shipton has recently returned after exploring the possibilities of climbing Mt. Everest from Nepal, and his published reports suggest that the mountain is less difficult to climb from this side than by the old northern route. However, I am not going to consider the climbing problems of Mt. Everest here, nor am I qualified to do so: they are undoubtedly great by any approach. Of the other obstacles to be overcome in climbing Mt. Everest, by far the greatest is that provided by the difficulty of human life and muscular work at heights above 25,000 feet.

The atmosphere at this height is rapidly fatal to a man who is acclimatised to sea-level: at 27,000 feet death will occur in under an hour. Nevertheless, *acclimatised* men have climbed to at least 28,000 feet on Mt. Everest, and this brings into prominence the great changes that occur in men during acclimatisation which enable them to survive if they spend some weeks in the ascent: if rapid ascent were possible, as in a balloon or flying machine, the same height would kill them, and indeed several of the early balloonists lost their lives in this very way. The principal lack in the atmosphere at these heights is a sufficient pressure of oxygen. At 27,000 feet the barometric pressure falls to one-third of that at sea-level and the air remains of the same composition; hence at these heights the low partial pressure of oxygen does not saturate the blood in the lungs sufficiently to enable the body to carry out its normal functions. The effects of oxygen lack are very well known: they have been studied for many years in aeroplanes, on mountains, and also in low pressure chambers, in which the same atmosphere can be reproduced at sea-level. The two most striking effects of oxygen want are impaired functioning of the brain, and muscular weakness. The former leads to loss of judgment and intelligence and particularly to loss of any critical insight by the sufferer into his

own condition. The latter is seen by the greatly reduced capacity for muscular work: a muscular task can only be performed slowly as the lungs are able to gather enough oxygen for its performance.

In acclimatisation these disabilities are reduced by three adaptations on the part of the body. Most noticeable in the acclimatised man is his deep and fast breathing. The respiratory system becomes able to carry this on as the kidneys get rid of some of the alkali reserve normally carried in the blood, and so the air in the lungs is changed more frequently. Less obvious but equally valuable is the increase in haemoglobin, and in the number of red blood corpuscles. Lastly, changes occur in the component cells of the body, enabling them to work at unaccustomed low oxygen pressures.

But even the fully acclimatised man can only climb and work slowly; for each step taken he must breathe several times to collect the oxygen to go on. While climbing, the muscles use up oxygen and leave less for the brain, and a minute's rest is often necessary before a skilled action can be effected. For example, when taking photographs at great heights the ordinary settings of a camera need far more concentration than lower down, and mistakes often occur which are only found on developing the film. One climber recounts how he looked at the camera he was carrying but could not think what it was for and did not use it. The slowing up of all mental and physical processes puts the climber at a great disadvantage should an emergency arise. While the loss of muscular power and slow working are so evident that they are allowed for in planning a high mountain expedition, the effect of oxygen lack on the *brain* is far more insidious, for the sufferer is usually little aware of it. Many instances can be given of loss of judgment and intelligent action in those suffering from oxygen want. The general effect is very like that produced by alcohol, for both alcohol and oxygen want lead to failure of normal oxidations in the cells of the brain. We do not yet know whether an acclimatised man could even retain intelligent control of his body to climb

at 29,000 feet but it is certain that this is very near the limit where this ceases to be possible.

Acclimatisation is a slow process and its full development requires several months. In a mountain expedition time is allowed for it to occur at the lower camps before attempting to go above 20,000 feet. It proceeds to develop progressively at heights up to 18,000 feet, but at greater heights most observers agree that men's condition does not improve further; and what has been called high-altitude deterioration sets in above about 22,000 feet. All agree that sleep and appetite are fickle above this height. Unfortunately it is not possible to predict accurately by examining a fit man at sea-level, whether he will acclimatise well, and there is very great individual variation, so that at present, experience on mountains must remain the chief guide as to who may be physiologically suitable to climb at great heights.

These difficulties could be overcome if it were possible to provide a man with plenty of oxygen. In flying, this is done either by carrying cylinders of oxygen supplying a face mask or by increasing the air pressure by a sealed pressure cabin. Oxygen equipment has been tried on mountain expeditions, but has never fully developed for this purpose. In the past it has often proved cumbersome and unreliable. It was pioneered on Mt. Everest by Professor Finch in 1922, and there is no doubt that climbing progresses very much faster at 26,000 feet using oxygen, in spite of the considerable extra weight to be carried.

Many self-contained breathing sets are in present use for rescue work in mines or for men working near fires or in poisonous atmospheres; but none of these is in the form most suitable for the climber. The



A Sulphur mine on Mt. Anconquilha, Chile, where men earn their daily bread at 19,000 feet. The workers rarely go below 17,500 feet where their living quarters are situated.

requirements of the Services for oxygen apparatus in flying and diving have led to much research on the best ways of supplying a man, and, with the knowledge now available, it should be possible (with adequate care and preparation) to develop a climber's equipment that would be reliable, and worth

the extra load carried by giving a great gain in the speed of climbing and efficiency. The climber requires many hours' endurance from any oxygen set that he uses. Also, he becomes acclimatised during the long, easier stages of the ascent, and so breathes deeply and rapidly. His breathing is still very deep when he uses oxygen equipment because this adjustment of respiration is a slow process, and the acclimatised man has a large respiratory volume to excrete Carbon Dioxide. This only passes off in a number of days on return to sea-level. The equipment must therefore be designed to take account of this unusual volume of respiration. I think that by using proper oxygen equipment at 25,000 feet, climbers could at least double the height previously climbed in a day, and continue this in the later stages of the ascent. If this hope can be realised, the whole plan of an assault on Mt. Everest would be greatly simplified, and the chance of being caught by a break in the weather would be lessened.

There are still some people who believe that Mt. Everest can be climbed without using oxygen. They argue that man, unaided by breathing apparatus, has climbed to 28,000 feet and that a further 1,000 feet cannot make very much difference. This overlooks the nature of the limits on his performance and the fact that at about this height two vicious circles are set up, the first making it progressively more difficult for the climber to keep warm, and the second making it rapidly harder for him to ascend further.

The most extreme cold is common on Mt. Everest, and it is accompanied by violent winds. A man normally keeps warm by oxidative processes, so oxygen is essential to produce heat; but in breathing cold, dry air very rapidly, a large part of his body heat is lost as the warmth and evaporated moisture in his breath. As he climbs higher, at each breath he loses the same amount of heat; but as the atmospheric pressure falls, he gains less and less oxygen until finally a point must be reached where he is not gaining enough oxygen to make good the heat lost by breathing and, even with perfect clothing, he must get colder and colder. It appears likely that this point may be reached below the summit of Mt. Everest. That it is no figment of armchair science is supported by the following statement taken from Sir Francis Younghusband's account of the 1924 expedition. He said "The going was

good, the day was perfect; but by the time they reached 27,500 feet they were feeling in distress. Norton felt it bitterly cold and shivered so violently as he sat in the sun during one of their halts that he suspected the approach of malaria." We now know that in fact he was not suffering from malaria, but simply from the result of oxygen lack; and this is no isolated instance. Men who have got cold at these heights find that they do not get warm again until they descend; but this effect can be overcome by the use of oxygen, and in 1922, chilled climbers found they rapidly became warmer when breathing oxygen. In 1933 a number of heat interchange respirators were used to warm and moisten the inspired air; they proved effective but unpopular. The common occurrence of frost-bite is another consequence of oxygen lack. In addition, a second vicious circle occurs as follows: the muscles used in breathing consume part of the oxygen taken in. At sea-level this is a minor fraction of the whole, but with the violent breathing at great heights, it becomes a larger and larger fraction, until finally a point is reached where all the oxygen that the lungs can obtain from the air will be used up by the respiratory muscles (and other basal metabolic processes), leaving none over to be used in other muscles for climbing. When this point is reached, further ascent is quite impossible. That it has already been closely approached there can be little doubt. Again, quoting from the account of 1924, "At about 27,500 feet there was an almost sudden change, says Somervell. A little lower down they could walk comfortably, taking three or four breaths for each step; but now, 7, 8 or 10 complete respirations were necessary for each single step forward." Now measurement of the oxygen used by the muscles of the chest in breathing shows that at this height they will take a large fraction of all that the lungs can gather; when this and basal metabolic processes take the whole, further ascent is impossible and man can go no higher. For reasons that I have not space to expand now, this cannot be avoided by more perfect acclimatisation.

It has sometimes been suggested that it is "unsporting" to use oxygen equipment as an aid to climbing; but the conditions at the top of Mt. Everest require a man to make every preparation he can to meet them. It is just as unsporting to use nailed boots to ensure safe and speedy climbing as to use

forethought to overcome the far more powerful and insidious danger of oxygen lack. Everest is an adversary against whom man



Arterial puncture at 20,000 feet; this gave oxygen saturations of 58-65% in seven well-acclimatised men.

REPORT OF A CASE OF ADENO-CARCINOMA OF THE DUODENUM TREATED BY PARTIAL DUODENECTOMY

History and Examination

Mrs C., aged 53 years, a housewife and finisher in a coat making factory, presented on 23.2.51 in medical out-patients department with many years' history of backache and lower right thoracic pain, a cough with occasional sputum and, more recently, dyspnoea and palpitations on moderate exertion.

She had been losing weight for two or three years but her appetite was poor and she was having a protein deficient diet. Her stools had been black for some months, but she had been taking ferri. et ammon. cit. Menopause was 13 years previously, apart from one loss eight years ago, there had been no further bleeding.

Clinical examination at that time revealed nothing abnormal except pale mucous membranes and a palpable spleen. She had a hypochromic microcytic anaemia with a haemoglobin % of 50, for which there was no obvious cause.

Two weeks later, in spite of fersolate gr. three t.d.s., her haemoglobin % had dropped to 42. There were no haemorrhoids and sigmoidoscopy to 15 cms. revealed nothing abnormal.

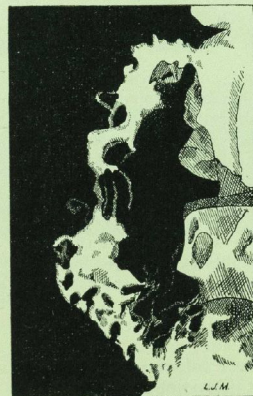
Four days later on admission to the Medical Unit, she complained of general malaise and back pain as before. Her spleen was palpable two finger breadths and liver one

must use his wits as well as his muscles; to climb under these conditions requires the best that mankind can produce in strength, skill and determination. The climber needs the best equipment to assist him, he needs special food, special clothing and shelter at night; all these receive great care and attention before setting out. For the last stages of the climb he needs in addition the oxygen which the atmosphere cannot supply. Considering our accumulated knowledge of this problem, I think that to make no provision for this last most essential requirement would be to jeopardise the success of any future venture, and to take risks of such a nature that no one who has studied them carefully can consider justified.

This article has been slightly adapted from a talk given in the Home Programme of the B.B.C.

finger breadth below the costal margin. She also had choilonychia. Blood pressure 135/85 mm. Hg. Peripheral sensation and reflexes normal. There were no other abnormal clinical signs.

Special Investigations



Drawing of X-ray, showing passage of Barium and evidence of intrinsic lesion in the Duodenum.

Tests of stools for occult blood were strongly positive. Her plasma proteins were reduced, total - 5.7, and A/G ratio - 4.7 : 1.0. A fractional test meal showed alcohol fast a chlorhydria; there was no blood in the aspirations, but bile was present. Barium meal and X-ray showed no lesion in the stomach, but there was considerable

irregularity, deformity and narrowing of the second part of the duodenum. This seemed to be due to the presence of an intrinsic lesion, which was diagnosed as a carcinoma of the duodenum. The figure is a drawing made from this X-ray plate.

She was transfused with eight pints of blood, and her haemoglobin rose to 82 per cent.; she was then transferred to the Surgical Unit.

Operation

On 17.4.51 at laparotomy the 1st and 2nd parts of the duodenum were found to be occupied by a hard mass which extended almost to the point of entrance of the bile and pancreatic ducts, which were not involved in the growth and were not dilated. In order to excise the growth, however, these ducts had to be divided and the duodenum was cut across at the junction of the vertical and horizontal parts, and the distal end was closed. The stomach was divided at the incisura. Then a jejunal loop was brought up in front of the transverse colon and anastomoses were made between it and the fundus of the gall bladder, the head of the pancreas and the cut end of the stomach. Because the common bile duct was not dilated the gall bladder was used for the anastomosis; and as the pancreatic ducts were not dilated the whole of the cut surface of the head of the pancreas was joined to the jejunum, since it was found to be almost impossible to stitch the pancreatic duct to the mucous membrane of the jejunum. This junction of pancreas and jejunum was clearly the most likely of these anastomoses to leak. Drains were placed in the right kidney pouch. There were no macroscopic deposits in the liver and none were found elsewhere in the pelvis or abdomen.

Post-Operative Progress

For the first three days only a little fluid came from the drains but after the fourth day there was copious discharge of increasingly bile-stained fluid which was removed by continuous suction. The stools became pale but never clay coloured, and she was taking a low residue but adequate diet and her condition steadily improved.

APOLOGY

We very much regret that the article by Dr. Louis Rose in our last issue appeared under the name Louise Rose. We send sincere apologies to Dr. Rose for this mistake.

Suddenly on the 13th post-operative day she vomited about 1½ pints of bright red blood and there was a gush of arterial blood from the abdominal wound, which had to be packed to arrest the haemorrhage. Intra-venous blood was given and the stomach was kept empty by aspiration. The pack was left in for 48 hours and three days after its removal there was copious discharge of alkaline, bile-stained fluid from the wound for a further ten days. Although continuous suction was maintained and the skin was painted with aluminium paint there was considerable auto-digestion and much discomfort. This was finally overcome by painting the surrounding skin with barium mucilage, containing 3-4 times the usual amount of mucilage, and drying it off with a hair dryer, and the skin quickly healed. From then on she made rapid progress and in spite of such a stormy convalescence was discharged home fit on the 44th post-operative day.

Pathology

Histological examination of the growth removed at operation showed an adeno-carcinoma involving the mucous membrane but not the muscle coats of the duodenum.

Follow-up Note. When seen at six weeks, three months and six months after discharge the patient was very well and had no complaints.

Conclusion

This case is considered of interest in that although no symptoms or signs pointed to any affection of the alimentary tract the cause for hypochromic anaemia was discovered by radiological examination. Although this does not in any way detract from the need for full clinical examination of any patient it does demonstrate the great assistance given to the diagnosis of operable carcinoma in situations where it may be least suspected.

I am indebted to Professor R. V. Christie, Dr. Kemp-Harper, and Dr. Hanbury for their investigations, and my grateful thanks are due to Professor Sir James Paterson Ross for his help, and permission to publish this account.

I. G. SMITH,
H/S. Surgical Professorial Unit.

HOUSEMEN—WHY DO THEY WORK ?

by J. MCO.

AN embezzling stockbroker learns to break stones, a bag-snatching debutante is taught to sew mail-bags, and we are startled by their change of station. "Fancy that," we murmur, as we scan our headlines, or "Can't imagine so-and-so," if we chance to know them personally.

Stranger things have happened. We have known *bon vivant* students swallow gastric diets, homeopaths tolerate massive chemotherapy, and men in love have darned their socks. We pause, aghast, but soon forget them.

There is a stranger, homelier paradox at our feet. Consider the junior houseman. His industry is as well authenticated as the idleness of the conventional medical student is unsurpassed. We regard it as natural as the tadpole turned frog. But is it not odd that a good-living, hard-drinking student with many outside interests and social commitments should, at the whim of some jovial examiner, become an austere recluse working fourteen hours a day?

Explanations abound. Consider a few.

"He is keen and interested in his work," says his chief, benevolently.

"He takes a personal interest in each one of us," say the patients, gratefully.

"His job is full of interest and variety," say the minions of the Minister of Health, uneasily.

These explanations we dismiss, and talk of probabilities. Consider the weary fellow who has spent six months "on the House" as his lowly post is gaily dubbed. Let us catch him at an unsuspecting moment. We find him weighing himself, anxiously having his chest X-rayed, or estimating his haemoglobin. At some such idle moment we may hope to glimpse the truth. Boldly, we tap an emaciated shoulder, and ask its owner the question which heads this thesis.

"I am keen and interested in my work," comes the reply. Indulgently, we tap another shoulder.

"I take a personal interest in each one of my patients," says the next.

Daunted, we tap a third, and this one tells us that his job is full of interest and variety.

So we become a medical student ourselves, and after ten years of careless study, we are "on the House." Now we know the answer.

After six months' hard labour, there is more to come. Before proceeding to this next six months, we have to have a Reference. And here lies the explanation. The reference is a slip of paper conventionally inscribed. "Keen and pleasant to work with," "popular with nurses and patients alike," or some such improbable stuff. It is for this conventional scrap of paper that we work. Who knows when next the phrase "exceptionally able" is due to recur ?

We knew a houseman once who studied the references his Chief had given to previous employees. He disliked the recurrent comment, "When in difficulties, has the good sense to ask the advice of his seniors, frequently." The day before his job was due to end, he scoured the Casualty department until he found a multiple injury. Unceremoniously he dragged it off to the nearest theatre. Scarcely pausing to grab a passing anaesthetist he set to work. Wound toilet, intravenous therapy, antibiotics, prophylactics, plaster, prostheses, nothing was omitted. Anaesthetists came and went, and still he toiled. His reward? Proudly he passed round his testimonial, bearing the words, "Is quite capable of taking considerable responsibility."

Much forethought and care is spent composing these tributes to a man's skill and ability, still more in earning them, yet we cannot conclude without disclosing an astonishing fact. *These tributes are never read again.* They are carefully copied out, applicants for jobs post them, secretaries sort them, but nobody reads them. The reason, of course, is that every applicant has a little boxful of them which he turns over, broods over, and types out from time to time, so that committees have an impossible number to read.

As a result, they select their man for certain special qualities (which I must not disclose) and these they discover best by looking at him for ten minutes over a board-room table.

THE WARD NAMES OF ST. BARTHOLOMEW'S HOSPITAL—2

by G. W. MIDDLETON.

PERCIVALL POTT

PERCIVALL POTT (1713-88) was born in Threadneedle Street son of a scrivener. At the age of 16 he was apprenticed to William Nourse at St. Bartholomew's. In 1736 he obtained the Grand Diploma of the Barber Surgeons Company and after practising in the city for 8 years, was appointed Assistant Surgeon at Bart.'s. In 1758 whilst riding in what is now known as the Old Kent Road, he was thrown from his horse and fractured his leg. Pott was carried across London Bridge to a house in Watling Street where his doctors advised amputation. Nourse, however, advised conservative treatment and the fracture healed (fracture of the lower end of the Fibula is still called a Pott's fracture). Whilst he was immobilised Pott turned to writing medical articles including "Remarks on that kind of Palsy of the lower limb which is frequently found to accompany a curvature of the spine and is supposed to be caused by it, together with its cure"—1799—now referred to as Pott's Disease. He also described Pott's Puffy Tumour (osteomyelitis of the skull bones).

Pott left the city in 1768 to live in Hanover Square and died there of pneumonia in the following year. A portrait by Reynolds hangs in the Great Hall.

FLEET STREET

Fleet Street has always been closely connected with St. Bartholomew's Hospital and for many years contributed to its funds.

In 1927 the "Committee of the Fleet Street week for Bart.'s" presented £25,000 to provide a complete floor in the Hospital.

In recognition of this gift Fleet Street ward was so named.

The name "Fleet" is derived from the Anglo-Saxon word FLOET meaning river. The River Fleet is formed from two springs, one in Kenwood, Hampstead, and the other in Highgate. It now runs in sewers under Farringdon Street and enters the Thames just underneath Blackfriars Bridge. Cowcross Street is named because the cattle were brought to Smithfield Market along the street which originally crossed the Fleet River where it now crosses Farringdon Street.

ANNIE ZUNZ

In 1913 the trustees of Mr. Siegfried Rudolf Zunz promised a grant of £10,000 to the Hospital on the condition that a ward of not less than 20 beds in the Hospital be named in perpetuity the Annie Zunz ward.

The name Annie Zunz is to be found in other hospitals in London.

REES MOGG

In 1938 Mrs. Graham Rees Mogg gave to the Hospital the sum of £20,000 for the Rebuilding appeal. She was a daughter of Sir Frederick Wills and married Lt.-Col. Graham Rees Mogg, O.B.E., F.R.C.V.S., who was a Governor of the Hospital.

SANDHURST

A tablet in Sandhurst Ward reads as follows: "The Governors of St. Bartholomew's Hospital direct that Mark Ward be known as Sandhurst Ward in Memory of William, 1st Viscount Sandhurst, G.C.S.I., G.C.I.E., G.C.V.O., Privy Councillor, Lord Chamberlain to His Majesty King George V from 1912-21 and from 1908-21 Treasurer of the Hospital. On his death in the latter year, some of Lord Sandhurst's friends made a special contribution to the General Funds of the Hospital in affectionate appreciation of his able administration and faithful services."

There is a portrait of Lord Sandhurst in the Clerk's Office.

GARROD

Sir Archibald Edward Garrod (1857-1936) was born in London, the youngest son of Sir Alfred Garrod—Physician to King's College Hospital. Sir Archibald trained at Bart.'s and after service in the 1914-18 war, returned to Bart.'s and was chosen as first Professor and Director of the new Medical Unit. He had only held this job for a year when he became Regius Professor of Medicine at Oxford in succession to Sir William Osler. He published many works, at first clinical, and later biochemical. He was particularly interested in Pigments in urine, alkaptonuria, cystinuria, and inborn errors of metabolism.

WORK IN PROGRESS

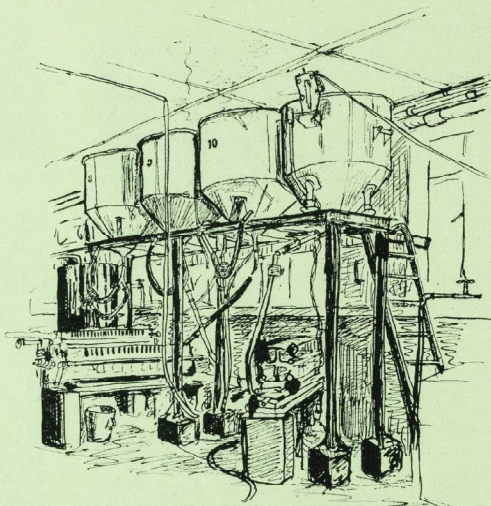
THE WELLCOME RESEARCH LABORATORIES, LANGLEY COURT, BECKENHAM

As the tide of Victorian middle class prosperity began to recede, England was left with the sorry architectural débris of a neo-gothic age. Among the less deplorable examples is Langley Court, at Beckenham, the present home of the largest research laboratories of the Wellcome Foundation.

To his credit the original owner, no doubt a typical specimen of the nineteenth-century *nouveau-riche*, was careful to hide his establishment from the outside world. From his buggy, as it clattered up the elm lined drive, he surveyed with complacency prosperous farmland, park and pasture, now metamorphosed into playing fields, roomy enough to exorcise, in healthy sport, the complexes of an average sized public school. For us, however, the sylvan concord of the drive ends on an unresolved final cadence—the well preserved specimen of *English Baronial, late 19th Cent.*, castellated and turreted and surmounted by a cupola. One turns with relief to the genial figure of Dr. Parish, the Clinical Research director of the laboratories, who welcomes us in a kindly Scots burr and outlines a programme for the afternoon, into which evidently much thought and preparation have gone.

The Wellcome Research Laboratories were founded in 1894 to further research work in medicine and allied fields, as a result of Roux's pioneer work on the serum treatment of diphtheria. Expansion was rapid and in 1898 they moved to Brockwall Hall, Herne Hill: it was here that they won the fight to be allowed to perform experiments on living animals. In 1922 they moved to their present quarters in Beckenham, which is particularly associated with the A.P.T. and T.A.F. preparations of diphtheria prophylactics. Among the many eminent names connected with the organisation at different times are those of Sir Percival Hartley, Sir Henry Dale, Sir Patrick Laidlaw, J. W. Trevan, and A. T. Glennie, and Professors J. H. Burn, J. Mellanby and J. H. Gaddum, all of whom became Fellows of the Royal Society.

Our tour starts with a general survey of the work in progress at Beckenham Laboratories, with special reference to the preservation of stock cultures by drying and freezing and the preparation of toxoids and vaccines. This is given in the Staff Recreation Room, where frivolous dart and playful cue are shamed into silence by the practicalities of laboratory technique, delivered by Dr. Francis against a formalistic background of flask and bottle, retort and rack. With our own theoretical knowledge refreshed and conditioned to commercial processes, we are now ready for the high spot of the day. The stables are indeed the focus about which much of the establishment revolves, and the laboratories maintain the largest in the country. At the moment they contain four hundred animals, all of which are in condition fine enough to be painted by any ex-P.R.A.,



and are not merely the export rejects one's textbooks seem to imply.

Each beast is treated with a consideration which many patients in hospitals might envy. On arrival at Beckenham it is first placed in quarantine for fourteen days, during which time its temperature is charted twice daily and the titre of the natural antibodies estimated. Further precautionary measures include an initial immunizing dose of tetanus toxoid and a mallein test for glanders, though in fact this latter has never been positive in the whole of the organisation's existence. After the neophyte has passed this ritual of initiation he is started on antitoxin production, the choice of serum to be produced depending on the animal's own potentialities and on the demand at that particular moment. This problem of demand was particularly to the fore during the most recent of the large scale massacres which distinguish the present century, when the extensive resources of the whole Wellcome Organisation were placed at the disposal of the British Government.

At the stables the routine work is in progress, and we are shown toxoid inoculation and blood withdrawal. Except for the site of election, a shaven patch on one side of the neck, and the larger scale of apparatus employed (for in these Brobdignagian wards our syringes and W.R. tubes become enlarged into bicycle pumps and Winchesters), the procedures are inherently the same as in a hospital ward and use the same sterile precautions. The difference lies in the behaviour of the human and the equine patient: here the horses remain as still as if they had equally marbled *Commendatores* mounted on them. Perhaps, though, the hospital patient is not entirely to be blamed for his attitude towards venepuncture: indeed, one would oneself be resentful of the line of attack employed by the average medical student. At the Wellcome Laboratories there were two alternatives in finding men to carry out these machinations: firstly to train technicians to handle horses, and secondly to instruct grooms in some of the mysteries of laboratory technique; the latter was in practice found to be the more satisfactory and is certainly recommended by its excellent results.

Following our schedule we accompany in theory the recently taken blood to the serum refining and purification processes, where selective treatment with proteolytic enzymes leads to removal of the surplus proteins. The use of refined serum reduces the quantity to be injected into the patient and also the risk of serum sickness. Upstairs there is a short theoretical discourse on the production of diphtheria toxin and its conversion into the familiar toxoid: this is well illustrated by models of the processes involved.

Guinea pigs and rabbits have been marshalled welcome us back to the billiard room, and obligingly demonstrate their skin reactions to various common toxins, under the benevolent eye of Dr. Oakley who, realising the arid, nay brutal, descriptions of such reactions in the textbooks, is well aware of the indelible effect on the mind of such visual demonstration. As an appetiser to tea he delights himself and us by a chemico-bacteriological legerdemain presented with true professional aplomb. Nowhere is the generous hospitality of our hosts more bountifully displayed than at the tea table. Thus fortified we are ready for an admirable summary of the afternoon's tour in the form of a film, the commentary of which is in the dulcet tones of Alvar Lidell, coping manfully with words, with whose meaning he cannot, in fairness, be expected to be familiar.



We thank our hosts for the cordiality of their reception and the valuable gift of their time; henceforth we shall know something of the efficiency and human qualities, which lie behind the label on the bottle. The charabancs shout along the lane—my feet are at Moorgate, and my heart under my feet. The tour is over.



The Wellcome Laboratories.

It did not take the early industrialists long to realise that to plough back a substantial proportion of profits into research was a sensible long term policy that paid handsome rewards. Cut-throat competition is a poor substitute for intelligent foresight, a fact of which Sir Henry Wellcome was well aware when he dictated the terms of his now famous will, a quotation from which forms a suitable end for this article. Under Sir Henry's will all the shares of the Wellcome Foundation were vested in five trustees, whose aim is:

"the advancement of research work bearing upon medicine, surgery, chemistry, physiology, bacteriology, therapeutics, materia medica, pharmacy and allied subjects, and any subject or subjects which have or at any time may develop an importance from the invention and improvement of medicinal agents and methods for the prevention and cure of disorders and the control or extermination of insect and other pests which afflict human beings and plant life in tropical and other regions and elsewhere."

BURBANK AND BLEISTEIN.

We wish to express our indebtedness to the Wellcome Foundation in the preparation of this article, and in particular to their clinical research director, Dr. Parish, who was kind enough to read this manuscript and to suggest many improvements.—B. B.

EXAMINATION RESULTS

SOCIETY OF APOTHECARIES Final Examination

Surgery
Ladell, R. C. H.

Medicine
Ladell, R. C. H.

January, 1952
Midwifery
Ladell, R. C. H.
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THE PATHOLOGY OF THE PERFORATED APPENDIX

by HARRY KARN

To the surgeon the decision, "Operation or conservative treatment?" for cases of Acute Appendicitis of over 72 hours duration is a difficult one.

The clinical course in any given case is dependent on the underlying Bacterial spread, the result of a combined activity of a mixed Bacterial Flora of both Aerobes and Anaerobes, and the resistance of the peritoneum. These can only be estimated by direct examination at laparotomy.

The delayed form of therapy advocated by the Ochsner-Sherren school has two great disadvantages:—

(a) The progress of the case rests on circumstantial clinical evidence. A multiplicity of clinical examinations, the appearance of a mass in the abdomen, repeated rectal examinations, observations on the Temperature and Pulse variations, repeated W.B.C.

(b) The patient is subjected to starvation, a prolonged stay in hospital and is absorbing toxins with the inevitable permanent effects on the constitution. Finally operation is necessary three to six months later.

Recent experiments have collected the inflammatory products in acutely inflamed Appendices in dogs by using poly-ethylene artificial envelopes. *THREE TOXINS* have been isolated.

(1) **FIBRINOLYSINS.** Of these **STREPTOKINASE**, an enzyme product of Streptococcal growth, is an activator of the **LYSIN** Factor. It prevents **FIBRIN** deposition about the necrotic appendage by *lysis* of this protective barrier.

(2) **HYALURONINASES.** The chief component of the "**SPREADING FACTOR**." Produced by Streptococci, Staphylococci, and B. Coli. It provides a mucolytic surface permitting the ready diffusion of bacteria over the protective serous surfaces and aiding their dissemination into the general peritoneal cavity.

(3) **LECITHINASE.** The lethal Alpha Toxin of the Type A Clostridium Welchii organism producing tachycardia, lethargy and severe haemolytic destruction.

The gangrenous area in the Appendix offers a suitable medium for the synergistic growth of the bacterial flora of the intestinal tract in the vicinity, resulting in the produc-

tion of an exudate having invasive and lethal properties depending on the degree of production of these three toxins.

The body can react only by:—

(a) The **ANTI-ENZYM** protective activity of the cells of the peritoneal lining and the exudation of Polymorphonuclear Leucocytes.

(b) **FIXATION OF THE ENZYM**ES in the cells of the body once the infection has been initiated.

The use of the Antibiotic drugs may result in the destruction of certain of the bacteria present, breaking the synergistic bacterial combination and diminishing the toxæmia.

THE ROLE OF SURGERY

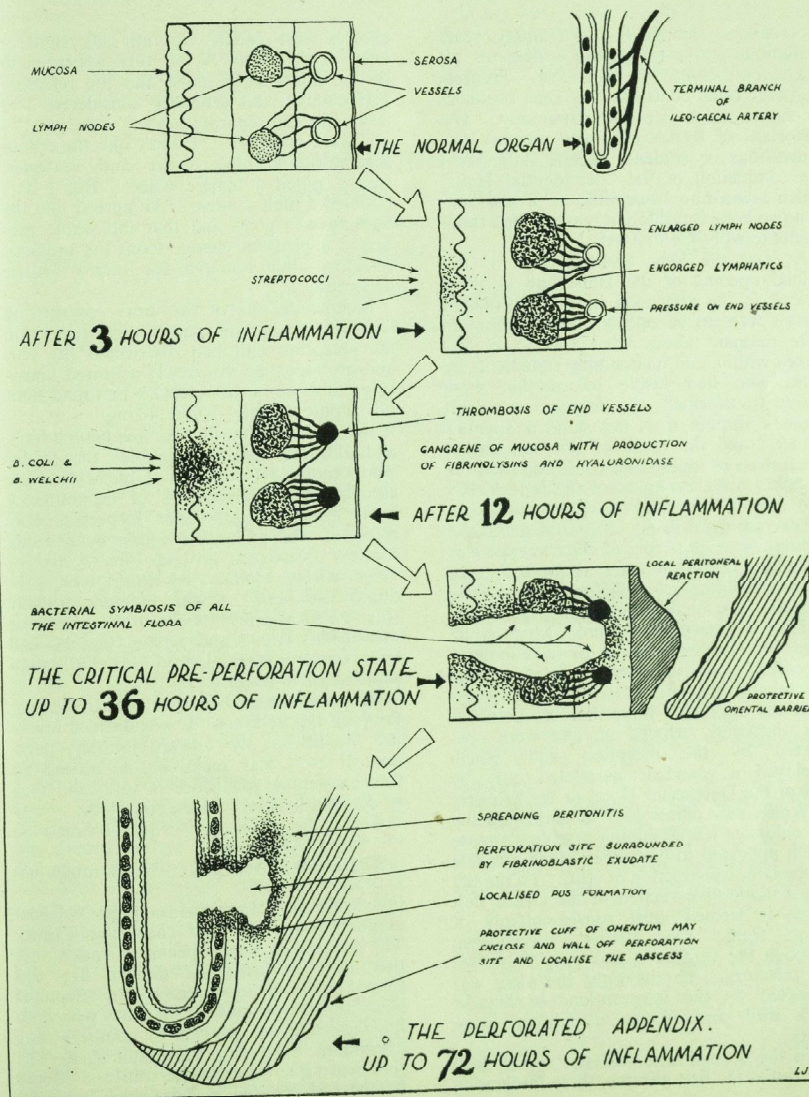
Streptolysins and Hyaluronidases destroy the protective peritoneal and omental reaction exudates, and permit the diffusion of the bacteria and their toxins.

Active surgical intervention at a certain critical stage in the pathological processes may disturb the equilibrium of the natural defences, and, rather than aid in the localisation, may in fact merely hasten the diffusion of the infection. It appears that this process is reaching its maximum about 72 hours from the onset of the disease; surgically speaking this is the time interval notorious for the highest overall mortality rate. Though it is the duty of the surgeon to remove the septic focus, undue interference at this precise stage may stir up the process of bacterial invasion and do more harm to the body defences than good.

Realising the factors at stake the following advice may safely be given to those who operate on the occasional Acute Appendix. If at operation on a case of over 72 hours' duration, the Appendix is found to be surrounded by dense adhesions, it is unwise to carry out extensive manipulations that may open up vascular areas for the further diffusion of bacteria and their toxins; it is far safer to accept the underlying pathology and merely drain the Appendix Abscess. Only if the Appendix can be shelled out with ease, with the minimum of manipulations, should it be removed. If the organ is surrounded by a protective cuff of omentum, do not disturb the enveloping tissue, remove the Appendix and cuff of omentum in one piece.

See page 377 for references and acknowledgements.

THE PATHOLOGICAL STAGES OF ACUTE APPENDICITIS



PARADISE REGAINED

HISTORIANS recount how for many years Columbus strove to acquire a fleet for his great venture into the unknown. Progress was very often confronted by such obstacles as suspicion, malice and parsimony. The historians of Bart's may also recount how generations of students eagerly anticipated the completion of the "Residential Hall," which seemed so susceptible to procrastination (we hope for different reasons than those encountered by Columbus).

At last the long awaited day for the official opening of the Hall—and at three o'clock in the afternoon its once forbidden portals were to be opened wide. Rumours were rampant about what was to be expected within, and unassuming statements by those who had inside information were hastily transformed into dogma; as we all know—"rumour does not stand a dogma's chance," and the result of this speculation was a mass of ideas more confusing than the original. Like explorers of the Nile Valley who find the doorway of a previously undiscovered mausoleum, the students stood without, none quite sure of what to expect.

Without doubt the external appearance of the new building was sufficient to predispose even the least imaginative, and to give their criticism a precocious foothold, which could have been either a help or a handicap, dependent upon whether it tended to predilection or antagonism.

At the appointed hour the curious sight-seers intrepidly tripped in, and were confronted by the reception hall, which displayed a grandeur paralleled only by that of the Dorchester Hotel or the Ministry of Works new offices in Whitehall. Facing the onlooker was a shining marble staircase which appeared to have been made obsolete by the later construction of a lift. To the left was a diminutive version of the Green Belt which it seemed must consist mainly of shoots from "Our Gracie's" aspidistra. Through the verdure it was possible to see the refectory. To the right the view was restricted by the interventions of first, a brick wall, and second, a pair of swing doors.

To the alumni who had not turned heel and run at the first glimpse, three fascinating

choices were patent: to turn left, right or keep straight on. A left turn appeared to be the intention of most and the refectory was entered and critically considered. "I don't like the separate tables" said one, "I do" said another. "I don't like the colour scheme—dark blue chairs and sea-green walls," piped a female voice, "But I do," boomed a male student. All agreed that the lighting was good and that the whole presented a pleasant change from the previous refectory—that synonym for interior artistic decoration!

Meanwhile one of the more enterprising individuals who had made a right turn from the reception hall had discovered the bar, and on imparting this newly acquired knowledge to those in the refectory he found himself unintentionally soliloquizing.

It was found that the bar was behind bars, and although this may perplex the reader who needs time to sort out his words, the actual scene became one of despondency from which the self-styled inspectors only retracted when they found that by pressing buttons scattered around the walls of neighbouring rooms, odd noises were produced elsewhere. At this juncture, tragedy was only narrowly averted by someone missing his friend and finding that he had been inadvertently locked in the sound proofed piano-room.

Respects were then paid to the upper floors of the building. It was decided not to use the lift for the upward journey, paradoxical as it may seem, but to ascend by foot examining each floor in turn, and then to descend by lift. On the first floor,

"There was a Door to which I found no key:

There was a veil past which I might not see";

but being as determined as Bruce's spider another door was tried and entry gained. The wardrobes were opened to make sure that they worked; the electric fire was turned on for the same reason; the telephone was "tested" by most of the party who finding they received answers to numbers rung at random, were not a little astonished. The time-worn queries as to the comforts offered by the bed resulted in deleterious bouncing

upon the mattress. In the ensuing haze a voice was heard reiterating Stevenson:—"Was it only pagan Jupiter plucking geese upon Olympus? or were the holy angels moulting?"

Having beat a hasty retreat from this ill-fated room there only remained the descent by lift. This proved more tedious than anticipated, for after waiting what seemed

like an eternity for the lift to reach our floor it descended with an almost imperceptible motion. Let it be said, however, that it reached its destination a little before the building was closed; the party having spent a very enjoyable half hour in the lift!

"Are you going to live in," asked a friend of mine; "I'll tell you tomorrow," I replied. TROGLODITES.

EXAMINATION RESULTS

UNIVERSITY OF CAMBRIDGE

Examination for M.Chir. Degree

Joly, J. S.

Rowntree, T. W.

February, 1952
Stephens, J. P.

ROYAL COLLEGE OF SURGEONS

At the Primary Examination held in February, 1952, the following were successful:—
Calderwood, R. W. L. Freeman, P. A.

DEATHS

Dr. Frank Hubert Robbins died recently at the age of 65. Dr. Robbins was the son of a well-known dentist. He was educated at St. Paul's School and Pembroke College, Cambridge, before coming to Bart's in 1909. Most of his years in general practice were spent in Golders Green, where he was regarded as an outstanding practitioner by both patients and colleagues. He held many appointments outside his practice and was at one time Master of the Rahere Lodge. Two of Dr. Robbins' sons were stricken with Infantile Paralysis, from which one of them—a medical student—died. We send our sympathy to his family.

Dr. Walter Henry Pollard, who was a well-known General Practitioner in Birmingham, died recently at the age of 84. Dr. Pollard was trained at Bart's, and he held the senior entrance scholarship in science. He graduated M.B. in 1895, and after a few years of practice near London he moved to the Birmingham district in which he practised for the rest of his life—a period of over fifty years. Dr. Pollard gave up his general practice a few years ago, but continued as chairman of a medical recruiting board up to his eightieth year. He took an interest in his Branch of the B.M.A., of which he became President shortly before the war, and was Mayor of Smethwick soon after the first war.

We announce with regret the death of Miss Margaret Anderson, who was for many years woman superintendent of the East End Maternity Hospital in Stepney. Miss Anderson was created O.B.E. in 1932, in recognition of her services in the East End of London. Her life's work lay in reducing the death rate among the mothers and babies of her area. She was trained at St. Bartholomew's Hospital and at Queen Charlotte's; at the time of her retirement in 1938 she was described as one of the outstanding obstetrical women of the world.

From page 374 (The Treatment of Acute Appendicitis).

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Acknowledgements

My thanks are extended to Professor F. Gordon Bell for his helpful criticism and advice in the preparation of this article.

CORRESPONDENCE

CONTROVERSY

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

Dr. C. P. Wendell-Smith's article in the *Bart's Journal* of October, 1950, on "Matthews Duncan's History of Midwifery," made most excellent and enjoyable reading, but there is one statement of Matthews Duncan which must be vigorously challenged. He says: "Smellie made no single improvement in midwifery so great as to be worthy of being coupled with his illustrious name."

I would like to suggest that any one of the following would, in itself, be sufficient to confound such a statement.

1. Midwifery Forceps. The lock on practically all modern forceps was Smellie's invention.

Although he makes no claim to the "invention" of the pelvic curve on the long forceps, his model was one of the first to be made, and his account of it the first to be published.

2. Mechanism of labour. The more that is known about the mechanism of labour the more accurate is Smellie's original description found to be, and the more erroneous is the "higher mathematical" descriptions of Matthews Duncan and the contributions of other writers of the 19th Century.

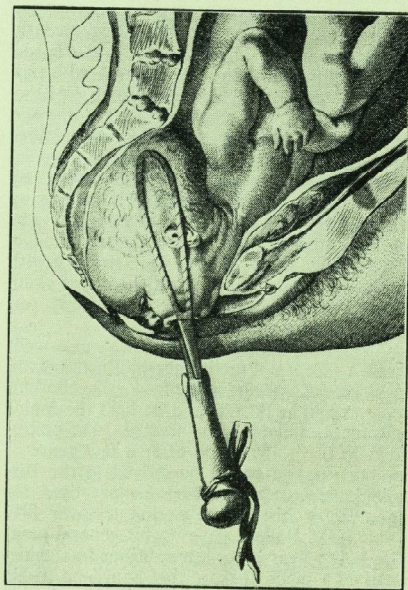
Today, students and practitioners will learn far more, and more accurately, about all aspects of labour from Smellie's original works than they will from the now meaningless symbols of Matthews Duncan's outmoded obstetrical writings. In most instances, they will obtain better and more useful information from him than from most modern text-books.

To take one example of the value of the difference between Smellie's and Duncan's writings.

Duncan proved, to his own satisfaction, that the foetus engaged in the pelvis in the L.O.A., R.O.A., R.O.P. and L.O.P. positions. That, therefore, "internal rotation" was only through a quarter circle. This erroneous belief has been copied from textbook to textbook to this day, and is still largely taught to students. It is not even original, for he freely acknowledges the work of Naegele, William Hunter and others in this connection,

Smellie, a century before Duncan, proved, to his satisfaction, that the head usually engaged the L.O.L. or R.O.L. diameters and only very rarely in the oblique. It has taken 200 years, X-ray and other "modern advances" to prove Smellie was correct, and yet, such is the influence of Matthews Duncan, that his false doctrine, on this issue, is still, as stated, being taught to students.

3. Teaching. It can be said, without fear of contradiction, that Smellie was not only the best but the first modern Midwifery Teacher. No mean artist himself, he (and others) produced diagrams which are better than anything now seen in textbooks. Although some of these were partly or mostly his own work, he had no false pride and got Mr. Rymsdyke (a better artist) to draw the majority. The original "Table of Diagrams" (1754) may be seen in the Bart's Library. An example is here reproduced.



Face Presentation. Mento Anterior.
Forceps delivery (drawing by Smellie,
assisted by Dr. Camper).

His "phantom" for demonstration purposes was almost certainly better than anything we have now.

4. His lifework—the three volumes "Theory and Practice of Midwifery," are as alive today as when first published. The logical approach, systematic layout and presentation have never been equalled in any obstetrical publication before or since. It is full of original "improvements" and quotes at least a dozen so-called "new discoveries" of the last 20-30 years.

The sly humour, apt words, and good English, which make the volumes so eminently readable, are, no doubt, partly due to the famous Tobias Smollett, who read and advised Smellie on this aspect of his work.

Duncan attributes to William Hunter (1774) the insistence of leaving midwifery to nature whenever possible. By implication, therefore, he does not do credit to Smellie, who preceded him. Yet Smellie again and again declaims against "meddlesome midwifery." There is no doubt that Smellie would be considered ultra conservative in his methods today.

I do not think that students will be wasting time by devoting considerable study to Smellie's original works, and Practitioners and Obstetric Consultants will be rewarded again and again by a detailed study of the methods he employed and describes with such accuracy and completeness. There are many authorities who are of the opinion that to this day he is the greatest practical exponent of midwifery, and, certainly, there can be no denying that he had the patience, method, experience and skill since unequalled by any Obstetrician, who has attempted to submit his writing for the benefit of posterity.

As a Bart's man, an apology is tendered for attacking one of the really great, Matthews Duncan. But he should not have been guilty of such a misstatement, especially as he appears to give all the credit to his other fellow Scot—William Hunter—who actually ought to have learned even more midwifery than he did from Smellie.

In no way is there any desire to belittle Matthews Duncan, who, incidentally, paid tribute to Smellie, apart from this "understatement." He was a great man—a very great man. A lovable and fine personality, a wonderful teacher and a great gynaecologist. But in his place in medical history, he cannot hold a candle to Smellie as

Physician Accoucheur. Perhaps this accounts for his misstatement, for he never seems to have fully appreciated the accuracy of Smellie's works.

Anyone interested in the History of Obstetrics should consult Glaister's "Life of William Smellie" from which much of the material for this letter has been obtained.

I am much indebted to Professor R. W. Johnstone who has drawn my attention to the fact that the sentence under discussion might mean that Smellie was so illustrious that no one of his improvements can be singled out as worthy of his name. If this is correct, all criticism must be withdrawn, but as worded, it is certainly liable to the interpretation I have given it, especially if the whole of Matthews Duncan's remarks on Smellie in his "History of Midwifery" are taken into account.

I would like to thank Mr. Bert Cambridge for the photograph and Mr. Thornton for his unflinching help.

Yours faithfully,

C. RUTHERFORD MORISON.

Harrogate, Yorkshire.

UNDER YOUR STETHOSCOPE

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

May I, from inside my plaster of Paris, add a few comments to your editorial and articles in the February *Journal*?

I am still at the stage when I sleep "in spite of" a fracture board, but once asleep I dislike being woken up unnecessarily. I object strongly to the destruction of pleasant dreams by a kind voice enquiring "Would you like anything to help you sleep?"—however kind the voice. And can you tell me why every other person who passes my bed knocks against it? These little things do matter, especially when they are repeated.

Sometimes I wonder if doctors realise how much extra work they create for the nurses (it does not need long in bed to realise how hard nurses work), merely by entering the ward at awkward times, or by demanding special tests and treatment at week-ends. Yes, it does happen sometimes and in some places. And must I really stop my quiet conversation with my neighbour when the great ones are at the far end of the ward? Surely the degree of reverence and self-abasement shown before these almighty personages is often out of proportion. I may be completely

in their power while I am here, but why should I let myself be examined in a draught, or prodded on that painful spot by everyone in turn?

Even the best of doctors have a few bad habits, and the one I have found most disturbing is indecision: "Well, we'll see what it's like in a week's time." They will not commit themselves. They loath being even slightly wrong, almost as much as the patient minds them being *really* wrong. If the choice were to arise, I would rather be told something definite and risk disappointment later, than to have my anxious queries parried with well-meant platitudes. Waiting is never easy, but it would be made easier if I could be told exactly what I am waiting for and why.

It has not happened to me yet, but I know others who, after waiting months for a hospital bed, have on admission still had to wait more than a week before even the preliminary X-rays were taken. It is not easy for the disgruntled patient to understand such lapses. But I must admit that if this is the worst criticism I can produce then I must be getting excellent treatment!

Consideration for the sick can only be learnt by putting ourselves in the position of our patients. Do you think we ought to try this more often and more realistically?

Yours etc.,
P. U. O.

Abernethian Room.

REVIEWED FROM BELOW

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

May I point out that your correspondent "Cerebus," in castigating your reviewer for the "howler" which appeared in the notice of Dorland's Medical Dictionary, himself committed one almost as great. It is true that the homo- of homosexual is derived from a Greek and not a Latin root, but I doubt if even your reviewer could have believed that it came from "hominus." Even he must have dimly remembered that the Latin for man is "homo."

But I am impelled to write to you also on behalf of my acquaintance, Cerberus, the many-headed dog which guards the entrance to Hades. He is always willing for his name to be used in letters to earthly editors, but he does stipulate that it should be spelt correctly.

I should like to add that in questioning

your correspondent's wisdom in launching out in so frail a craft as his memory of Latin I bear him not the slightest hostility. I shall, in fact, be delighted to meet him in the course of my navigational duties, when, for the sum of one obolus, I will provide him with his passage and a sop to appease his outraged namesake.

I remain, as befits my immortality,
Yours ever,

CHARON.

Adrift on the Styx,
Ides of March, A.U.C. 2705.

THE QUEEN'S ENGLISH

The Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

I should be most grateful if you could supply a translation in English of the letter of your correspondents *Messrs. Burbank and Bleistein* for, as their names suggest, they have not yet mastered our native tongue.

I am, Sir,
JAS. EMBLETHORPE.

Orpington.

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BOOK REVIEWS

THE PHARMACOLOGY AND THERAPEUTICS OF THE MATERIA MEDICA, by Walter J. Dilling. 19th Edition, 1951, Cassell pp x + 630. Price 21s.

A book with a lineage as long as this (the first edition appeared in 1884) needs little introduction. It is one of the accepted standard works on Pharmacology and Therapeutics, and although too detailed for the student reading for his early examination in Pharmacology, it will be of great value in his later studies and as a work of reference.

The drugs are so arranged that those having comparable actions appear together, and a comprehensive index serves the needs of the reader seeking information on one particular drug. A valuable part of the book is Part III which deals with general therapeutics classified under the various "systems" of the body.

In this edition there has been considerable revision based on the British Pharmacopoeia of 1948. There are not many points at which criticism can be levelled against this book, but one might hope for a clearer typographical lay-out in future editions. It is admittedly difficult in a book in which the subject-matter must be grouped under many headings, to devise a scheme of type which is clear and yet tasteful, but one wishes that greater prominence had been given to the name of a drug where it appears as a heading. It would then be immediately clear to which drugs any subsequent paragraphs on *preparations of actions and uses* referred. This is, however, a minor criticism and detracts little from the value of the book as a whole.

GUY'S HOSPITAL, 1725-1948, Edited by Hujohn A. Ripman, for Guy's Hospital Gazette Committee (1951). Guy's Hospital Gazette, pp. 176, illus. Price 18s. 6d.

Following the introduction of the National Health Service in 1948, several histories of hospitals have been published, to mark, as it were, the passing of an epoch. The present volume contains chapters on the History of Guy's Hospital, by the late Sir William Hale-White, brought up to date by Hujohn Ripman, the editor of the book; The Medical School, by Prof. T. B. Johnson; The Dental School, by F. N. Doubleday; Nursing at Guy's, by Dorothy H. Smith; Guy's Hospital in 1948, by Sir Herbert Eason; and the Historical Lists forming the concluding section.

Owing to its nature and scope, this book makes no pretence to take the place of *A Biographical History of Guy's Hospital*, by Wilks and Bettany, published in 1892, to which we shall still turn for information regarding eminent Guy's men of the past. But the new short history is beautifully produced by Adprint Ltd., contains a remarkable collection of illustrations, several being in colour, and, at current prices, is wonderful value for 18s. 6d.

It is of interest to note that this book is published out of the profits from the sale of the *Guy's Hospital Gazette*. We would welcome a short history of this Hospital on a similar scale, or, better still, a History of the Medical College, which is long overdue. But let us hope that publication will not be delayed until our *Journal* shows a surplus! J. L. T.



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HOSPITAL JOURNAL

Vol LVI

MAY, 1952

No. 5

ESPRIT DE CORPS

We have seen and read much of the new College Hall at Charterhouse Square. We have read of its architecture, admired its furnishings and sampled an excellent lunch in the new refectory. It is many years since the students of Bart.'s last had a hostel of their own, and we are glad indeed that this new building is of so excellent a quality. So much has been heard—and such is only natural—of the material make-up of College Hall, that its importance as a social institution seems almost to have been overlooked.

From all over London and its suburbs the students have travelled to Bart.'s. They have lived according to their means in "digs," or flats, and the lucky few have lived at home. So living, it has been hard indeed to maintain the team spirit so essential to College life. The social life of Bart.'s people has been strictly limited, and has seldom been associated with the hospital. The sentiment, that one saw enough of one's contemporaries during the day without going out with them at night, has not been altogether lacking; and this was not surprising. More surprising was that a house so divided stood so firm, that old Bart.'s men gained a reputation for "clannishness" wherever they foregathered, and that all were united at least in their pride in the name of Bart.'s.

Not only were the students widely scattered. They were divided further into pre-clinical and clinical; a divide crossed only by the bridge of the games field, the river or the golf-course, and not crossed at all by those (and they seemed not few) who played no game.

That was the position. For the majority, it will remain unchanged, some cannot afford to "live in," others will not want to, but at least a nucleus will do so, and they can provide the corner-stone upon which to build a real college life, a true students' union. Clinical students will live in the midst of the pre-clinical stronghold, and another bridge will cross the divide. Already the residents speak of "the day boys" and we welcome this sign of their pride.

If we are to take full advantage of the opportunities thus given to us, there is surely more that can be done to bind all Bart.'s students into a single community. Clubs can be formed—an account of a new one appears elsewhere in this issue—dances less formal (and cheaper) than the Dorchester Ball can be held, and the sport club dinners should be held at Charterhouse instead of in the restaurants of Soho. These things can be done and we shall hope to see them. An added interest, and a stimulus to such ventures, might well be provided by one or two formal occasions in the life of the Medical College. At other medical schools in London, Orations are held to open the sessions (Lord Horder addressed King's on such an occasion last autumn—but the opportunity for him to do the same at Bart.'s does not arise), and prizegivings have not been unknown even in the Great Hall. Is it too much to expect their return?

We hope to see these things and with them a drawing together of all the students at Bart.'s. The College Hall has provided the opportunity for a great reformation. It is our duty to grab that opportunity.