RIFLE CLUB.

The annual general meeting of the Club was held on Thursday, December 8th, 1899, when the officers for 1900 were elected:

President.—H. J. Waring, Esq.

Vice-Presidents.—Howard Marsh, Esq., Dr. Edkins, E. W. Miles, Esq., W. R. Read, Esq.

Captain.—R. J. Morris.

Secretary.—Norman Maclaren.

Committee.—C. R. V. Brown, E. F. Travers, C. F. Feilding.

The following matches have been arranged:

Wed.,	May	16	Silver Spoon Competition ...	Runemede.
,,	,,	23	Dulwich College	,,
,,	,,	30	Silver Spoon Competition ...	,,
,,	June	6	Royal Indian Engineering Col.	,,
,,	,,	13	Inter-Hospital Match	,,
Mon.,	,,	18	Whitgift Grammar School ...	Woldingham.
Wed.,	,,	27	Silver Spoon Competition ...	Runemede.
,,	July	4	Rifle Club Prize Meeting ...	,,
Thurs.,	,,	12	Inter-Hospital Challenge Cup	Bisley.

The regulations for the Silver Spoon Competitions will be the same as last year.

Correspondence.

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

"PERNICIOUS ANÆMIA."

SIR,—In the recent volume of *St. Bart.'s Hospital Reports* I see an interesting account of a curious condition of colitis found at the post-mortem of a case of pernicious anæmia (see p. 299). I attended a patient, female, aged 44 at death, who had all the clinical signs of pernicious anæmia. For several years she frequently passed masses of gelatinous and fibrinous-looking mucus, strongly suggestive of some form of colitis. I sent some of this material to the laboratory of this Hospital, and the report was, it *might* come from a case of malignant disease of the bowel, but there was nothing very definite to make out. I had specially asked to have it searched for evidence of *Anchylostoma duodenale*, the reply being in the negative. Now this case lasted long enough to quite remove the suspicion of there being any malignant disease. Twice the patient rallied so as to place in doubt the diagnosis of pernicious anæmia, but eventually the anæmia and enlarged spleen with other classical signs proved the truth of the diagnosis. The patient died of colliquative diarrhœa in Scotland, and although I telegraphed to have a post-mortem, unfortunately it was refused. The changes in the blood-cells under the microscope were very marked, and yet improved when the last rally occurred under forced feeding with chopped underdone beef, port wine, red marrow extract, and Liq. Sodii Arseniatis. Even the spleen could scarcely be felt during this rally. In the early stages of this case the symptoms pointed to an undoubted gastric ulcer, but when bismuth and morphia were administered the constipation with anæmia increased to an alarming extent. Also when iodoform in any form or hæmoglobin was administered the lemon-tinted anæmia with sickness and headache would be more marked. Castor oil in dram doses, alternated with simple warm water enemas, gave the greatest relief to the aspect and feelings of the patient.

In certain books the condition of the bowels is said to be a consequence of the disease, but after watching this patient I felt convinced there is some association between a diseased large bowel having something to say to the production of an animal poison, which by its absorption destroys the blood and produces the entity called pernicious anæmia. I tried to get the relationship of the organic to the inorganic sulphates of the urine made out, but the Clinical Research Association failed to carry out the research. In any case this patient's urine did not yield the usual excess of pigments seen in pernicious anæmia. In private practice so few cases of this disease are met with, that it is impossible to make useful comparisons. My chief object in writing is to direct the attention of those attending the post-mortem room to make further observation on the condition of the intestinal tract in all cases of pernicious anæmia, as, in spite of the great researches by Dr. Hunter on this disease, its cause is still unknown.

Yours truly,

March, 1900. J. KINGSTON BARTON, M.R.C.P.

Appointments.

BROOK, CHARLES, M.R.C.S., appointed Consulting Surgeon to the Lincoln County Hospital.

* * *

BROOK, W. H. B., F.R.C.S., M.D., B.S.Lond., appointed Surgeon to the Lincoln County Hospital, *vice* Charles Brook, appointed Consulting Surgeon.

* * *

BROOK, W. H. B., F.R.C.S., M.D., B.S.Lond., appointed Coroner for the Lincoln North District, *vice* Dr. George Mitchinson, deceased.

* * *

RANDOLPH, W. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the Gravesend Hospital.

* * *

LEGG, T. P., F.R.C.S., M.B.Lond., appointed Senior Surgical Registrar and Tutor at King's College Hospital.

* * *

DRUITT, A. E., M.R.C.S., L.R.C.P., D.P.H., appointed House Surgeon to the Torbay Hospital, Torquay.

* * *

CORNISH, C. V., M.R.C.S., L.R.C.P., appointed House Surgeon to Out-patients at the Hospital for Children, Great Ormond Street.

* * *

SEWELL, E. P., M.B., B.C.Cantab., nomination to R.A.M.C.

* * *

ADAMS, P. E., M.D.Lond., M.R.C.S., L.R.C.P., appointed Civil Medical Officer to the South African Field Force.

* * *

EVANS, LAMING, M.B., B.C.Cantab., F.R.C.S., appointed one of the Surgeons to the Welsh Hospital for South Africa.

* * *

JONES, T. C. LITLER, M.R.C.S., L.R.C.P., appointed Civil Medical Officer to the South African Field Force.

New Addresses.

EMERY, W. D'ESTE, Esq., Rosslynn, School Road, Moseley, Birmingham.

HULSI, OTTO, Esq., from 20 to 20 Upperton Gardens, Eastbourne.

OLDFIELD, JOSIAH, Esq., from 122 to 30, Harley Street, W.

STAWELL, R. DE S., Esq., from 22, Margaret Street, W., to St. Mary's Court, Shrewsbury.

Birth.

BEST.—On March 18th, at The Firs, Waltham Cross, Herts, the wife of F. H. de Graves Best, M.R.C.S., L.R.C.P., of a son.

Marriage.

JONES—BURMAN.—On February 16th, at St. Matthew's Church, Upper Clapton, by the Rev. J. Cullin, M.A., William Black Jones, M.D., B.S.Lond., of Llangammarch Wells, Breconshire, eldest son of the late Rev. William Mead Jones, D.D., to Elizabeth Ada, third daughter of William Kimin Burman, of Clapton, N.E.

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same as last year.

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To the Editor of the 'St. Bartholome

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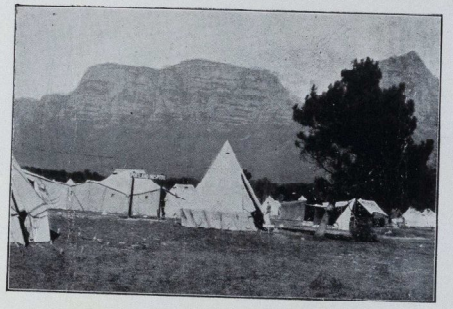
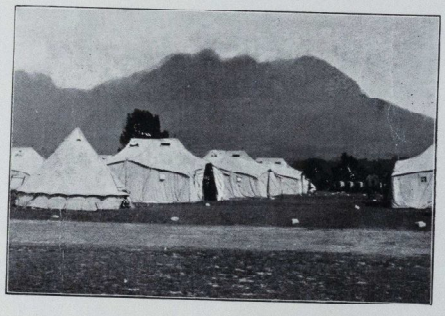
March, 1900. J. KINGSTON BARTON, M.R.C.P.,

ST. BARTHOLOMEW'S HOSPITAL JOURNAL, APRIL, 1900.





THE PORTLAND HOSPITAL, RONDEBOSCH, S. AFRICA.

Photos by Dr. H. H. Tooth. *Adlard & Son, Imp.*

St. Bartholomew's Hospital Journal.

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NOTICE.

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

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

All communications, financial or otherwise, relative to Advertisements ONLY, should be addressed to J. H. BOOTY & SON, *Advertising Agents, 30, Holborn, E.C.*

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

St. Bartholomew's Hospital Journal,

APRIL, 1900.

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

With the Portland Hospital.

SOME LEAVES FROM MR. BOWLBY'S DIARY.

TUESDAY, February 27th.—I had hardly finished packing my hold-all, *en route* for Kimberley, when the staff sergeant arrived in great excitement with a wire from Captain Bagot, "Cronje surrendered with all his forces Majuba Day," and everyone was, of course, delighted. Then the surgeon-general arrived, and, much to my delight, allowed Major Keogh, of No. 3 Hospital, to accompany me north. He is an exceedingly nice fellow, and has arranged No. 3 excellently, and has been very nice to us of the "Portland," and I was very glad to help him to get to the front even for a short time, as he was very keen to do. We drove down to the hospital train at 1 o'clock and lunched on board, and got away at 2 sharp. The train takes about 100 patients, and consists of corridor carriages on bogie wheels, the whole carriage being turned up inside and beds placed lengthwise with a middle aisle, down which one can walk the whole length of the train. There are two nurses and two surgeons, who live in carriages just like "wagonlets," and our mess of six was a little crowded, but very comfortable. It was dark when we reached Worcester, and I had been nearly as far as that before when we went to Ceres.

February 28th.—We had an excellent night, and woke to find ourselves on the Karoo 320 miles from Capetown and nearing Beaufort West. There had been a lot of rain quite recently, and it had laid the dust and made the air pleasantly cool. The surface of the land is very like ploughed land gone out of cultivation for two or three years. There is a great deal of bare reddish soil and patches of growth of small bushes from a few inches to a couple of feet high. Where there is a watercourse there are also mimosa bushes, and a few of them had flowers. Large areas of the land are flat and covered more or less thickly with stones, but there are innumerable hills or "kopjes" from 50 to 1000 feet, rising very abruptly from the plain, and to the west of the line there is a considerable range of hills parallel to the railway for fifty or sixty miles, and at a distance of from a few hundred yards to five miles. On the east the hills are more scattered and isolated, and now and then the plain stretches unbroken to the horizon. The characteristic shape of the hills is that of a sugar-loaf with the top cut off, and they consist of masses of loose stones and dirt with no vegetation at all.

There are a few farms many miles apart where water can be got, and round these there are sometimes a few gum trees. Large flocks of sheep with kaffirs as shepherds may be seen here and there, and in other places flocks of ostriches. A little past Beaufort West we passed a cloud of locusts, but none of them got into the train. Near this place is a sanatorium for consumptive patients, situated on the slope of one of these stony hills and looking across the Karoo, with no sign of trees for miles; a more

desolate place could scarcely be imagined. The train wound its way very slowly upwards, the line curving a good deal to keep on the flatter ground, but almost always ascending. Many of the higher hills, as well as the smaller kopjes, were curiously steep at the summit, the earth and smaller stones having been washed away, leaving the rock exposed. The rock itself is soft and shaley, and is quite shattered by the weather into large and small fragments. The kopjes called the "Three Sisters" showed this condition very well, so I photographed them as typical examples. Four hundred miles from the Cape we reached Victoria West, and got out to talk to some officers of the Tasmanians, who are at a small camp there, who told us that Kitchener had paid them a visit this morning. All the line from the Cape is guarded by small camps, and every little bridge has a sentry near it, so that several thousand men must be thus employed. The line next passed through flatter country, but as we had now got 4000 feet up we were really on the level of the mountains and hills we had passed through earlier, and had reached the general level of the "High Veldt," this level being about maintained all the way to Kimberley. At Richmond Road Station we heard that 200 Boer men were sixty miles north-west, retreating from Prieska, and that a force had gone out from De Aar to try and cut them off, and that the Boers were trying to cut the railway. I think myself that all they want is to escape home, and I fancy they will find it difficult to do so, as all our forces are now between them and the Free State and Transvaal. It is quite likely they are rebels from the Cape Colony, for there are plenty of these, and there are many families where the father stays in the Colony and the sons go and fight for the Boers, and so they hope that when the war is over they will be all right with either side. I believe that the word "karoo" means dust, in which case we are lucky to travel after heavy rain, which has well wetted everything. The future of the Karoo is entirely dependent upon water-supply, for it will grow anything with a little water, and there are now many little water-pumps driven by air, like small windmills, wherever there is a farm; for water can be got almost anywhere at a depth of 15 to 25 feet or less, and a good system of irrigation costing a large expenditure would quite possibly make the thousands of square miles of Karoo a prosperous country. As it is, it feeds 6,000,000 sheep, who eat the bushes, and ostriches, who apparently eat the stones. We passed last night a train with 100 Boer prisoners who were captured trying to relieve Cronje. They mostly spoke English well, and I expect a good many of them were not Boers by birth at all. We reached De Aar at 3.30 p.m. It is composed of a few straggling houses with tents and iron buildings around them, and store-heaps and horses and mules. Most of the troops and stores have been moved up to Orange River and Modder. We left at 4 p.m., and soon found that cattle and horses had replaced ostriches, and that the land grew a coarse, dry grass (which English horses and cattle would turn up their noses at), as well as the usual bushes. Farms also were more numerous, *i. e.* one every three or four miles. The land was a large plain with scattered flat-topped hills around it, but no longer so high or stony or rocky as on the Karoo, out of which we had now passed. We saw some of the C.I.V. at De Aar, and thought they looked as fit and manly and hard as the best of our troops. After leaving De Aar we ran through very flat open country all the seventy miles to the Orange River, and saw lots of cattle, horses, and ostriches, arriving at De Aar just after sunset. We were delayed there an hour while the train with the captured Cronje on board passed through, and then we crawled on in the dark to Modder. Rudyard Kipling was in the train the last trip it made, and Dr. Boswell had a piece of shell from Modder which he intended to make into an inkpot, whereupon Kipling wrote these lines on the shell:

"Beyond the trenches' outer bink *
I flung my message from afar,
And now I serve to hold the ink
Whilst men write lies about the war."

March 1st.—We got up at 5.15, when there was the beginning of what turned out one of the most beautiful sunrises I have ever seen, and as the red light opened over the plain we found that we were at the edge of the camp on the north side of the Modder River, and as soon as we were dressed we walked out to see the houses which had been shelled and the bridge which had been blown up by the Boers and afterwards repaired; then we met Col. Townsend, the P.M.O., and after breakfast we went to the station, to find that a train had just left for Kimberley, and although the next one was supposed to go at 9.15 it did not actually start till 4. So we spent the morning at or near the station. The camping ground is a large plain of red earth, all grass and bushes there might have been having disappeared. The rivers Riet and Modder unite a little above the railway bridge, and at this place is a small peninsula with some gum trees and a house or two, which used to be a place of recreation in better days, the swings being still there, for Modder was the Richmond-on-Thames of Kimberley. The river banks are thickly covered with bushes, and lots of our men and horses were bathing there at 6 a.m., and at that hour two batteries of artillery and some cavalry moved away northwards. A little later the news came that the 4000 Boer prisoners were arriving, and soon after 10 the head of a long column appeared in a cloud of dust, the men marching with an escort of mounted infantry and Tommies. The Boers were the usual ragged and unkempt lot of men, of all ages from sixteen to sixty or more, but most of them men of about thirty to forty-five. They were a hard, stolid, quiet-looking lot, very robust, looking capable of a lot of hard work, and none

* *Bink*,—a bank or perpendicular edge,—a word used north of the Tweed. Trust Mr. Kipling for knowing the ins and outs of his mother tongue.—ED.

the worse for what they had gone through. They did not appear dejected, and took very little notice of their surroundings, but afterwards some of them and our Tommies engaged in a good deal of chaff. They said that our lyddite shells did very little harm to them,—and I think they meant what they said,—but that they surrendered because they had no food. It appears certain that they only lost about 300 killed and wounded, whereas I *hear* our casualties were about 1200.

At 4 p.m. we got into an open luggage truck with our valise, and as we were next the engine we got plenty of coal-dust all the journey. The rail runs right through the Boer position at Magersfontein, and we could see many of their trenches. All the country at Kimberley is much more grassy than any we had as yet passed through, and there are many respectable-sized thorn trees north of Magersfontein. The kopjes are low, and most of the Boer trenches are at their foot and not on their tops. Nearing Kimberley we came on their trenches facing the town, and then we came to the large *débris* heaps near the mines, where our guns were placed. When we reached Kimberley itself we found a straggling town on a flat plain with rising ground to the north, and we drove to the club, where I had an introduction to Capt. Tyson, the manager. It was fortunate I had, for the place is full of officers and others, and we had to put up our camp beds in a large dining room instead of elsewhere; but we had nothing whatever to complain about, and got a very good dinner considering that it was just a fortnight since the relief came. I went and saw Dr. Ashe afterwards, and heard from him the trials that they had gone through, and how no food could be got without tickets from the military, who took possession of all foodstuffs and regulated them. One hundred and ninety-seven big gun shells of 100 pounds were fired into Kimberley in eight days, and also 2000 small shells during the siege of four months, and although a good deal of damage was done only seven people were killed and twelve wounded. Men were placed so that they could see the flash of the big gun, and they either blew a trumpet or beat a gong to warn people, as the shell took about thirty seconds to arrive. Dr. Ashe and many other people had bombproof shelters of sandbags, etc., and in one of these he and his wife slept for five nights when the bombardment was at its worst. There were, of course, numerous extraordinary escapes, and by the end of the siege every one had got used to small shells, but the big guns shook their nerves a good deal by the tremendous noise the bursting shells made. Roberts and Kitchener rode over here from Klipp Drift this morning and were received at the Town Hall by Rhodes and others, and speeches were made and everyone left in excellent spirits. It is believed that a column will march to Mafeking 10,000 strong probably, and that Roberts and Co. go on to Bloemfontein in two days, and expect a big fight before they get there. There are very few wounded here, but 170 came in to-day, and we are going to see them in hospital to-morrow morning.

March 2nd.—A lovely morning; breakfasted at 8, and went off for a stroll round Kimberley, which showed little evidence of a siege unless closely looked for, though sand-bag fortifications could be seen. Then we went into the gardens to see the big gun made at the De Beers workshop, named "Long Cecil." It is a splendidly finished gun, and is said to have shot well, though it is very extraordinary when it is considered how difficult gun-making is and that these makers had never made a gun before. By a singular misfortune the maker himself, Mr. Labran, was the last man killed by the enemy's shell. We then found Major Peard, R.A.M.C., and I found in him a former pupil and a very nice fellow. He is in command of the Medical Corps here and took us round. We found about 100 sick and wounded in the drill hall, all from Paardeberg. Many of them were Canadians, and not a few of them were French Canadians, a further testimony of their loyalty. Some of them—six—had been bayoneted by the Gordons in this way: during the night the Canadians and Gordons were making trenches near to the enemy's position, and the Canadians were lying down firing when the Gordons were entrenching behind them. After a time the Canadians retired to occupy the trenches, and the Gordons, thinking they were Boers, stuck them, whilst others fell on to the fixed bayonets sticking up in the trenches. It is evident that the Canadians, who spoke with a strong accent, were not credited by the Gordons when they said they were friends. They thought it was a Boer trick. Fortunately the wounds were slight or, at least, were doing well. They were not nearly as big as I had expected. Then we went to the schoolrooms and saw about sixty wounded men of the Yorkshires, the Buffs, R.E.'s, R.A.'s, and others. There were no cases too bad to allow of their being sent to the base, and no need for us to stay with them. Afterwards we went to the convent and found thirty wounded and sick men and some Boers, but all pretty well, and then on to the "Christian Brothers' Schools," where there were twenty or so cases of enteric. From there we went to the Civil Hospital, and met there Dr. Ashe. There were eight more cases or thereabout, but all convalescing except an officer—very severe fracture of the thigh in a very bad condition, and probably a case for amputation later on if he can stand it. He was shot eight days ago, lay out for twenty-four hours, and then was taken in an ox-wagon to the field hospital, which he reached on the fourth day. Yesterday he was brought here from Paardeberg in an Australian ambulance by Dr. Lowe, a St. Mary's man and a very nice fellow. We had the patient under chloroform, took off his splints and dressings, saw to his thigh with Dr. Ashe, and left the man in his charge under very favourable surroundings. Lowe tells me he is attached to the Field Hospital of the Sixth Division, and has consequently seen a good deal of

the fighting. Three hundred sick and wounded were treated in three days by their hospital; three amputations done. The Boer laager was in an awful condition, full of dead horses and smashed wagons, dead men, with the ground pounded to bits by our big shells, and the most awful stench from the decomposing masses of dead matter. The wounded were not treated at all, and had either died or were in a horrible state from complete neglect. There were about 300 of them. The Boers had left their laager and retired into the pits dug in the side of the trenches, and had been without food and almost without water. The river was full of dead horses and some Boers. Their losses are not yet estimated at all. Our own men fought for two days without any regular food supply,—no bread, and very little beyond two biscuits per day per man, and some very tough beef from the trek oxen. They seem to have stood it very well. All our wounded are now sent down from the field hospitals either to Jacobsdal, Modder River, or here, so we shall go back to Modder at 9 a.m. to-morrow, and then home. We lunched at the field hospital with Peard, and met Capt. Fell, an old student, there. Then we walked over to the Sanatorium and called on Rhodes, as I had an introduction to him. He was very civil, and asked us to dinner. We walked on to the Du Poits Mine and saw the barricades there and at the neighbouring mines, which were our strongholds in the siege, and from these we could see the Boer positions, and we finished up by a visit to the De Beers and went up to the top of the winding gear, about 200 feet, from whence we formerly watched the Boers and used our searchlight, and afterwards we went on to the Sanatorium to dine.

March 3rd.—We got up at 5.30 and left Kimberley in a luggage train at 7 a.m., reaching Modder River Station about 9.30. We then walked across to the camp ground and met Mr Cheatle at his little hospital on the river and saw several patients with him. After that we walked back to lunch at the Modder Hotel, now headquarters, and then at 3.30 Mr. Cheatle, with myself and Burchell and Heaton, of the R.A.M.C., rode off to see Magersfontein. Keogh had a bad headache and could not come. In describing Magersfontein it is necessary, first of all, to state very briefly the position from Modder onwards. North of Modder, for two or three miles on each side of the railway, the ground is a flat plain of dust and red soil, without tree, bush, or grass. There is no change from this as you pass forwards till at about two miles from the river the ground gently rises a little and becomes covered with small bushes and innumerable ant-heaps about two feet high and two feet across at the bottom and shaped like a sugarloaf. There are also innumerable holes, a foot or two deep and six inches to three feet across, many of them dug by the ant-bear.

From the rising ground one looks over what appears to be pretty flat country of exactly the same character to some kopjes about 4 or 5 miles away. And to these kopjes, on the right of the railway line, the name of Magersfontein is given. On the left of the railway line the kopjes recede so that they are distant some six or eight miles. The point of attack was the most prominent part of the kopje called Magersfontein. On the 11th December, our big guns having been placed on the rising ground, we shelled the Boers and attacked their position, but did not press the attack. We also did a very foolish thing in striking our tents as if for a forward move, and this could be plainly seen by the enemy. The guards were on the south side of the river, and at nightfall they crossed the drift to the further side, and after feeling, advanced in a densely black wet night, taking their position on the right of our advance; Heaton was with them, and told me that he could not see the two men who led his horse, and the only way touch was kept was by having ropes passed right along the lines for men to hold. They advanced very slowly, tumbled over bushes and into holes, running against ant-hills, but they gradually made their way to the right side of the nearest high kopje, and were distant from it about 1000 yards or more, when they heard a terrific crashing fire on their left at daybreak, and before they could well understand what was happening the men of the Highland Brigade came rushing through them, and then on till they reached and passed the field guns which were on the right flank of the Guards, and then for the rest of the day the Guards and the guns kept firing, but could never get through, although at one time some of the Guards reached the trenches on the extreme right. It seems quite clear that the Highlanders got quite near the position of the enemy without realising it. When the Guards had taken open order as they drew near, the Scots remained in close formation of quarter column, the same formation in which the Guards had started, but which was never meant for the actual attack. Heaton tells me that every ant-heap concealed one of our men, but that as they did not stop the bullets the dead were found behind them next day in large numbers. Burchell showed me the spot where the Highlanders first met the fire, not forty yards from the trenches, and where he counted ninety-seven dead in a space the size of a tennis court. So much for a brief description of the battle. As we rode on and got nearer to the kopjes, the ground which had looked flat and bare became rising ground with bushes, and these were most numerous to the right of the Guards' advance. As we rode on we practically saw no signs of the Boer trenches till we were within fifty or one hundred yards of them. Even then you had to look hard to see that there was anything between you and the kopjes, which rose very abruptly from the plain, and it came quite as a surprise to find that right across the line of our advance was a deep trench four or five feet deep and two or three feet wide. This was cut within ten yards of where the kopjes rose from the plain, and followed closely the outline of the kopje itself, so that it was not a straight line, but curved into the curvatures of the ground. When one passed across the trench it could be seen that towards the advance the earth had been heaped up about a foot, and that earth had been packed in bags, and then the whole had been very densely hidden by bushes or stones, and then getting down into the trench itself and standing towards the Modder, one realised at once that the ground sloped gently away—almost as smoothly as the "glacis" of a fort for more than a mile, giving a field of fire which could not be surprised. All along the trenches, and behind them, lay innumerable sheepskins sodden with the recent wet, and thickly scattered everywhere were tins which had contained milk, sardines, tea, meat, coffee, etc., and bones and old boots, ragged trousers and shirts. Behind them the stones and rocks of the kopje had been more or less smashed with shells, large twisted pieces of which lay around. We tied up our horses and climbed a small kopje to see what was behind it, and then one saw flat ground of half a mile across, with another hill and lines of entrenchments made since the battle, rising across the open ground. All the country was much broken right away to Spytfontein, five miles further on. Just behind the kopjes rough huts and shelters had been made of stone and bush, and we picked up two letters among the stones and took them away. Then we mounted and rode to the right, past where the Scots had been cut up, and on to where the Guards had attacked, and then again dismounting, we climbed the highest kopje of all and surveyed the whole position. It was near sunset and a lovely evening, and from that kopje one could see with glasses everything going on at the camp and for miles around, whilst eastwards the view extended across an open country past the Modder and the Riet Rivers, to the distant hills in the Free State, some of which were thirty or forty miles away. But in the plain, 1000 yards from the kopje, were some bushes, and here the ill-fated Scandinavian Brigade had been placed by the Boers, and here all of them to the number of some fifty or more were killed or wounded, being cut off when the Scots retired save one wounded man, who, with a sound comrade to help him, was allowed to walk back to the trenches unharmed by our men. The Boers had put them where they dared not go themselves; in front of most of the lines of trenches was a single thin wire fence, not barbed except for one strand, and there was but *one* line of trenches. After hearing Burchell and Heaton, who were both at the battle, and after seeing the single trench, I can have no doubt but that the position *could* just possibly have been rushed at the point of attack, and that the Boers in the rest of the trenches, which were two or three miles long, would probably have got away over the kopjes to their horses and retired to the next hills and retreated to Spytfontein if necessary, and the latter even, if possible, a still stronger position. It is now known that the extreme right of the Boer position, which extended past the railway, was only held by 200 men, and if this had been known the Fighting Fifth and two other regiments, which made a feint attack along the railway, might have pressed that attack home and got to the Boer rear, and really routed them in conjunction with the frontal attack. It is easy to be wise afterwards. The trenches as I saw them are not as they were left. The Boers fairly bolted from them at ten minutes' notice, and left food half cooked, clothes, cartridges, etc., and also a lot of roughly made toys, such as guns, horses, soldiers, etc., cut out of wood, or twisted out of metal which they had probably made while waiting a weary two months, only to be turned out and captured. All these things, and also almost all the cartridge cases, bullets, and portable bits of shell, had been taken away by the Tommies who crowded to the trenches when the Boers cleared out. I am told that our advance was signalled to the Boers by a man near Modder with a lantern. He was caught, convicted, and sentenced to eight lashes; while, if it were true, he ought to have been promptly hanged.

March 4th.—A wet morning, but it cleared enough to let us walk over to see the last of the Boer prisoners. I was introduced first to Albrecht; he is the officer in command of the Free State Artillery, and he has held this position for many years. He was in the Franco-Prussian war, a man of about fifty-eight, of middle height, with slightly forked beard and very keen grey eyes, with dark brown hair and bronzed skin. He struck me as a man of determination and activity, and one likely to prove a good leader. In conversation with myself and others he expressed great admiration for our infantry and artillery, but said that the mounted infantry had chiefly to think of keeping their hats on, and were not much good. It is a fact that some of our men cannot ride nearly well enough to be of use, and their helmets shake loose or fall off with the jolting. He also told us that he came very near abandoning his guns at the Modder battle when our troops got across on the right flank. The other Boer commanders I met included Dolmorains, Roose, Jouste, Jourdain, most of them being Transvaalers, and I thought they seemed a manly and independent lot of men. I have also met and talked to many of the other prisoners. The Free Statters mostly say they did not want the war, that they would willingly make peace now if they could, and that they want to get back to the farms. The Transvaalers are some of the same opinion, but many of them are not, and say that although we may beat them we shall yet have to pay for it, which is very likely true. Amongst the Boers I have seen there seem to be two very distinct varieties: in one the men have brown or even sandy hair, freckled skin and grey eyes; in the other they are very dark and swarthy with black hair, and black or dark brown eyes. Some of them, I should think, have negro or Kaffir blood in them. After leaving the Boer camp we strolled along the Modder where the battle was fought, and found a very muddy stream with bushes growing along its high banks, and contrasting well with the sandy waste around. Then we inspected the Boer cannon which had been captured at Paardeberg, and soon after 1 p.m. we left for the Cape in a very crowded train, *en route* for Rondebosch.

A Letter from South Africa.

NAAUWPOORT, S. AFRICA;
March 4th.

DEAR MR. EDITOR,—It seems to me likely that of the many old Bart.'s men out here now the majority have a few friends at the old hospital. Also of these old Bart.'s men the majority are bad correspondents; therefore there must be many of your readers who would like to hear something of the life we are leading.

Eager to fill a long-felt want, I have bought a penny bottle of ink for threepence, taken off my coat, rolled up my sleeves, seated myself on a camp bed, and lighted a pipe. So far is easy; but now where to begin. Leaving the docks at Southampton was only interesting from being utterly unlike anything one had read about in the papers. A few stragglers on the wharf standing and shivering in the slushy snow—I find the idea rather refreshing this afternoon,—a solitary cornet playing such inspiring airs as "Say Au Revoir, but not Good-bye" and "Auld Lang Syne;" the prevailing depression was so great that no one had sufficient spirit to throw the musician into the dock.

At last we steamed out and began to look around. We found that there were six civilian surgeons on board. No one seemed to know anything about us. We had no instruction, except that we had on board enough anti-typhoid serum to inoculate 500 men. This was interesting, but very soon the wily old time-expired man began to think he would like to be excused duty. They turned up seventy or eighty in a morning with a "orrible 'acking corf," or something equally distressing, and we had to arrange for their treatment. Then we began to be thankful we had tried listening to chests in the surgery; but even that is simple compared with practising auscultation just over the twin screw of an Atlantic liner. We had an interesting epidemic of pneumonia; some twenty cases, nearly all atypical and, fortunately, mild. Only one died, on which we congratulated ourselves. The treatment was novel. All ordinary drugs were exhausted before we had left home a week, so we had to make up mixtures from Liquor Ammon. Fort. and pure chloroform. Brandy, however, we had, and none of us came from the Temperance Hospital.

We had a great tug-of-war, table against table, and the doctors' table, much to our own and everybody else's surprise, beat all the other tables representing the British army. I believe they thought some occult methods had been used, and left the ship with an enhanced respect for the powers of medicine.

We were met by a specimen of the R.A.M.C. I only hope, as I certainly believe, he was not a representative specimen. Much to our delight, he told us we were ordered to Naauwpoort. We started at night in a comfortable saloon.

The Mayor of Capetown and several ladies and gentlemen were down bringing bags of biscuits and grapes for everybody. It was an interesting commentary on this "war of capitalists," to find these old citizens coming down night after night, standing in a platformless station, where every little breeze fills your mouth with dust, to try and add to the comforts of the men who, as they said, had come to fight their battles. One of them said to me that for the past few years the feeling of impotence had become almost unbearable. They were becoming ashamed of acknowledging that they were Englishmen. If England had not taken up their cause at last, it would have meant the alienation, at any rate of all our South African colonists, and, he believed, of our colonies all over the world. In fact, it would have been the beginning of the downfall of our Colonial Empire.

The journey up was interesting. It took two days and nights, and we slept the third night in the carriage, it being much more comfortable than anything they could have rigged up for us in the camp. We did not go fast, and part of the way had an advanced guard and rearguard, all the men having their guns loaded beside them and fifty rounds of ammunition. This was owing to a rising near Victoria West. It was reported that 800 Boers were going to attack our train. Then we began to regret that we had a saloon, as the authorities had not indulged us in a red cross; indeed, as we were sharing the carriage with other officers they could hardly have done so.

Here, at present, six of us share a marquee.

We are not overworked; indeed, as I write, three are asleep on their beds, and one of them, I regret to say, snores. I have five marquees full of patients, each marquee containing nine beds.

Tommy on active service is a queer patient. On my first day I had five new tents, with the patients just arrived, with some injuries, but mainly dysentery and enteric. They were lying about out of bed, and absolutely refused to retire until they had had a wash. Most of them had not had a wash for about a week. It was curious in going over them afterwards; they nearly all said they felt much better since their ablutions. Their weak points are a desire to eat all they can get, and walk about. If either their dysentery or enteric is bad it makes one nervous. As regards teeth extraction I desire no better patients. Marvellous skill is not nearly so much required as a determination to see simple orders carried out. The best way seems to be after giving the order to proceed to carry it out. You say, I must have a trench dug round this marquee; then get a spade and dig it. One could get on faster, only one constantly trips over red tape.

The climate is grand, as long as it doesn't flood out the marquee. We have eaten Queen's chocolate; we have seen Boer prisoners and Kimberley refugees; we have seen a train with Kitchener in it; heard ourselves cheered from every window in Queenstown; had all the skin burnt off our noses; learnt the nice gradations of difference in saluting a colonel or returning the salute of a Tommy. The only things I regret are: there are no other Bart.'s men with me, and no ladies tried to kiss me when we embarked. I believe this was done for the C.I.V. Why these distinctions?

R. DERWENT PARKER.

Adenoids.

A Paper read before the Abernethian Society, December 7th, 1899.

By STEPHEN PAGET, F.R.C.S.

THE Abernethian Society is bound to be practical, and I will not trouble you by repeating what the text-books say about the pathology of adenoids. They are a hypertrophy of that lymphoid tissue which is stored here and there along the alimentary canal, in the medulla of the bones, and in the spleen; the same lymphoid tissue that is present in the tonsils, and in Peyer's patches, and round the vermiform appendix; and these stores of lymphoid tissue are more abundant in children than in adults. Why some children should have adenoids and enlarged tonsils, and not all children, we do not know. Both the adenoids and the tonsils run in families, but it does not follow because the children have them that the parents had them. They are not the result of inflammation; you come across little children who never had a day's sore throat, yet are choked up with adenoids and tonsils. The bacillus of tubercle is found in about 15 per cent. of adenoids, but it does not follow that these cases of adenoids are cases of primary tuberculosis of mucous membrane.

Adenoids, sheltered and hidden in the naso-pharynx, remained unrecognised till Meyer discovered them. The date of his account of adenoids in the 'Transactions' of the Medical and Chirurgical Society of London is November 23rd, 1869. Before Meyer, nothing was known about them, or next to nothing. The troubles that they caused were put down to enlarged tonsils in those cases where the tonsils were enlarged, and in those cases where the tonsils were not enlarged the child's troubles were put down to "a faulty habit of breathing," and he was told that if he did not keep his mouth shut he would grow up ugly. There was no diagnosis, and the treatment was a bandage under the chin at night. If the tonsils also were enlarged they were removed, and the adenoids were left behind; and then came a belief that it was wrong to remove enlarged tonsils, because it did no good. Therefore people were advised, if their children had big tonsils, not to let anybody meddle with them. Anyhow, though the tonsils were removed, yet the adenoids were left behind.

What happens when adenoids are left to themselves? The child outgrows them. You come across families where the younger children have adenoids, and the older children have had adenoids, and have outgrown them. We do not know much about this outgrowing of adenoids, yet we can hardly doubt that it does happen. But the adenoids leave their mark on the child; he grows up with it written on his face, "I had adenoids when I was a child."

Are we not bound to make a clear distinction between those who have adenoids and those who have had them? More than once I have had cases sent to me for removal of adenoids, and have found no adenoids there to remove,—not cases of adenoids, but cases showing the final results of adenoids.

Take first the cases that have adenoids, the small children with the typical signs of obstruction. The child is pale, and looks stupid—and many of them are stupid; his nose is pinched and narrow, and he is subject to coryza; his palate is pinched and high-pitched, a sort of Gothic roof to his mouth instead of a Norman arch, so that the upper incisors are in advance of the lower incisors; he has a heavy, slack, open mouth, and a weak, receding chin; and, because his Eustachian tubes are more or less blocked, the membrana tympani of each ear is sunken, the handle of the malleus tilted backward, the cone of light shifted or lost, and the folds and shadows of the membrane very strongly marked. And with these defects of structure you get a history of various troubles. He is dull and listless, and somewhat deaf, and subject to frontal headache; he is always catching cold in his head, and when he has a cold it "flies straight to his ears." His voice is stuffy and non-resonant, and he makes odd grunting noises over his food, and at night he snores and chokes in his sleep, and is subject to night terrors and incontinence of urine.

One or two points in this familiar picture are worth considering. First, the shape of the hard palate. It is just as though you had squeezed it between your finger and thumb till the upper incisors stuck out a third of an inch or half an inch in front of the lower incisors, and the roof of the mouth was narrowed into a sort of trough just fitting your finger. This Gothic palate has been taken as a sign of deficient cerebral development; it has been found in many imbecile or idiot children, and has been attributed to premature ossification at the base of the skull, with consequent arrest of the development of the brain. But there is another explanation, that it is due to the mouth kept open in childhood, and the nose kept blocked, hindering the lateral expansion of the bones of the palate.

Next, take the night terrors and incontinence of urine. We are too ready to attribute incontinence of urine to something wrong with the prepuce, and to forget that it occurs among little girls as often as among little boys. Half the children who wet the bed, and more than half, do it because they have adenoids; their breathing is impeded, their blood does not get enough oxygen, their inhibitory centres fail, and the full bladder forthwith empties itself—*hinc illæ lachrymæ*. As for the night terrors of children, they are very curious things. Even if we admit that they are often due to adenoids, yet the fact remains that night terrors are something different from bad dreams, and may fairly be called epileptiform. We may not be able in all cases to draw a hard and fast line here, but nightmares in some adults, the sort of nightmare that I would venture to call "incubus epileptiformis," and night terrors in some children, the intolerable sort of oppression that makes the child half frantic, even after it has been shaken out of sleep—these are very different things from the ordinary nightmare; they are more like the aura of an epileptic fit. In these night terrors the image or hallucination may be vivid and elaborate, or may be so vague that the child cannot speak about it, as in Robert Louis Stevenson's poem of the Sick Child:

> "Why is the room so gaunt and great?
> Why am I lying awake so late?
> Some of the things are so great and near,
> Some are so small and far away,
> I have a fear that I cannot say."

These night terrors of children are something more than dreams. And in practice, when you come across children with these terrors, treat their brains as well as their stomachs; give them bromide, and examine them for adenoids.

Now, having taken the typical cases of adenoids, let me submit to you that there are three sorts of exceptional cases. One is congenital adenoids, another is adenoids in adult or elderly people, and the third is what may be called latent adenoids.

Children may be born with adenoids; you do get babies, only a few months old, so stuffed up with adenoids that they cannot take the breast, and are hard to feed with the bottle, and may need to be fed with a spoon, and are half choked in their sleep. These congenital cases are rare, and they may be mistaken for common cold in the head, or for diphtheria, or for laryngismus stridulus, or for the snuffles of inherited syphilis. And they are anxious work, because the infant is in some slight risk of suffocation during sleep. This risk may be prevented by laying a bit of narrow drainage-tube along the floor of the nose, on one or both sides, as far as the naso-pharynx; but the adenoids must not be left, they must be removed, in spite of the fact that the patient is only a few months old.

Adenoids in adults or in elderly people are very rare, yet perhaps they are overlooked. I remember especially one case, a woman of sixty, where I never thought of them, and went on treating the deafness with Politzer's bag, and so forth, till a better man found and removed them, and cured the patient. We must bear in mind the possibility of them when we get a case of deafness, even in an elderly person, if there are such troubles as come of adenoids, and a sunken membrana tympani; and we must do our best to see the

adenoids with the posterior rhinoscope, and thus spare the patient the discomfort of a digital examination.

Latent adenoids are so common in children that we must not let them out of our minds. By latent adenoids I mean those that set up troubles in the ears, but do not wholly obstruct the naso-pharynx. The child keeps its mouth shut, does not snore or have night terrors or incontinence of urine, does not look like a child with adenoids; but it does have earaches and deafness, and possibly acute inflammation of the middle ear with perforation. Children don't get the earache for nothing; and these cases of latent adenoids, where the growth occupies Rosenmüller's fossa on either side, and presses on the openings of the Eustachian tubes without blocking the breathing, are rather common, and often overlooked. For, among the London poor, there is a belief that the earache is part of the necessary business of childhood, almost as natural as teething. Nothing is done for it, and so much might be done; so many children might be saved from pain, deafness, and otorrhœa, and all the trouble and risk that otorrhœa brings with it. Hot fomentations, cocain, gentle Politzerising, a drop or two of laudanum—these things have a wonderful effect on the ordinary earache of childhood, and often succeed in cutting it short without perforation of the membrane.

Unhappily, just as the parents of the child neglect the earache, so we ourselves often overlook the cause of that earache. Setting aside the specific inflammations of the throat, I believe that adenoids are responsible for 80 or 90 per cent. of the earaches of childhood. And it is a good rule in practice, in every earache, to suspect adenoids, and to make careful examination of the naso-pharynx; and to bear in mind that adenoids may be latent, not wholly obstructing nasal respiration, but filling Rosenmüller's fossæ, and setting up inflammation in the middle ear.

I submit to you, gentlemen, that these are the chief sorts of adenoids: first, the common typical cases, and then the three exceptional conditions—congenital adenoids, adult adenoids, and latent adenoids. Hitherto we have considered the cases that have adenoids. Now take that vast array of cases, the people who had adenoids in childhood, who have now what we call chronic hypertrophic rhinitis. I don't believe in chronic hypertrophic rhinitis as a separate disease; it is only Greek for a thickened and congested nasal mucous membrane. The more I see of this chronic hypertrophic rhinitis, the more sure I am that it is, nine times out of ten, the result of adenoids years ago. The nasal mucous membrane is everywhere thick and stuffy, the inferior turbinated bones so big that they almost touch the septum, and the septum thickened, and perhaps deviate or spurred. And the naso-pharyngeal mucous membrane, like the nasal mucous membrane, is coarse, and thick, and puffy: there are no growths, nothing to be gained by operation; not adenoids, but the result of adenoids. And when we make a digital examination in these cases that have not got adenoids now, but had them during childhood, we find the naso-pharynx just what we should expect—cramped, pinched, unexpanded. Like the hard palate, it has never had a fair chance, it has never got fair play. The whole face is set and fixed: the open mouth, the weak, irresolute chin, the Gothic palate, the upper teeth in front of the lower teeth, not biting on them, the snoring at night, the non-resonant voice, the non-expanded naso-pharynx, the whole picture of nasal obstruction—you feel sure that the patient has adenoids, the whole picture is the picture of adenoids, and then, when you examine him, you find none. Everything is there except the adenoids. And they were there once.

It is therefore right that we should recognise this great difference between those who have adenoids and those who have had them. Now let us consider this question, What is the way to examine for adenoids, and what do we feel when we do it?

The easiest way, of course, is to use the finger. Yet we may in many cases see adenoids with the posterior rhinoscopic mirror; and this method should be used in all cases where it is practicable, and on all except small children. In some cases, again, you are so positive that the adenoids are there, that you put off the examination till the child is under chloroform; and this is not a bad plan, only you run the risk of taking a case that has had adenoids for a case of adenoids. It has happened to me more than once that a child has been sent up for operation by one of the gentlemen working in my Out-patient Department, and has been put under chloroform, and has then been found to have not adenoids, but only the unexpanded naso-pharynx and the hypertrophied mucous membrane that are the result of adenoids.

Anyhow, the examination for adenoids is not difficult. If the child is small, put him on your own knee, and lean his head well back against your left arm, and let somebody hold his hands. Don't use any sort of gag or guard; pass your finger back along the whole length of the palate, and make sure that you get well behind the soft palate, not bruising it; and in some cases it is kept strained back against the wall of the pharynx. Having got behind it, crook your finger well up into the naso-pharynx and go straight for the posterior border of the nasal septum; that is the great landmark, and it feels just like the back of a table knife: make sure that the tip of your finger is straight down on it, then on either side of your finger you have the firm rounded openings of the Eustachian tubes; and these hard prominent swellings are so marked that you cannot fail to feel them, standing out one each side of the middle line. In some children they feel so large that they are the most striking feature of the naso-pharynx. Then immediately behind each Eustachian tube you feel Rosenmüller's fossa, the lateral extension or pouching of the naso-pharynx, and then you touch the back and the vault of the cavity. That is all that we feel in the healthy naso-pharynx, and it can all be felt in a moment if we go straight for the back edge of the septum as our landmark.

If adenoids are present, what do they feel like? It has been said that they feel like a bag of earthworms, or like a varicocele, or like this or that. They do not all feel alike; some are soft and friable, and bleed at a touch, some are as tough as an old enlarged tonsil; some are pendulous, and move under your finger, some are sessile. Anyhow, you feel that the naso-pharynx is blocked and half choked up with softish outgrowths from the mucous membrane; your finger can hardly move, you cannot come down on your landmarks. In many cases you feel a deep cleft down the middle of the mass of adenoids. And in some cases—what I have called latent adenoids—you find the fossæ of Rosenmüller filled up, but the rest of the naso-pharynx free.

Now, before we come to treatment, consider what we feel when we examine, not a case that has adenoids, but a case that has had adenoids, a case of chronic hypertrophic rhinitis. In every case, or nearly every case, we find the naso-pharynx cramped and narrowed. Mostly it is narrowed in its antero-posterior diameter; and in some cases the upper part is sloped forward, so that the vault of the pharynx is lost, and you get a sort of penthouse instead of a broad arch. And this narrow pharynx is made narrower still by the thickness of the mucous membrane that lines it. But there are no adenoids, nothing to remove; and if you operate as for adenoids you will do little or no good, and may do harm. The time for operation was years ago; the case is not adenoids, but the result of adenoids: you want the galvano-cautery, not the curette. If you do find adenoids, so much the better—operate at once; and there are other cases, what may be called borderland cases, where the curette may do some good. But we must be guided by what we feel, not by what we expect to feel; we must not operate on what is not there; we must distinguish the cases that were adenoids from the cases that are adenoids.

Finally, give me leave for ten minutes to submit to you some questions touching the operation. You will see it done nowhere better than here; there is no question about that. Let us consider the subject under three heads:—(i) before the operation; (ii) the operation; (iii) after the operation.

(i) Before the operation we must make sure that the child is not a bleeder, that he is in fair general health, and that he is prepared for the operation with as much care as though it were a major operation. Do not operate on sickly, white-faced, shaky children; do not take it for granted that their feeble condition is due to their adenoids, and will stop when these have been removed; give them Parrish's food and cod-liver oil for a fortnight, and see how they are then. Most of the cases are not urgent; if the child can wait a day, he can wait a week or more. Then, prepare him for the operation; see that his stomach is empty, that he is not likely to vomit under the anæsthetic; but do not starve him too long, lest he should be faint under it. Four times at least I have suddenly seen a child come to the very edge of death over this "little operation;" one from vomiting and choking, and three from chloroform syncope. Prepare the child: improve his health, make him fit to bear the sudden poison of the anæsthetic.

(ii) The operation raises many questions. You must have an anæsthetic, and chloroform is usually given, yet there is much to be said in favour of the A.C.E. mixture, and gas will do for some cases. One thing I am sure about, that the anæsthetic is often given to excess. You only want the child saved from fright, and kept still for about two minutes; I hate to see a child lying in profound unconsciousness, pale and relaxed long after the operation is finished. Don't abolish the cough-reflex; just get the child to keep quiet till the gag is out of his mouth, and then the sooner he wakes the better.

For the right instrument to use, I believe that the forceps, as you see it used here, is the best, because it gives the least amount of bleeding. But the forceps in Mr. Bowlby's hands is one thing, and in a beginner's hands is another; and I wish to speak about the curette, not the forceps, because the curette is the easiest instrument for a man's first cases. Afterward he may take to using the forceps if he is not satisfied with the curette; but I believe that he will be satisfied with it. As for the artificial finger-nail, though it is used by one or two eminent surgeons, yet I mention it only to condemn it; and the natural finger-nail is, if possible, even worse.

The position of the child during operation must be considered. Against the fashion of putting the head right back over the edge of the table, so that it hangs upside down, there are two objections: first, it increases the bleeding, which is a serious matter with some children; next, you cannot work well with the patient's head not steadied, and upside down. Try to remove a back tooth, or to do a harelip, with the patient in this extraordinary posture; you must have the head fixed, and the patient immediately under your hands and eyes. There is only one position that gives you these advantages; the child must lie on his back with his head thrown back a little on a hard pillow. He may lie on his side if you like, it is perhaps safer for your first few cases, but it makes the operation rather more difficult.

And, with regard to the use of the curette, I would submit to you that we must take care not to use a curette that is too small for the work. It must be large enough to encircle the growths, and sharp enough to cut through them, and curved enough to reach up to the highest point of the vault of the pharynx. And, of course, we must start at the top of the vault, and not halfway down. The following rules might be suggested:

1. A large curette must be used.
2. It must be put up to the very top of the vault, and the back of its blade must be hitched against the back of the septum, as if one were going to raise the patient's head with it.
3. It must be held overhand, with the fist, not like a pen; it must be firmly pressed down round the growths, and must cut them clean off, so that you hear it go crunching through them, first down the middle, and then down each side, four or five cuts altogether.
4. The instant that the curette is out of the child's mouth, turn him quickly over on to his side, hips and shoulders, and raise his head. Then, keeping the gag in, and having made sure that your finger is perfectly clean, feel for any remnants of growth not removed. You may be able to scrape away these remnants with your finger, but that is not a very satisfactory way, and it is best to make sure exactly where they are, and then apply the curette, or a smaller curette, till you feel that the whole naso-pharynx has been well cleared.

This paper has to do with adenoids only, not with enlarged tonsils, but we must consider those cases where enlarged tonsils and adenoids exist together. In my earlier cases I sometimes removed the tonsils first, and then a few days later the adenoids; and there is no great objection to this method in the case of feeble children. But I have never had any trouble come of doing the tonsils and the adenoids together, and it saves the child from the extra risk of taking chloroform a second time. With larger children it is not necessary, it is not even kind, to give chloroform for the removal of tonsils; cocain will ease the pain. But, though adenoids often occur without tonsils, yet tonsils, in children, seldom occur without adenoids. We must take each case on its own merits, and for our first few cases, if there are large tonsils and adenoids co-existing in a very feeble child, it may be safer for the child, and easier for ourselves, to do the operation in two stages, not all at once.

(iii) The treatment after operation, with most surgeons, is practically *nil*, but one or two eminent surgeons advise, and practise, frequent irrigation, etc., with various sprays or lotions. There is room here for different opinions, but I believe that a really clean curette and a really clean forefinger will ensure safety from infection, and that if infection should occur you could not stop it with sprays and lotions. I don't believe antiseptics are necessary after the removal of adenoids. Take, for a similar instance, the operation for cleft palate; I have read in a German book on surgery that the child, after this operation, should be laid on a table three times a day, and the head inverted over the back of the table, and the line of union irrigated with some antiseptic. It would be hard to imagine a worse method. And as with the operation for cleft palate, so with adenoids; the thing is to be aseptic yourself, and leave the rest to nature.

One or two things after the operation are to be noted. Some blood always runs down into the stomach, and is vomited, and it is well to warn the parents that this will happen, or they will be alarmed to see the child "bringing up blood." There is no particular pain on swallowing, because the raw surface is protected by the palate from the touch of the food; it is not like the operation for the removal of tonsils. There is generally slight shock, at least among the ill-fed, thin, nervous children of a London out-patient department; they are faint and miserable for a day, or even for two days, and want nursing. And half the troubles that may follow the operation—otitis, bronchitis, even pneumonia—come because the child is not taken into the wards, but must be turned out again back into the slums.

Gentlemen, I've tried your patience long enough, and I only ask leave to say what seems to me the chief lesson that comes from having throat and ear work, and that is the certainty that we often overlook adenoids. They occur in children who don't look as if they had them, and in grown-up people who look too old to have them; they occur in the majority of all cases of otorrhœa and of throat deafness in early life; and where they occur, there they ought to be removed.

A Visit to the Camp at Modder River.

With some Remarks upon the Varieties of Continued Fevers observed.

By Dr. H. H. TOOTH.

ON February 5th I was sent by the Principal Medical Officer of the South African Field Force, General Wilson, to Modder River to render any assistance I could to the medical officers there in connection with an outbreak of enteric fever among the troops there encamped.

I was the guest of the officers of the Guards' Field Hospital, and was received by them with a kindness and cordiality that I shall never forget. Physicians do not, as a rule, figure in campaigns, though there seems to me to be ample scope and material for pure medical experience.

Owing to the kindness of Surgeons Lieut.-Col. Magill and Majors Crooke-Lawless, Beevor, and Sheldrake, I saw large numbers of interesting cases—such cases as one could never see in ordinary civil practice.

I cannot but think that your readers may be interested to hear some account of the Field Hospital of the celebrated Brigade of Guards, who have taken so large a share in the fights of Belmont, Enslin, Modder River, and Magersfontein.

After two days and three nights in the train I got to Modder River, and found my way through the huge camp to that of the Guards' Brigade, which was in a sandy plain in a bend of the Modder. The field hospital and bearer company lay behind the Guards' camp. About two miles to the north lay our batteries and outposts, with the kopje of Magerstontein 5000 yards beyond. Morning and evening, when the light was good, our 4·7 guns bombarded the Boer trenches, and I was greatly interested by a visit to the batteries and outposts during the bombardment.

The field hospital is supposed to accommodate 100 patients; but, owing to the great amount of sickness at the time of my visit, there were at times as many as 130 patients or more. Except the mess-tent, which is also the operating-tent, the tents are all bell-tents of the regulation pattern. They each contain six patients, mostly lying on the ground on a waterproof sheet and blanket.

When I first came there were many cases of undoubted enteric fever lying in these tents, and many other cases of high temperature, some of which might have been enteric. Some of the temperatures were very high, 103° and 104° being quite common. Though all was done for the patients that could be, the circumstances under which they were placed were intensely uncomfortable for sick people. The heat in a tent under a tropical sun must be felt to be appreciated. In order to get air the flies had to be raised, and every gust of wind brought a cloud of dust and sand over the unfortunate patient.

The dust-storms are the curse of these parts. The wind gets up suddenly, and in a moment one finds one's self in a thick cloud of dust. Nothing will keep it out; however carefully one may close one's tent up, the interior is only one degree less dusty than it is outside. It is impossible to have a meal while a dust-storm is in progress. At all times of the day small whirlwinds, known as "devils," sweep across the camp. They are powerful enough to raise sand,

pieces of paper, etc., hundreds of feet into the air; if they pass over the latrines, as they frequently do, the result may be imagined.

There is little need to look too critically into water-supply as a source of infection by enteric fever when one has contaminated sand from all parts of the camp in one's mouth and on one's plate.

The cases of continued fever, of which there are large numbers, come under three heads.

1. *Undoubted enteric fever.*—There is, of course, the same difficulty in diagnosis as is experienced in civil practice; but it seemed to me that the severe cases showed pretty constantly the foul brown, central-streaked tongue, with sordes about the lips, frontal headache, mental dulness, tremulous lips, and spots on the abdomen. Diarrhœa was more often absent than present in the early stages. Where these symptoms existed Widal's blood-test gave positive results, provided the case was not too early. As is often the case in tropical countries, the disease may begin acutely, so as to lead one to diagnose sunstroke, and, in fact, I think one may say generally that at Modder River the prodromal stage of malaise was generally absent.

When the diagnosis was reasonably certain the patient was removed from the field hospital to a school-house near Modder River Station, which was turned into an enteric hospital, where he could have more attention and nursing than was possible in a bell-tent, and where also he could enjoy the luxury of a stretcher to lie upon.

There were four nursing sisters attached to this hospital, whose services were of the greatest value; for I shall always maintain, without any disparagement of the orderlies of the R.A.M.C., that no *man* can compete with a woman in the nursing sphere.

However, this accommodation soon became full to overflowing, and then it became necessary to remove large numbers of enteric cases—mostly, of course, in the early stages—by ambulance wagon and train to Orange River and De Aar, where there was more hospital accommodation. It seems a risky proceeding to be carting off bad cases of enteric fever in jolting ambulance wagons and trains without any special accommodation; but in view of an immediate general advance, with almost certain influx of wounded, no other course was possible.

A word in passing on the application of Widal's blood-test in the field. There were days when it was impossible, owing to the dust-storms; but, on the whole, it seemed to be fairly satisfactory both in its positive and negative aspects. I am afraid, however, our *modus operandi* may provoke a smile from our friends in the Pathological Laboratory. The platinum loop was used as a measure of the blood drawn from a prick of the finger. A number of drops of sterilised broth-culture, supplied for inoculation by Professor Wright, were added on the slide to a dilution of something over $\frac{1}{100}$. The cover-slip was sealed temporarily with oil, and in about half an hour to two hours clumping might appear. My own blood clumped well, as I had lately been inoculated.

2. *Sunstroke.*—This is very common, as many as ten bad cases a day coming into the Guards' hospital alone. The condition is very interesting and the pathology very obscure. Surgeon-major Beevor was so kind as to summarise the principal points in the history of a case, which are as follows:

Most of the cases were among men on outpost duty, which involves lying out in the sun for most of the day watching the enemy. The only shelter is a blanket stretched over the trench on short posts. This is an insufficient shelter. The blankets are dark brown, and, being very porous, the sun seems to strike through; but it certainly offers a certain amount of shade, so that the men are tempted to lie under it without their helmets, and generally without their jackets. Other duties are performed in the sun, such as trench-cutting, and the heat is such that the men open their shirts and expose their necks and chests to the sun.

The onset is generally sudden, with great general weakness, a fainting attack, or even a convulsion. There is also intense headache, generally posterior, but it may be frontal; the pains are felt down the back of the neck, or even down the whole spine to the back of the legs. There may also be stiffness of the neck muscles, and movement may be painful. When brought in the temperature is generally very high, it may be 104°. The tongue may be dry and brown, as in an enteric case, at first, but this soon alters to a moist creamy fur. Very frequently the symptoms do not begin at the time of exposure, but the night after, generally about 3 or 4 a.m. There may be vomiting and diarrhœa, but not necessarily.

Very frequently (almost constantly in the bad cases) the patients complain of subjective flashes of light in the eyes on sitting up in bed. The fever continues high night and morning for about three to six days, and then the temperature falls rapidly. During this time the headache continues, but, unlike most other headaches with fever, is less, or even disappears, at night-time, so that these patients generally have fair nights. The debility is intense, almost amounting to a general paresis, and it may continue for weeks after the acute stage is passed. There is, unfortunately, a great tendency to relapse, and it is a question whether a man is fit to resume duty in a campaign if once badly affected by the sun. The treatment is simple, and consists of phenacetin for the headache, a light diet and cooling drinks, and, where possible, ice to the head. The tendency for enteric to begin very acutely gives one a feeling of insecurity in the diagnosis of sunstroke whenever there is much enteric fever about.

3. *Simple continued fever.*—When large bodies of men are encamped in hot countries there will be a number of cases of continued fever of which the cause is obscure; these generally receive the provisional name of simple continued fever.

Undoubtedly a large proportion of these are mild cases of enteric fever—how large it is at present almost impossible to say. The diagnosis, obscure at the front, becomes more certain, under careful observation, at the base. Some of these cases at the beginning are apparently sun cases, but, instead of resolving in about a week, the temperature remains up for several weeks, with also a constantly furred tongue, general wasting, and great debility. At the base they improve, but they tend to relapse. I saw one of the Guards' officers who was a case of this description. Surgeon-major Sheldrake had seen him at Gibraltar with a slight attack of a similar description, which was then thought to be Malta fever. He suggested that this was a lighting up of the same disease, which I think very probable. I may say, however, that since writing this I have seen the same patient at Wynberg, where the opinion is that he is a case of enteric fever. It would appear probable that some of the sun cases may not resolve, but take on a chronic course.

I cannot close this letter without some reference to the gastro-enteric troubles to which the men are liable in this campaign.

Simple diarrhœa is, of course, very common, and as a rule, if taken in time, as amenable to treatment as it is in England. Castor oil and opium and some chalk mixture, with a milk diet for a day or two, is all that is necessary.

But there are numbers of much more severe cases which merit the name dysentery, in which there is great pain, tenderness, and bloody stools. These must be due to a fairly severe colitis, but it is doubtful whether true ulceration ever occurs. As a rule the cases are fairly easily treated, and when one comes across a very obstinate case, it is generally in a man who has served in India, and has probably had dysentery there. I have not come across a case of secondary abscess of the liver in the African disease, but there has been hepatic tenderness and probable perihepatitis in several of my cases of men who have been in India.

In the treatment of these cases rest in bed is, of course, essential. The ipecacuanha treatment is used by some, but it is rather a severe treatment, and seems to be rarely necessary.

We have found a very satisfactory method in the use of repeated doses of magnesium sulphate. This is given in drachm doses every hour for about twenty-four hours. The effect seems to be of the nature of an internal lavage. The diarrhœa is rather increased at first, the motions larger and more watery, but the pain and tenderness are rapidly relieved and the blood rapidly disappears. This is followed by bismuth carbonate and chlorodyne, or a simple opium draught every three hours, with the best results. When these means fail, and that is generally in the Indian cases, I have found great relief from large enemata of boracic lotion about 10 per cent. The nitrate of silver injections are only suitable for the very chronic cases, of which we have not yet had any.

Looking through the admission and discharge book of the Guards' Field Hospital, I was struck by the fact that up to about December 23rd dysentery figured very largely in the admissions, but at about that date four cases of enteric fever were admitted—men of the same company who had been very much together, and who had presumably been infected at the same source. From that time the admissions of dysentery diminished almost to the vanishing point, and enteric cases came thick and fast.

At the close of the war many interesting points in connection with the spread of enteric fever will probably be discussed; not the least interesting will be the question of the mortality among inoculated patients. As far as we have seen at present inoculation does not confer immunity; but at Modder River, at any rate, the mortality was strikingly low as compared with the non-inoculated.

Some apology is owing for the sketchy nature of these remarks, but tent life, though very pleasant, is not conducive to steady work, literary or other.

Two Cases of Hæmatokolpos.

THE following cases have lately been under the care of Dr. Champneys in Martha Ward.

R. S—, æt. 19, housewife, admitted November 11th, 1899. Applied at the Hospital thinking herself pregnant.

No pregnancies. Married at eighteen, ten months ago. Husband alive. Has never menstruated; no molimen. In the last fortnight or three weeks has thought that her abdomen was becoming bigger, also that her breasts were getting larger. Has had jumping pains in the left side of the abdomen. Pain under the left breast. Has been getting thinner since marriage.

Present condition.—Well-nourished, healthy-looking woman; not anæmic. Tongue clean, appetite good, bowels open every day; chest natural, breasts large but inactive; pulse 80; good volume and tension; temp. 97·4°; urine 1016; no sugar, no albumen. Sometimes has difficulty in passing her water; has to get up twice at night, occasional slight incontinence. Abdomen flat, abdominal walls very fat. Abdomen generally deficient in resonance except above.

Per vaginam, nymphæ large, vaginal orifice imperforate. Vagina is closed by membrane which is rugose, except for space of about the area of a split pea on its summit, but rather nearer to the anterior extremity, which is smooth. The rugose portion probably represents the hymen, and the smooth portion a membrane closing the orifice. The urethra will admit two fingers, and admits one finger easily.

Per rectum an elastic resistance is felt in front of the bowel as high as the finger can reach.

Bimanually and per rectum.—Resistance and obesity prevent satisfactory examination; but there is apparently a large swelling filling the pelvis, surmounted by a small nodule, apparently the uterus.

November 17th.—Under an anæsthetic the tumour is felt to be of the size of a fœtal head, fairly filling the pelvis, and rising to the brim.

Operation.—A sound was passed into the bladder, and the tissue half an inch posterior to the urethra was divided with scissors, until the vaginal cavity was opened. There at once issued the characteristic fluid, dark chocolate in colour, and odourless. This opening was enlarged later by the removal of a circular piece of tissue the size of a threepenny piece, which was one sixth inch thick. The vagina was washed out with iodine lotion until the lotion returned clear, and the vaginal mucous membrane was stitched to the cut edge of the skin by interrupted sutures.

Per vaginam.—The vagina was found dilated, the walls being less thick than normal. Uterus to the back, on the right, unenlarged. Cervix small, natural in shape and texture.

23rd.—Stitches taken out; vagina patent, no discharge.

27th.—Patient discharged quite well.

Seen some two months after operation, quite well, menstruation occurring normally.

A. M—, æt. 18. Box maker; admitted January 8th, 1900, complaining of pain in the back, swelling in the abdomen, and retention of urine; single.

History of present illness.—For about the last twelve months she has had pains in the lumbo-sacral and hypogastric region *about* every month, together with headache. She has never seen anything. At these times she had to give up work for a day; no sickness.

January 7th, 1900.—She could not pass her water, and had pain at the same time.

8th.—A doctor was called to see her, as she had not passed water since 7th inst. A catheter was passed, and the urine drawn off. The doctor then discovered a swelling in the abdomen which the patient had not previously noticed, and advised her to go to the hospital at once. On admission patient was again suffering from retention of urine.

Present condition.—Healthy-looking girl; no anæmia. Appetite good; bowels very irregular, she usually has to take medicine; urine normal; breasts inactive. Rising to within one and a half inches of the navel is a rounded obscurely elastic swelling like the gravid uterus, with well-marked dextral obliquity. The right side of its summit is composed of a small hard body the size of a bantam's egg. Vulva is well formed, except that there is a dark blue protuberance projecting from the vaginal orifice, the summit of which is marked by the hymen.

Per rectum an elastic swelling presses backwards against the sacrum, flattening the bowel. Impulse is conveyed to this from the abdominal swelling.

Per vaginam.—The cervix is not dilated; it lies to the right and at the top of the vagina. The uterus is about the size of a plover's egg, anteflexed, and to the right.

9th.—Patient was anæsthetised, and the hymen was incised with scissors, and a dark chocolate-coloured, rather viscid substance escaped, together with a lot of mucus. The cavity was then washed out with iodine water till all was returned clear. The membrane was quite thin, and almost transparent.

12th.—Patient quite comfortable; no further discharge since operation.

22nd.—Discharged quite well.

A Case of Serous Perimetritis, with some General Remarks upon this Disease.

By J. L. MAXWELL, M.D.

FORTUNE, with one of those freaks that we often see in hospital practice of bringing together similar cases of a rare nature, has favoured me with the observation of three cases of serous perimetritis in the past twelve months.

I think a few remarks on these, with a fuller history of one of them, might be of some interest. In the first I was present only at the operation; the second I had ample opportunity of examining, but was unhappily not able to be present at the operation. The third case has come into my hands since I left the hospital, and through the kindness of Dr. Champneys, who operated upon it, I have been able to watch its course from start to finish; it is the history of this case that I shall give you more fully.

But to revert for a moment to the definitions of the disease in question, I turned up Dr. Playfair's book, only to be met with the remark, "Peritonitis attended with the effusion of serum has been quite unnecessarily described as a special variety of pelvic inflammation under the name of serous perimetritis." One cannot help thinking that Dr. Cullingworth might as well omit serous peritonitis from the varieties of tuberculous peritonitis, as the distinctions are quite as marked. I therefore consulted Hart and Barbour in the hope of better success, to find the subject completely mixed up with a form of plastic peritonitis in which loculi of fluid remain between the adhesions. Turning to Matthews Duncan's lectures, I find he describes serous perimetritis as a clinical variety of perimetritis, and illustrates it with a case which is in many respects similar to the one here described.

M. N—, æt. 34, multipara, was delivered of a live child on December 6th, 1899. Previous labours natural. Present labour quick, the child being born before the midwife who attended the patient arrived. No vaginal examinations appear to have been made. The patient described her lying-in period as natural. The lochia had quite ceased by the fourteenth day. Patient began soon after this to feel weak, but without definite symptoms. I saw her first twelve weeks after confinement, when she came to me because of extreme weakness. She then appeared like a patient in the last stages of malignant disease or chronic phthisis. She complained of no special pain, of fourteen days' constipation, and really of nothing else but weakness. I made an abdominal examination, and found what will be described later. I made no pelvic examination, owing to the fourteen days' constipation, but ordered enemata and purgatives, which acted well. Three days later I examined her, and she then went into hospital. I will simply append Dr. Champneys' note.

Per hypogastrium, etc.—Lower abdomen greatly distended. Walls very thin. Move well with respiration. Rising to within two inches of the navel and somewhat to the right of the middle line is a rounded, fixed, scarcely sensitive induration; this is densely hard and inelastic. No enlarged glands in groin. On inspection, the perinæum, including the anus, bulges considerably. Labia majora œdematous and almost translucent. The posterior vaginal wall projects through the vaginal orifice, but otherwise looks healthy.

Per vaginam.—Posterior vaginal wall pushed against symphysis, and cervix itself can only be reached with difficulty. Posterior vaginal wall is elastic.

Per rectum.—Rectum expanded laterally, smooth, feels healthy. It is flattened against the front of the sacrum by an elastic swelling which occupies the recto-vaginal space down to the perinæum.

Bimanually.—The swelling occupies practically the whole of the pelvic excavation, and is absolutely fixed.

The posterior vaginal wall was opened with a dilating trocar, and thirty-one ounces of strong-smelling fluid, nearly clear, and containing many colourless clots, were evacuated. A glass drain was inserted.

Patient suffered from considerable rises of temperature after the operation, probably from imperfect drainage, but her convalescence was so speedy that she was up within fourteen days of the operation.

Of the other two cases I have seen, one was diagnosed as a pelvic abscess, and opened as such. The other was diagnosed as a cyst, probably broad ligament, and operated on by abdominal section. It was interesting to note the appearance of this from the inside of the abdomen, an aspect not so frequently observed. I therefore append a very short note.

C. F—, æt. 31, operated on by Mr. Harrison Cripps for ovarian cysts on July 6th, 1898, when two small ovarian cysts were discovered and both ovaries removed.

Further history: since operation patient has had monthly losses lasting about ten days. One month ago noticed pain and swelling in hypogastrium.

Examination: posterior vaginal wall bulges. Finger in rectum feels elastic resistance above bowel, reaching bimanually to navel.

August 16th, 1899.—Abdominal section by Mr. Harrison Cripps. Encysted collection of fluid in Douglas's pouch. The sigmoid flexure adherent to the fundus of the uterus forming the roof of the sac. Adhesions broken down and one pint of fluid evacuated with a good many colourless clots.

The wound healed by first intention, and convalescence was uninterrupted.

Now I should like to add a few comments on these cases. None of these cases was diagnosed, and this difficulty of diagnosis corresponds with Matthews Duncan's account.

The leading point about these cases seems to be their chronicity. In my own case there really was nothing except the fact of recent confinement and a history of constipation to lead to a suspicion of pelvic disease at all; while in the last case a cystoma was diagnosed, and no suggestion of inflammatory trouble was made.

Then there is one sign that strikes me in connection with all these cases, and is also very marked in the case described by Matthews Duncan, and that is the bulging of the recto-vaginal septum forwards into the vagina, and downwards so as even to bulge the perinæum. Though no doubt this may be caused by any fluid swelling in like position, I at least have not seen it with pus or blood. I take it if there is anything in this difference it is because the two latter are so much more acute.

Serous perimetritis, then, we may define as an encysted fluid swelling of a chronic inflammatory nature, characterised by the presence in it of colourless clots, occupying the pouch of Douglas, and reaching to a greater or less extent into the abdominal cavity. The bacteriology of this condition should prove a subject of great interest, but the difficulty in diagnosis renders it doubtful how far one would be prepared to make a proper examination in any given case. I think I have sufficiently made out my case for regarding serous perimetritis as a distinct division of perimetritis, and trust these few remarks will not have been without interest.

Surgical Notes.

IT is proposed under the above heading to give from time to time brief notes of surgical cases of interest from the wards and out-patient room, and especially to record some of the more interesting cases shown at "Consultations."

The value and interest of the "St. Bartholomew's Consultations" is clearly indicated by the large number of students, many of them belonging to the past, who gather in the old theatre week by week. Not only are consultations most interesting, but they are perhaps one of the most valuable practical teaching instruments at St. Bartholomew's. By watching the methods of examination of surgeons of great experience, observing the different opinions expressed, and the reasons given for these opinions, we cannot fail to get very valuable lessons in surgical diagnosis. Our gain would be greater could we learn the after history of every case. Amid the press of other work the cases are apt to be forgotten, and even if this be not the case, it is not always easy to follow up the cases afterwards. In these notes an effort will be made to give notes of some of the more interesting cases *after* the diagnosis and treatment have been completed. The steward's number and ward of each patient will be given so as to admit of easy reference. The editor invites the co-operation of house surgeons and dressers in carrying out this scheme, and will be glad to receive intimation, or, better, short notes of cases of interest. Of course no case will be published without the permission of the surgeon under whose charge is the patient.

On December 21st, 1899, Mr. Lockwood showed a man, aged 21 (No. 3392, Casualty), with a swelling on the right side of his neck. The patient stated that the swelling had existed for eighteen months. Three months previously it had become suddenly larger, and during the last two months it had doubled in size. The swelling was oval in shape and measured about 2 inches by 1½, beneath and adherent to the right sterno-mastoid muscle about its middle. As to whether it was solid or fluid opinions were equally divided. The skin over the swelling was not, nor had it been, inflamed. There had been no pain. The glands in the other side of the neck were slightly enlarged. There were no enlarged glands in the groins or axillæ. Two opinions as to the nature of the swelling were expressed. 1. Those who considered the swelling solid regarded it as lympho-sarcoma. 2. Those, on the other hand, who were of the opinion that the swelling contained fluid were inclined to the view that it was a softening tuberculous gland. All, however, concurred in advising its removal.

On the same evening $\frac{1}{300}$ mgr. of Koch's tuberculin was injected, with a view of seeing if the patient gave any reaction which would support the view that the disease was tuberculous. No reaction followed.

Two days later $\frac{1}{10}$ mgr. was injected without result. The value of these observations, as negative evidence against the gland being tuberculous, is discounted by the fact that Koch's B tuberculin was used. For obtaining the tuberculin reaction it is advisable to use Koch's old or A tuberculin.

A few days later the swelling was removed, and appeared to be a suppurating tuberculous gland. The result of microscopical examination, however, proved a surprise, as it revealed the hitherto unsuspected fact that the swelling was really a dermoid cyst.

The case illustrates the great difficulty, even impossibility, there often is of deciding whether a swelling in the neck is really solid or fluid. A good working rule with regard to glandular swellings in the neck is, when in doubt, suspect tubercle. In this particular case this rule did not apply.

H. J. P.

Notes.

WE must ask our readers' indulgence for the late issue of the JOURNAL this month, and also for the fact that we offer them rather a "heavy" number. Both events are due to very regrettable and quite unforeseen circumstances.

* * *

The second of the two misfortunes we sought to rectify by a search through the manuscripts left upon the shelf from previous issues. Perhaps one of our many poets might come to our aid, we thought, with something which in brighter days our critical discrimination had rudely discarded. So we re-read the products of the young man's fancy which the spring had brought us, perspired once more through "The Ballad of the Dissecting Room," "The Grateful Patient's Ode," "The Lament of the Chronic," and other effusions—to no purpose. Better a heavy number than these, we sighed.

BUT we anticipate an objection—that for our JOURNAL to be heavy is no new thing. And we acknowledge the justice of the criticism. It is only when we consider how often, even to weariness, we ask our readers to remember that we are dependent upon them for the wherewithal to render our columns more to their taste, and are much more eager to accept their help than they are to give it, that we breathe freely again. Our critics are many, our contributors few. Is it too much to hope that this fair and open statement of our case may entice some of our readers to quit the former category and join the latter?

* * *

To our contemporary the *Broadway* we desire to apologise for our error in stating that it once paid our columns the compliment of calling them "*Times*-like." The expression was "pre-eminently respectable." In the current number of the *Broadway* we are accused of the Pharisaism of once having claimed for our JOURNAL that it "had attained to conditions as near the ideal as possible." In the face of the above plea to our readers the accusation sounds grotesquely funny. It may be remembered that in commenting upon the recent struggle between our contemporary and the Dean of the Medical School whose organ it is, we vouchsafed the opinion that a not too rigid censorship was an inevitable part of the ideal conditions of management of a hospital journal. To transfer our opinion of the conditions underlying the management of our JOURNAL to the literary merits of the JOURNAL itself is too deliberately mendacious to need discussion.

* * *

WE regret to announce the death of Mr. William Parsons, which took place on April 4th from pneumonia. Mr. Parsons came to the Hospital as an Assistant Dispenser on May 6th, 1869, and was promoted to the post of Head Dispenser on June 23rd, 1887, upon the occasion of the resignation of Mr. Jeffs. With this sad event a very familiar figure passes out of our Hospital life, and we lose the co-operation of the head of an important department of the Hospital work. Mr. J. L. Moore, who has been assisting in the department during the past seven years, has been appointed to succeed Mr. Parsons.

* * *

TO our appeal made two months ago on behalf of the R.A.M.C. South Africa Fund, we have pleasure in acknowledging the following subscriptions:

Five Shillings: C. B. Dale, G. H. Cressey.
Three Shillings: T. J. H.
Two Shillings and Sixpence: A. Coleman, H. M. K. M.
Two Shillings: J. C. N., S. W. C., W. L. B.
One Shilling: J. J. Scrase, N. M. Wilson, G. H. S., G. J. B., H. J. P., I. J. C., W. M. F., A. R. T., P. V. B., H. K. K., J. C. M., H. F. M., T. W., C. A. A., H. J. W., F. E. B., N. E. G., W. H., H. B. S., P. P. N., E. T., P. H. E., C. U. C., J. W. Malim, T. G., P. H. G., L. F. C., P. S., G. P. F., H. W., L. D. R., J. M. P., H. P. P., W. S. D., T. R. H., H. W. J.

Total £3, which we have handed over, with all due editorial apologies for the smallness of the amount, to Mr. Charters Symonds, Honorary Secretary of the Fund.

WE are not alone in our regret at the lack of response to our appeal; it has evidently been shared by "H. R. M. R.," who has most generously put himself down upon the library subscription list for £1000, doubtless as a protest against the small list of contributors. The Librarian still awaits this handsome donation; so does the Editor.

* * *

THE date of the Annual View Day is May 9th.

* * *

UPON the same date—a misfortune we have had occasion to lament before—falls the Presentation Day of the University of London, an event which is of special interest this year, in that the function takes place in the new University building at the Imperial Institute. H.R.H. the Prince of Wales is expected to present the diplomas upon this occasion.

* * *

PHYSICIAN (*to mother of patient suffering from anorexia nervosa*): "Has your daughter had any trouble or worry lately?" Mother: "No, sir." Physician: "Is she in love, do you think?" Mother (*emphatically*): "Oh, *no*, sir; I'd know if she was in love, sir!" (—— ? .)

Abernethian Society.

ANNUAL GENERAL MEETING, MARCH 15TH, 1900.

THE President, Mr. A. R. J. Douglas, being in the chair, the minutes of the last meeting having been read and confirmed, the poll was declared closed by the President; Messrs. Scholfield and Dixon were elected scrutineers.

The President then called upon the Secretary, Mr. E. M. Niall, to read the report of the Committee and balance-sheet for the last year. The report ran as follows.

Your Committee, in presenting their Report, deeply regret the death of the Society's former Treasurer, Sir James Paget, who through so many years took such an active part in the affairs of the Society; and also that of Sir Richard Thorne Thorne, who was a former Secretary and President, to both of whom the Society owed a great debt for the interest which they always took in its proceedings.

In reviewing the events of the Session just completed, it congratulates the Society upon the success of the meetings that have been held. The average attendance has been slightly over forty, which compares very favourably with that of last Session.

Of the Sessional Addresses delivered, that in the summer was delivered by Dr. Klein, who took for his subject "The Relationship of Bacteriology to Medicine;" that in October by Dr. Church, who gave a *résumé* of the progress of medicine during the reign of Queen Victoria, that in January by Dr. Calvert, who discoursed upon the "Office of Warden."

These were largely attended.

All these addresses have been published in the HOSPITAL JOURNAL.

Of the eighteen ordinary meetings, four were devoted to discussions, clinical and pathological. At these meetings numerous pathological specimens were shown, and at one or other of them the following members made short communications:

Mr. J. C. Forbes, on "Ovarian Tuberculosis" (with microscopical specimens).

Dr. J. L. Maxwell, on "Tuberculous Salpingitis" (with microscopical specimens).

Dr. J. H. Thursfield, on "Posterior Basal Meningitis" (with pathological specimen).

Messrs. G. V. Bull, C. S. Myers, and S. P. Pollard gave the histories of interesting cases for diagnosis.

At the remaining fourteen, papers were read by the President, by three members of the teaching staff, by one present and seven past members of the Junior Staff, and by two other members of the Society.

Of these papers five have been printed in the HOSPITAL JOURNAL.

The financial position of the Society is at the present time good, there being a balance in the bank of £44 3s. 4d.

During the past year one hundred and thirteen new members have joined the Society.

Your Committee desires to draw the attention of members to the rules of the Society now in force, which were drawn and passed at a Special General Meeting on June 28th, 1892, and to the difficulty which has since arisen in the working of these rules. It therefore thinks it would be beneficial to the affairs of the Society if a sub-committee of the Society be appointed to inquire into their working, and to remodel such as they thought fit, and to embody in the revised rules the recommendations of the sub-committee appointed last year to inquire into the financial relations of the Abernethian Society with the Amalgamated Clubs.

Dr. J. H. Thursfield then rose and proposed that the final paragraph in the Committee's Report be omitted. He said that it was with regret that he found himself unable to accept that part of the report referred to, but really he thought that it was not a suitable matter to have been introduced into it. They all remembered how at last year's General Meeting a great deal of time was spent in discussing the rules, and the present Committee were practically appointed on the distinct understanding that they would carry out certain measures, and yet they came now before the Society without even attempting to have seen into the matter or carry out certain suggestions that were then made, but by embodying a suggestion in their report attempted to shelve the whole matter upon the shoulders of others; he therefore felt it to be his duty to move the omission of that part of the report referred to.

Dr. J. L. Maxwell rose to second the proposal. He most strongly objected to the passage in the report which Dr. Thursfield had proposed should be omitted. A sub-committee had been appointed to inquire into the working of the Society's rules, and also into the financial relations existing between this Society and the Amalgamated Clubs, and to report early in the year to the Society the result of their inquiries. Here they were well on into another year, and not a word had they heard of that sub-committee and its report. He would like to know why it had been shelved, and how the Committee, not having carried out the wishes of the Society in this matter, had the audacity to embody in their report such proposals. He had much pleasure in seconding the motion of Dr. Thursfield that these proposals should be omitted from the report.

The President having vacated the Chair, and addressing the house as an ordinary member, drew the attention of the house to the total want of knowledge the last speaker had shown of the affairs of the Society. He would call the attention of the last speaker to the fact that the sub-committee which he referred to had proceeded as directed by the Society, and the results of their inquiries and their proposals were delivered to the Society in a report which was read at a special general meeting held on October 11th, 1899, which had been summoned, according to the rules of the Society, to receive the report. The report as read was at that meeting passed by the house. Its proposals, far from being shelved, had been carried out by the present Committee to the letter. The complete list of members who joined the Society was now kept by the Society—the first time such a thing had been done for many years past. The chief difficulty had arisen in the correct working of the present rules of the Society, therefore he could not understand the attitude which Dr. Thursfield and Dr. Maxwell had taken up with regard to the Committee's report. The Committee, they would allow, ought to be able to judge the necessity of alterations in the rules better than an ordinary member, and why should not a report of the Committee draw the attention of the Society to such a necessity when one existed?

A member then asked to have the report of the sub-committee above referred to read again. The Secretary then read the report.

Dr. J. L. Maxwell desired to know at what meeting these minutes were confirmed. The Secretary regretted to announce that they had not been confirmed.

Asked how many members were present at the meeting, the Secretary regretted being unable to inform the honorary member upon that point.

Dr. J. H. Thursfield then rose and moved a formal vote of censure upon the Committee for the way the affairs had been conducted during the past year.

A member rose and seconded the vote.

Much discussion having taken place, Mr. E. C. Morland rose, and in a long speech defended the action of the Committee upon the various points raised, regretting the oversight which had occurred in the non-confirmation of the minutes of the special general meeting, which he thought might be put down to an oversight on the part of one of the secretaries. He begged, therefore, to propose that the President be asked now to confirm the minutes of the special general meeting held on October 11th, 1899.

A member rose on a point of order, that there were already two proposals before the house, and Mr. Morland's would be the third.

The President ruled that Dr. Thursfield's original motion was before the house.

Dr. Thursfield rose to say that he persisted in his motion, and thought that the house could see from what had been said that no reliance could be placed on the minutes of the meetings as now kept.

Mr. E. M. Niall pointed out to the house that to support his motion the last speaker was taking the minutes of the last annual meeting as correct. Now this was extremely unfair to the present Committee. Those minutes were drawn up during Dr. Thursfield's period of office, and the present Committee had absolutely nothing to do with them. If all happened at the meeting as Dr. Thursfield represented, why did he allow them to be confirmed? He presumed that there were present at the meeting at which these minutes were confirmed some members who had been present at the annual meeting. Was it likely that they would have allowed them to be passed as correct?

Mr. S. P. Pollard said they had the minutes of the meeting duly confirmed against Drs. Thursfield and Maxwell's memory of events which took place twelve months ago. On these grounds he would oppose the proposal.

Dr. Thursfield's proposal was then put to the meeting and lost by nineteen votes to ten.

Dr. Thursfield, with the permission of the seconder, then withdrew his vote of censure.

Mr. Morland's motion having been carried, the President signed the minutes of the meeting of October 11th, 1899.

The report and balance-sheet for the year were then passed.

The President in his farewell speech said that it was with feelings of deep regret that he now rose to address the house for the last time from the chair. He would always look back with pride and great pleasure on his term of office, and he could say that, although his official connection with the Society was now about to cease, his interest in its affairs would still be the same, and he hoped to continue to take an active part in its proceedings.

Dr. J. H. Thursfield then proposed a vote of thanks to the outgoing officers.

Dr. J. L. Maxwell, in seconding the vote, said that it was upon the energy of its officers that the success of the Society depended.

The vote was carried unanimously.

The scrutineers not having yet returned, Mr. S. P. Pollard anticipated matters by proposing a vote of thanks to the scrutineers.

This was seconded and carried.

The scrutineers here returned to the room and handed to the President the result of the poll, which was as follows:

President.—Mr. E. Talbot, Mr. J. Forbes and Mr. G. E. Gask, æq.

Vice-Presidents.—Mr. E. M. Niall, Mr. G. V. Bull.

Secretaries.—Mr. N. E. Waterfield, Mr. J. Corbin.

Additional Committeemen.—Mr. L. J. Picton, Mr. T. J. Faulder.

At a subsequent (special) meeting Mr. G. E. Gask was duly elected President. The above members, therefore, constitute the new Committee for 1900-1901.

"In the Spring"

A GRIEVANCE.

FEAR the poets of the spring and the clap-trap cant they bring
Of glorious summer suns and gentle breeze!
'Tis the periodic time to burst forth into rhyme,
And write of rippling rivulets and trees.

But for us there is no leisure or gay pursuit of pleasure,
To us there's little use for leafy trees;
The July exams. ahead bring the same old sense of dread,
And the same familiar trembling in the knees.

It's like walking to your doom as you seek that upper room
In the well-known red-brick building by the sea;
Try to swagger to your place (with a worn perspiring face),
And it's Heaven help the slackers in Room E!

And you try to write a treatise on hearts or diabetes,
Or anatomy forgotten long ago;
You pass the time reflecting, your scattered thoughts collecting,
And find you can't remember what you know.

Then the "viva" long impending—will it bring a cheerful ending?
And each his anxious aspect vainly hides;
There's the hoped-for termination to the cure'd examination,
There's—a possible "pink-papering" besides!

So we maintain it's wrong for long-haired men of song
To paint the season all "couleur de rose;"
For what it's like to work when you'd "dash'd sight" sooner shirk,
The sleepless toiling student only knows.

"UP NEXT TIME."

Reviews.

A MANUAL OF SURGERY, by CHARLES STONHAM, F.R.C.S. In three vols. (*Macmillan's Manuals of Medicine and Surgery.*) 25s. 6d. net.

This book consists of three volumes of very convenient size, as the title indicates. The publisher's name is sufficient warrant that the three volumes are tastefully got up, and that the printing is clear. There is also a large number of good illustrations, many of them new, and the rest taken from familiar sources, which considerably add to the value of the work. On seeing a new text-book of surgery one is inclined to wonder whether there is room for another, considering the number of excellent and well-tried ones now in use; and some justification is undoubtedly necessary for the appearance of this work by the well-known surgeon to the Westminster Hospital. In size and scope it takes an intermediate place between the smaller text-books ordinarily used and the larger text-books or systems of surgery perhaps more used for reference. It cannot be compared with either, but occupies a place of its own; it escapes the drawback to the smaller text-books of being so condensed as to be uninteresting to read; and by leaving out matter of merely historical interest, and confining itself to a practical account of surgery, it is enabled, in some respects, more to approach some of the larger text-books. Turning to the preface to see the position the author assumes, we see stated that "the object of this work is to give a succinct account of modern surgical pathology, diagnosis, and treatment, and it is intended as a manual for practitioners and students."

We may say at once that in our opinion the author has succeeded in his object, and we believe that the book will fill a want. It is probably rather larger than the average student will read, but for a man requiring a slightly fuller account than that given by the small text-books now in use, or in reading for some of the higher examinations, this work will prove useful. It seems rather a pity that the book could not have been made a little larger on the same lines, as certain portions of the subject which are of great importance are dismissed in a somewhat perfunctory manner. The book is essentially a practical one, and the diagnosis and treatment are particularly good,—in fact, the treatment is the feature of it. The style of the book is concise, and in most places clear, but one fault perhaps is that the author is inclined at times to dogmatise very emphatically on subjects which are at the present time still very debatable. The first volume is devoted to general surgery, and includes a chapter on deformities; the second volume is an account of injuries of various parts of the body, and includes a chapter on injuries of the eye by Mr. Donald Gunn, as also a chapter on amputations. The third volume consists of regional surgery, and is about double the size of either of the other two.

Some points deserve mention in Vol. I. The treatment of gonorrhœa is given fairly fully, and we notice with satisfaction that the irrigation method of Janet is described, accompanied with the remark that this plan has not received the attention in this country which it merits; which is true, but it is slowly gaining ground, and has been used with considerable success in some of the special hospitals in this country.

In Chapter X the account of septicæmia and pyæmia is very poor, and it is difficult to get a clear idea of the pathology from it.

The second volume begins with a chapter on antiseptic surgery, which contains much practical information, but it is almost ludicrous to read in all seriousness that, "should an instrument be fouled during an operation (*as by falling on the floor*), it must not be used again unless sterilised by boiling." Or again, in speaking of disinfection of the hands, "Care must be taken that the hands, after disinfection, are not fouled by touching anything which is not surgically clean—*being thrust into the pockets and the like*" (the italics are our own).

Chapters IX and X deal with fractures and dislocations. The account of them is shorter than one would have expected in a work of this size. Having said this, it necessarily follows that the author has made little attempt to discuss alternate methods of treatment, but has in most instances given the treatment or splint which appears to him the best; and perhaps these chapters are all the more useful to the practitioner on that account. We are sorry to see that Nélaton's pistol splint is recommended in Colles's fracture. The author recommends wiring of a simple fracture of the olecranon, "provided perfect asepsis can be secured." Here we think that the author takes up a position which, without further comment, might lead a student or practitioner astray. The question of wiring a fragment of the olecranon is not on the same footing as the operation of wiring a fractured patella.

The treatment of dislocation of the first phalanx of the thumb is dismissed in three or four lines, and one gets no idea of the trouble which so often arises and of the great difficulties of treatment.

In Vol. III the chapters on intestinal obstruction and hernia are, in our opinion, the best in the book. The diagnosis and treatment are dealt with as fully as this part of the subject deserves.

In speaking of fibro-adenoma of the breast, it is stated that "uterine disturbance is often present." Vague statements like this, it seems to us, only tend to confuse matters, and give rise to false ideas of pathology. Again, the account of cystic disease of the breast is not treated sufficiently as a distinct clinical condition; we would again object to the remark that "breasts which are the seat of chronic mastitis may become cancerous." The statement, although it may be true, has so little evidence to prove it, that it ought not to be made without comment. And lastly the space given to the differential diagnosis of breast tumours is about half that given to an account of the treatment by oöphorectomy.

Perhaps it is unnecessary to give an account of disease of the female genital organs in a general book on surgery, but it seems a pity to dismiss the treatment of tubal gestation, which often becomes one of the important surgical emergencies, in about twelve lines.

In treating of diseases of the testicle the author takes up a strong position on the question of castration as opposed to scraping operations for tuberculous disease, and no mention is made of acute torsion of the testis.

On page 377 it is stated that "splenectomy is a dangerous operation, and should never be undertaken without urgent cause." Some explanation of this would have been advantageous.

The accounts of disease of œsophagus and thyroid gland are far too short, and we are disappointed by the account of diseases of the tongue.

In speaking of supra-pubic drainage for retention of urine in enlarged prostate, no mention is made of the very troublesome urinary fistulæ which sometimes persist.

To sum up, we think the book will be useful to many. The style is pleasant, and the book is very readable, which is a great point.

A HANDBOOK OF NURSING, by M. N. OXFORD. (London: Methuen and Co. Pp. 277. Price 3s. 6d.)

A nurses' book by a nurse is always welcome, and those who do not expect too much from this volume should find it helpful. From cover to cover there is a store of useful knowledge of an essentially practical kind, and the author gives many details which others overlook. The book is divided into three parts, the latter two consisting of medical and surgical lectures, which include some elementary physiology and anatomy, and are particularly good; the chapter on asepsis, too, is quite up to date. But why are we given no distinct hints upon the nursing of children, and the diseases peculiar to them? Surely this is an important branch of the profession. And the method of disinfection for typhoid and phthisis sounds deplorably incomplete. We wonder, too, how many experienced nurses would agree with such suggestions as the following:—"Do not be anxious

to make the bed too often. If the patient (typhoid) be lifted out on a stretcher or another bed once a week or so he will do very well"!

The book, however, contains much of value worthy of a better setting. It is a bulky production, showing immense and laborious care, but the style is monotonously dull, and the author gives not a table or illustration, or scarcely a list of any kind to aid our memories. We should recommend it more to probationers than as a book of reference to older nurses, and heartily wish all success to such a painstaking effort.

Correspondence.

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

DEAR SIR,—In my letter on "Pernicious Anæmia" the phrase "Also when iodoform . . . was administered" should read "Also when *iron* in any form."

Yours truly,

March, 1900. J. KINGSTON BARTON.

Examinations.

UNIVERSITY OF DURHAM.

Chemistry and Physics. A. H. Bateman, C. P. Burd, M.R.C.S., L.R.C.P., C. Fisher, M.R.C.S., L.R.C.P., P. M. Risay.

Anatomy, Physiology, and Materia Medica.—C. Fisher, M.R.C.S., L.R.C.P. (Second Class Honours), W. R. L. Drawbridge, P. M. Risay.

CONJOINT BOARD.

Anatomy and Physiology.—G. E. Aubrey, F. M. Bishop, A. F. Forster, A. Hamilton, W. E. Lee, D. A. H. Moses, C. C. Robinson, W. H. Scott, R. A. H. Sunderland, R. J. P. Thomas.

APOTHECARIES' HALL

The diploma has been awarded to R. F. Ellery and F. E. Fielden.

Appointments.

CATOR, P., L.S.A., appointed Assistant House Surgeon to the Royal Albert Hospital, Devonport.

* * *

EDDISON, R. E., M.R.C.S., L.R.C.P., appointed Senior Resident Medical Officer, Royal Free Hospital, Gray's Inn Road.

* * *

EMERY, W. DE, M.D.Lond., appointed Lecturer on Hygiene to the Birmingham and Midland Institute.

* * *

FLEMING, J. K. S., M.R.C.S., L.R.C.P., appointed House Surgeon to the Metropolitan Hospital.

* * *

GILLESPIE, T., M.R.C.S., L.R.C.P., appointed Assistant House Physician to the Metropolitan Hospital.

* * *

GRENFELL, P. B., M.R.C.S., L.R.C.P., appointed House Surgeon to the Grahamstown Hospital, Cape Colony.

* * *

HAYDON, ARTHUR, M.D., M.R.C.S., L.R.C.P., reappointed Surgeon to the R.M.S. Severn.

* * *

HAYES, A. H., M.R.C.S., L.R.C.P., appointed Casualty Officer to the East London Hospital for Children.

JEAFFRESON, D., L.R.C.P., L.R.C.P.Edin., L.F.P.S.Glas., appointed House Surgeon to the Hertford Infirmary.

* * *

KEOWN, W. B., M.R.C.S., L.R.C.P., appointed Acting Medical Officer to the Brigade of Guards, Chelsea Barracks.

* * *

ROSE, F. A., M.R.C.S., L.R.C.P., appointed House Physician to the Metropolitan Hospital.

* * *

SANGER, F., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Metropolitan Hospital.

* * *

SCHOLEFIELD, E. H., M.B.Oxon., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Royal National Hospital for Consumption, Ventnor.

* * *

SYMPSON, F. MANSEL, M.A., M.D., B.C.Cantab., M.R.C.S.Eng., appointed Medical Officer to Her Majesty's Prison, Lincoln, *vice* Dr. George Mitchinson, deceased.

* * *

VINCENT, RALPH, M.B., B.S.Dunelm., M.R.C.P.Lond., has been appointed Assistant Resident Medical Officer, Queen Charlotte's Lying-in Hospital.

* * *

WINKFIELD, C. F., M.R.C.S., L.R.C.P., appointed Senior House Surgeon to the Hastings Hospital.

Birth.

ECCLES.—On March 24th, the wife of W. McAdam Eccles, M.S., F.R.C.S., at 124, Harley Street, W., of a daughter.

Marriages.

BUTLER—REED.—On March 20th, at the Cathedral, Cape Town, by the Dean, Thomas Harrison Butler, B.A., M.B., B.Ch.Oxon., L.R.C.P.Lond., of Port Elizabeth, South Africa, eldest son of Rev. G. W. Butler, of Broad Mayne, Dorchester, to Ellen, second daughter of W. H. Reed, Esq., M.R.C.S., L.S.A., of Allersleigh, Westbury, Wiltshire.

EMERY—NOWELL (PERRY).—On April 18th, at Old Market Street Chapel, Bristol, by the Rev. Wilfrid J. Moulton, B.A., Walter d'Este Emery, M.D., B.Sc.Lond., M.R.C.S., of Birmingham, to Edith Mary Nowell[("Edith Perry"), of The Wilderness, Redland, Bristol, daughter of the late William Nowell.

WILLETT—MATTHEWS DUNCAN.—On April 19th, at Minstead, Hants, by Rev. Canon Duncan, assisted by Rev. J. Duncan and Rev. Herbert Bull, and Rev. C. H. Compton, rector of parish, Herbert Burrows, of 16, Kent Terrace, N.W., eldest son of Alfred Willett, F.R.C.S., to Isabel, eldest daughter of the late J. Matthews Duncan, M.D., F.R.S., and Mrs. Matthews Duncan, of Minstead Lodge, Hants.

Death.

MYDDELTON-GAVEY.—On February 4th, at 16, Broadwater Down, Tunbridge Wells, after influenza, Frances Caroline, the dearly loved wife of E. H. Myddelton-Gavey, M.R.C.S.Eng., and daughter of the late Charles Catt, of Summerhill, Lindfield.

ACKNOWLEDGMENTS.—*London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review, The Practitioner, University College Magazine, The Student, The Hospital.*

St. Bartholomew's Hospital Journal.

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NOTICE.

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

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

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St. Bartholomew's Hospital Journal,

MAY, 1900.

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

THE *Daily Express* of May 12th contained the following sensational paragraph:

SCENE AT AN INQUEST.

UNSEEMLY BICKERING OVER A FEE.

A kind of general wrangle between coroner, doctor, and jury took place last evening at an inquest at St. Bartholomew's Hospital. It concerned the death of a man unknown, who committed suicide by throwing himself before a train at Aldersgate Street Station.

First of all, the coroner (Mr. Langham) complained that the body had not been photographed before.

Then Dr. H. Parker said he could not certify the cause of death, as the coroner had declined to allow a post-mortem examination.

At this point the jurors joined in, and the doctor finally made a fifteen minutes' examination of the corpse. On his return he recapitulated a list of superficial injuries, which a juryman observed was enough to kill ten men.

After further dialogue the foreman said, "You can arrive at a decision in fifteen minutes now, and I think it is gross negligence and a scandal that the body was not examined before."

Amenities ensued between the doctor and coroner, whereupon a juror inquired if they were always going to be at loggerheads.

Another threatened to have the doctor's fee disallowed, and was only appeased by that gentleman promising to send it to the Indian Famine Fund.

A suggestion that it should be shared by the jury was received with laughter.

Suicide was, of course, the verdict.

Mr. H. F. Parker has kindly written us a brief account of the facts connected with the above "unseemly bickering:"

"A man was brought into the surgery dead at 6.45 a.m. on the morning of May 9th, having thrown himself in front of a train at Aldersgate Street Station. I saw him in the surgery, and finding he was dead I did not make any minute examination or strip the body. But there was an obvious fracture of the right arm and right leg; no apparent head injury. A post-mortem, though asked for, was refused by the coroner, who presumably was satisfied that death was due to injuries sustained by being knocked down, consequently I did not turn the man out of his coffin to make any careful examination of the body.

"At the inquest, two days after death, I said that I was unable to state the precise injuries of which he died, whether death was due to injury of head, thorax, or abdomen, a post-mortem not having been permitted, but I was willing to allow that death was caused by the accident. The coroner therefore sent me to make a fifteen minutes' post-mortem, which I did. I examined the thorax and the abdomen (not the interior of cranium), and found that many ribs on the right side and some on the left side were fractured, and that there was extensive effusion of blood into the right pleural cavity. I stated that death was due to this, and was then pulled up by coroner and jury for not having discovered this before. A juryman then suggested that the reason why I did not thoroughly examine the body was that I might get a fee of one guinea,—an absurd proposition, for the post-mortem being disallowed that was an end to the matter as far as one knew, and my line of action was not taken with any idea of getting a fee.

"It seems to me that the coroner should either (i) have granted a post-mortem (as he could not have known at the time the nature of any superficial or deep injuries that the man had); or (ii) if he was satisfied that the man died as the result of the accident, he should have been satisfied with

the statement that the man was dead, and died as the result of certain (possibly unknown) severe injuries."

The above set of circumstances, with certain minor variations, is one that occurs not infrequently, and the unsatisfactory nature of the legislature that allows a coroner to refuse an autopsy and yet expects him to obtain sworn detailed evidence from the medical man notwithstanding, is sufficiently apparent. As Mr. Parker suggests, if a coroner is satisfied as to the cause of death, his satisfaction should not require any bolstering by the medical evidence. If he is not, then he should grant a full examination, instead of childishly hoping that the doctor will regard the enumeration of certain superficial injuries as complete evidence of the cause of death.

The "unseemly bickering" over the corpse of this unfortunate man did not end with the inquest. We learn that Mr. Langham, who can at times evidently be as great a stickler for the unexceptionable as mortal could wish, had the body sent to the Ilford Cemetery to be buried between the hours of 9 and 12 p.m., as it seems is provided by law for such persons as "do kill or murder" themselves. The cemetery keeper, unread in the mysteries of law, blankly refused to bury at such a ghostly time, and retired to his bed, leaving the body of the *felo de se* without the gates. Next morning it found its way to the City mortuary, pending more "bickering" between the coroner and the cemetery officials. Meantime instructions were given to the sanitary inspector to deal with the corpse, by this time somewhat rightly regarded as a nuisance. But the Ilford Cemetery authorities became duly awed and convinced by Mr. Langham's chapter and verse, and at length consented to inter the coffin in the prescribed manner. Whether unconsecrated ground, another indignity formerly the fate of suicides, was also insisted upon by Mr. Langham, we do not know. Probably not,—to have done so would argue rather more consistence, even in eccentricity, than we should be led to expect. But surely a troubled death and burial for a poor body already stretched out past endurance

". . . . upon the rack of this tough world!"

Certain Forms of Tubercular Peritonitis.

A Clinical Lecture delivered May 18th, 1900,

By Dr. GEE.

(Reported by Dr. T. J. HORDER.)

GENTLEMEN,—My remarks to-day will be based upon the case of Harry N—, a little boy three years old, who has been under my care in Luke for several months on and off. I argued his case out in a former lecture, and the opinion I arrived at—an opinion by no means fixed and certain, but wavering and uncertain—was wrong. I hope none of you will ever be ashamed of being wrong if your opinion is the result of reasonable argument; but if it is a wild guess, then it certainly is something to be ashamed of.

There were two points noticed about the little patient when we first saw him: he was very fat, and his appetite was voracious. But the only physical sign was a distended abdomen, and this distension was by wind, not water. No organ was increased in size and there was no dulness to percussion,—the note was tympanitic all over. To arrive at a diagnosis from a single symptom is often impossible and always difficult. There was no fluctuation to percussion, and therefore no proof of ascites, though ascites could not be absolutely excluded, because it may have been tympanites asciticus. Sometimes in these cases, though the abdomen is resonant all over, it gives good fluctuation, and if punctured, water is drawn off. And sometimes this may be done even when there is no fluctuation. In the lecture to which I have referred I quoted the case of a woman which illustrated this. But here the general condition of the boy—fat, flourishing, and ruddy—seemed to contra-indicate ascites: ascitic people generally look ill. We remembered that tubercular peritonitis is common in children and often causes a big belly,—often tympanitic, less often ascitic. But there was no evidence of tubercular peritonitis here; and as a matter of fact, though fully aware of the possibility of tubercular peritonitis, I said the child's disease was dilatation of the stomach. For we had found that this organ held thirty-one ounces of fluid.

He went out and was readmitted eight weeks later, having the signs of tympanites replaced by those of ascites.

The abdomen was as big as ever, but the size was evidently due to fluid, not wind. The patient was thinner, not so jolly; there was no rise of temperature; nothing but ascites. So there was still but one leg again for a diagnosis to stand upon. The abdomen was punctured upon three occasions with about a month's interval, and much water drawn off each time. This was done partly to relieve the symptoms, partly to cure the disease, and partly to help to a diagnosis by enabling us to feel something. But nothing was felt except the liver, and this was not sensibly enlarged. A month after the third puncture the note reads,—"child as jolly and thriving as ever, but the ascites persists." Still having the notion of tubercular peritonitis in mind, I asked Mr. Langton to make an incision into the peritoneum, because this sometimes cures, or hastens the cure, in this class of case. This was done, and the nature of the disease (the possible discovery of which was another reason for the incision) manifested: the intestines were seen to be studded with coarse tubercles. So now we have no doubt as to the nature of the complaint. The drainage-tube is now out, and the wound is healing well, but the liquid is collecting again.

Tubercular peritonitis is a disease assuming different forms in different cases. It sometimes passes through several forms in the same patient. Here it started as the tympanitic form, then became the ascitic form, and if the child recovers it will attain to the adhesive form.*

There are four chief forms of tubercular peritonitis: I, *adhesive*; II, *suppurative*; III, *tympanitic*; IV, *ascitic*.

Of I and II I shall not here speak, except to say that of I, the adhesive form, it is the commonest and most early detected, though not always so. There is at present a boy in Luke named Robert H—, who represents this form of the disease well; we can feel the adhesions. Also to say that in II, the suppurative form, abscesses appear (one usually) in the abdomen. A few remarks, however, about III and IV, the tympanitic and ascitic forms, as illustrated by Harry N—.

III. *Tympanitic tubercular peritonitis.* Here let me beg you to bear in mind that I am not speaking of tubercular peritonitis in general, but of this special form only. *Onset:* this is sometimes very sudden—instantaneous,—with very severe gastro-intestinal symptoms. As an hypothesis it has always seemed probable to me that a very sudden infection of the peritoneum takes place, as by the softening and sudden breaking down of a tuberculous gland; but this is a mere supposition. As to these gastro-intestinal symptoms, they are of three kinds: (i) *vomiting*, repeated for one or two days; (ii) all the symptoms of obstruction of the bowels,—*ileus*. These are very puzzling cases. I remember the case of a boy, six years old, taken with sudden pain in the belly and complete constipation. The ordinary remedies had no effect; he vomited after everything he took; he was febrile. Anyone meeting such a case would say, "This looks like a case of mechanical obstruction of the bowels." The fever is no help one way or the other. The obstruction yielded in five days, the vomiting ceased, the bowels acted, and tympanites commenced, becoming very great. (iii) By regular *gastro enteritis*,—all the symptoms of cholera. A little girl twelve months old, of a family with a tendency to tubercular disease, was in good health till two weeks from the onset of what turned out to be a fatal illness; during these two weeks she was feverish, and was supposed to be suffering from "teething." On March 13th she suddenly vomited, and the belly became big. Next day the vomiting continued and bilious diarrhœa began. On the third day she was seen; the vomiting and diarrhœa had ceased, but the child was considerably emaciated. The temperature was 102°; the tympanites was great; nothing was palpable in the abdomen, and there was a universal clear percussion tone even over the region of the liver. (I mention this because if you have read that the absence of the usual dulness to percussion over the liver always means free gas in the abdominal cavity, you have read what is not true; it is not so). The stomach seemed much distended, and showed itself as a globular resonant swelling in the left hypochondrium, reaching nearly to the level of the navel. The opinion I set down in my note-book then was this: that the tympanites was probably due to the severe gastro-enteritis: that there was no reason to suspect intussusception of the bowel or enteric fever, and that there was no proof of peritonitis. The patient improved a little till one month later, when the severe vomiting recurred, and obstinate constipation,—not diarrhœa,—which continued till April 21st, five weeks after the onset of the disease, when the signs of chronic peritonitis were well marked. The abdominal distension was great; a hard band about two inches by half an inch could be felt on the right side of the navel, and on the left side something of the same sort. The obstruction of the bowels gave way, but the child died about two months after the beginning of her illness.

So much for the sudden onset of tympanitic tubercular peritonitis. More often the onset is gradual; the abdomen gradually enlarges until it is very big.

As to the occurrence of *fever* or not; sometimes there is fever, and I have seen cases where tympanites and fever were the only symptoms. The addition of fever does not help much in the diagnosis. Often there is no fever; in the case of Harry N— there was no fever from beginning to end.

As to *indurations*, these form one of the best means of diagnosis as to whether the disease is tubercular peritonitis or not. Sometimes they accompany the tympanites; then you know where you are. A boy aged seven was healthy until Christmas, when the belly began to swell and be painful; at the same time his appetite for food failed, and he began to lose flesh. These symptoms increased until six months afterwards (note the difference; just now we saw a case where death occurred two months from the beginning of the illness): there was great emaciation, hectic fever, the bowels were open regularly, great and troublesome tympanites, abdomen globular, no fluctuation, elongated masses of induration, especially one crossing the belly on a level with the navel. He died, his illness having lasted just six months. Post mortem the opposed surfaces of the peritoneum were found glued together throughout by tough adhesions, everything was matted together, so that to remove an organ without tearing it was impossible; from the ribs to the pelvis was a continuous uniform sheet of false membrane, through which no viscera could be distinguished. Beneath the false membrane were seen the lenticular tubercles common in tubercular peritonitis. The lungs were also tubercular.

Sometimes there are no indurations (this was so in the case of Harry N—) even after paracentesis for the ascites.

IV. *The Ascitic Form.* (*a*) A slight ascites sometimes occurs with the onset of tubercular peritonitis, and disappears quickly, in a few weeks, followed by the occurrence of

* For a lecture by Dr. Gee upon Tubercular Peritonitis in general see the *Lancet* for January 1st, 1881.

indurations. I have met with cases where the number of indurations was extraordinary, scores, or many scores, all over the abdomen.

(*b*) Great ascites as the main symptom, again illustrated by Harry N—. The effusion is sometimes bloodstained, but this is a point of no importance. When the fluid is removed, spontaneously or by operation, indurations sometimes become palpable. We expect this in our present case, but are afraid the ascites may recur, and prevent their discovery. This is a curious thing, that this ascitic form is often associated with cirrhosis of the liver. The association is seen in adults also; but tubercular peritonitis is not so common in adults, despite what statistics say (for I recently saw some statistics which made out the disease to be more prevalent in adults than in children, a conclusion which is quite contrary to fact*). At present there seems no reasonable explanation of the association I have mentioned. Perhaps the tuberculous poison sets up cirrhosis like alcohol; and one is reminded of a similar association of ovarian tumours with cirrhosis of the liver. But we do not know the real cause of the connection.

Treatment.—For the tympanitic form, nothing. For the ascitic form, simple puncture (which in this case led to no cure, though repeated twice), then incision; and if no cure then, I do not know what will cure it, except time and patience; when, if the tubercle is limited to the peritoneum, the patient may get well, but if the lungs and other organs are affected the chances are small.

Enlargement of the Spleen in Children.

A Paper read before the Abernethian Society, March 8th, 1900,

By Dr. H. THURSFIELD, Medical Registrar at the Hospital for Sick Children, Great Ormond Street.

AT the moment when I gave as my subject for this paper Enlargement of the Spleen in Children I must confess that I had not considered it thoroughly, and consquently when I began to attack it in earnest I found my way beset by many unexpected obstacles. The spleen is one of those organs of the human body of which we know least, even in its normal condition, and its pathology is still more detective. My first difficulty was to ascertain what was the normal size and appearance of the spleen in children of different ages. Its weight appeared to be a more or less ascertained fact. It scarcely ever, even in the youngest children, weighs less than half an ounce, while in older children up to twelve years of age a weight above three ounces would appear to be abnormal. Its shape and general appearance differ post mortem far more than any other organ in the body; at one time it is thin, soft, and has a large superficial area; at another time it is firm, thick, and very small; again it is very soft, thick, and large; all these differences depending on the cause of death, the time that has elapsed between death and the examination, and lastly the condition of nourishment of the child. But, whatever the results of post-mortem examination may show, it is quite certain clinically that a definite enlargement of the spleen, so that it becomes readily palpable, is much more common in children than in adults. In saying this I mean to exclude carefully those cases of rickets in which, owing generally to a deformity of the chest, the spleen can be easily felt. In these cases the spleen is not enlarged, it is merely displaced—a statement easily confirmed by post-mortem experience. Indeed, I have yet to see a case of rickets, unaccompanied by other disease, in which the spleen is enlarged at all, in spite of the text-book statements to the contrary. It must be remembered that displacement takes place far more readily in children than in adults, owing to the wider spread of the lower ribs. Thus I have twice seen the spleen pushed downwards by a pleural effusion until nearly the whole organ was palpable, an event which I believe never occurs in an adult. To return to enlargement, the most common causes in the cases I have seen during the last six months have been typhoid fever, tubercle, and the disease which at Great Ormond Street is called splenic anæmia. Before I go any further let me warn you that splenic anæmia in Osler and Clifford Allbutt is not the same disease at all, but something quite different. The chief part of my paper I wish to devote to a consideration of this affection, because it is not uncommon, and because in the ordinary text-books it is not mentioned at all. But I should like first to make a few remarks about the other causes of splenic enlargement. The spleen in children's typhoid is usually, I think, very little enlarged; in fact, in a majority of the cases I have seen the spleen could only just be felt. On the other hand, it is occasionally very large and very hard; in one well-marked instance it reached to within one finger's breadth of the iliac crest in a child of eight years old; in her convalescence this enormous spleen could not be felt at all, so rapidly did it decrease in size. I do not know in which text-book the statement occurs, but I am constantly being told by the clerks in the wards that tenderness in the region of the spleen is a far more important symptom of enteric fever than mere enlargement. Wherever it occurs I feel sure that it is a mistake, and this case in particular I should advance as evidence. Though her spleen was so large, the child had not the slightest pain or tenderness about it. I believe tenderness in the spleen, or the region of the spleen, to be far more common in tuberculosis than in typhoid. In nearly all tubercular cases which come to the post-mortem table at Great Ormond Street the spleen is more or less enlarged, and since I have been there there have been but two tubercular cases out of some forty in which tubercles or caseous foci were not found in this organ. From this fact it is easy to understand the importance of splenic enlargement in the diagnosis of tuberculosis in children. In their case one is entirely deprived of the evidence supplied by examination of the sputum, for in ninety-nine cases out of one hundred children with pulmonary tuberculosis swallow their expectoration. One is therefore obliged to rely upon the physical signs. Apart from those signs in the chest, and the exceedingly important question of enlargement of the cervical lymphatic glands, a palpable spleen which is also tender is, I think, the most valuable piece of evidence we can find. I should like to remark in passing that of the cervical glands the group most frequently found diseased is that which lies underneath the sterno-mastoid muscle, and that in this group tubercle is not infrequently found when it is present nowhere else in the body. These glands drain the lower part of the pharynx. The enlargement of the spleen in tubercle is, I believe, never great. It is usually easily palpable, and occasionally a portion of its surface can be felt. In one such case it was noted during life that the surface felt unusually rough; at the post-mortem examination it was found studded with tuberculous masses in all stages of degeneration, some of them even calcified. The cause of the tenderness so often found in tubercular enlargement of the spleen I believe to be the perisplenitis, the adhesions which it so often forms with the parietal peritoneum.

The largest spleen I have yet seen in a child occurred in a boy aged six and a half. He was extremely anæmic, and at first he was believed to be the subject of leucocythæmia. An examination of his blood disproved this, however, and then the diagnosis of lymphadenoma was suggested; one physician who examined him stating that he could feel some small lumps in the spleen, which he thought to be the lymphadenomatous deposits found in Hodgkin's disease. Post mortem, however, there was no sign of these infarctions, and the glands, though large in some places, notably along the course of the splenic vessels, were quite soft and purple. The boy had just come home from India, where he had had an attack of malaria, from which his present illness dated. He died of profuse epistaxis, and though frequent examinations of his blood failed to show the malarial parasite, I have no doubt myself that he was an instance of malarial cachexia.

His spleen weighed 31½ ounces.

We have had one case of leucocythæmia in a child aged two years since I went to Great Ormond Street. Unfortunately the child died while I was absent, and so I did not see the spleen myself. It was large, but not very markedly so, though during life it formed a very prominent tumour. It weighed 10½ ounces.

Other causes of enlargement, I find, were amyloid disease in two cases, and two cases of rheumatoid arthritis so called; and in one case I feel sure, though proof is lacking, for the child is still alive, an infarct caused by mitral valvular disease. Three weeks reduced this spleen from a size which reached the iliac crest to an organ just palpable under the ribs.

I now come to the disease I spoke of at first, a disease called at Great Ormond Street splenic anæmia, but described abroad I believe as splenic pseudo-leucocythæmia. The frequency of this complaint may be judged from the fact that in six months there were ten cases treated in the wards at Great Ormond Street, and this year there have in six weeks been two further cases. Of these twelve cases four died; the remainder recovered and went out with the exception of one case still remaining in. Of the twelve cases nine were males, three females, but this I believe is not the true proportion; in a larger number of cases the sexes would be about equally represented. The youngest of these children was nine months, the oldest just three years. As a general rule the children are fairly well nourished and well developed, but the most striking characteristic in all of them is their extreme pallor. This is so marked in the more severe cases that after one has seen a few instances facial diagnosis becomes possible; particularly when the pallor is, as often, of a pale olive tint, unlike any other condition with which I am acquainted. On examination the spleen is always found considerably enlarged. The smallest I have seen in this condition was three fingers' breadth below the costal margin, and that in a child of under two years means that the edge of the spleen reached below the level of the umbilicus. In addition to coming very low down these large spleens in young children come unusually far forward; in one or two cases they have all but reached the middle line at the umbilicus; this I believe to be due to exceptional resistance of the peritoneal folds in young children, the lieno-colic fold directing the spleen forwards. In the adult these folds are much looser, and offer less resistance, so that enlargement of the spleen tends to bulge out the flank much more than is the case in children. The spleen in these cases, besides being large, is always very firm, and apparently quite free from any tenderness. I do not think there is any direct relation between the degree of enlargement of the spleen and the extent of the anæmia. The case in which the blood-count and hæmoglobin estimation were lowest was a case in which the spleen was unusually small for this condition, weighing only three ounces post mortem, a weight, however, still nearly double the average for a child of her age, that is two years. The *liver* in these cases is always more readily felt than normally, but I am rather doubtful as to whether there is any real enlargement in most cases: it is certainly always unusually firm. The lymphatic glands are in my experience very rarely enlarged,—in fact, they were definitely described as large during life in one case only out of twelve, and post mortem in no case except this one did they seem to be much larger than normal. The other *post-mortem* appearances found I believe I may claim as accidental. Thus in four cases there was definite broncho-pneumonia, and two of these died of this complication. On the clinical side, besides the typical pallor and the characteristic tumour, there are not many features of interest. The pulse is as a rule quite regular, but rather rapid, from 120 to 140 per minute; the heart is sometimes slightly dilated, the dilatation affecting the left ventricle especially; at the same time it has appeared to me that the impulse never has that forcible and slapping character so often found in the severe anæmias of adults. In three cases there was a definite systolic murmur heard over the heart, but it had the characters, as indeed one would expect, of an anæmic murmur, and in the one case of these three that died no valvular lesion was found.

Hæmorrhages were distinctly rare: one instance of epistaxis occurred, and some blood was found in small quantity on the pillow in another case. Two cases have shown subcutaneous petechiæ; both have recovered. There has been no instance of bleeding from the rectum, urethra, or other mucous membranes.

The temperature in the majority of cases is slightly raised, ranging between 99° and 100° with occasional irregularities when 103° or 104° is reached, after which it comes slowly down again.

Diarrhœa is a very constant symptom; it occurred in ten of these twelve cases, and in several instances, especially during the summer and autumn, was the most serious feature. Albuminuria was noted only once, and that just before the end in a fatal case.

The blood presents considerable alteration from the normal. I feel that I am now treading on dangerous ground, for blood examination has now become so accurate, and also, if I may say so, so complicated, that I shall be surprised if no one contradicts. I do not pretend that I have thoroughly examined all these twelve cases, but I believe myself justified in making the following statements. The red blood-corpuscles are in all cases very considerably diminished in number, sinking in one fatal case below one million to the cubic millimetre. More usually, however, the count gives a result of about 40 to 50 per cent. The fall in hæmoglobin is as far as I can judge about equal to this result,—that is to say, that the corpuscles each retain about their normal quantity of colouring matter, but the total quantity is considerably diminished. Thus in one case recently the corpuscles have been from 30 to 40 per cent., and the hæmoglobin estimated from 32 to 38 per cent. The red corpuscles are as a rule well shaped. The white corpuscles I believe as a rule show some increase; the highest count gave 35,000, making a proportion of about 1 white to about 110 red, but I believe this to be exceptional. More usually I have found the white corpuscles to number 20,000 or under. My chief difficulty here is to know what in these young children is about the normal proportion. Mr. Churchill, if I recollect right, not long ago told us that the proportion was higher in children than in adults, and if so it would appear that the absolute increase is not great in these cases. The relative increase of course is always considerable. With regard to the different varieties of white corpuscles I am still further at sea; so far as I am sure of my results the relative proportions of the different varieties remain about the same. The only fact that I am certain of is this: that I have not yet examined a case of splenic anæmia without finding both myelocytes and nucleated red corpuscles. I do not know whether these are peculiar to this condition, or whether they also occur in children's anæmia due to other causes. I have now been waiting for some time for a suitable case of simple rickets for purposes of comparison. Two or three cases of rickets I have examined with negative results as regards this point, but none of them were markedly anæmic. These are merely my own impressions at the present moment.

The *prognosis* in the majority of these cases is distinctly good; four out of twelve died, it is true, and this proportion corresponds exactly with Dr. Carr's statistics—the only ones I know. But, as he points out, there are always a large proportion of serious cases admitted, while the less serious do not come into the wards. Here I should like to refer to the Finch family, three different members of which were under treatment in the wards here within my recollection. I believe one is here now. They were all, I believe, cases of this affection, though my remembrance of the first of them is distinctly hazy. I saw her, however, about two years after her discharge, when a younger child was in the wards. Her appearance was then of robust health, and her spleen, which had been enormous, could not be felt. Yet she was several times believed to be at the point of death.

Treatment resolves itself at present into good food, good air, warmth, light, small doses of iron, and elixir of splenic extract. As to the effect of this last I must confess to considerable scepticism.

Now the question arises whether this is merely an exaggerated condition of some other more common disease, or whether it is a separate disease, *sui generis*. My own opinion I have already indicated, that it is really a disease by itself. At the same time I hasten to add that the majority of the authorities at Great Ormond Street hold the opposite view. The two diseases with which it is most commonly associated are rickets and congenital syphilis. Taking rickets first, in every one of these cases there was undoubted evidence of rickets, and in all but two the evidence was fairly strong. In these two the rickety changes in the bones were practically absent, and the evidence was limited to the presence of an abnormally wide fontanelle and backward dentition. Dr Carr's figures are very much the same, and at first sight it would look as if this were the real cause or at least the essential condition of the development of splenic anæmia. But there are some considerations against this view which must not be lost sight of. In the first place, of the children under three years of age admitted to the wards at Great Ormond Street the vast majority are distinctly rickety; indeed, I do not believe I should be overstating facts if I said that of London children under three of the class that comes to the medical side of the hospital nine out of every ten have rickets more or less marked. Therefore it is hardly surprising that the percentage of rickets in these cases should be so high. Secondly, as I said before, I believe enlargement of the spleen or liver in simple rickets to be a myth, repeated in the text-books by a bad tradition; at any rate, putting aside these cases, it is certain that in the numerous

* "The incidence is most frequent between the ages of twenty and forty" (Osler, *Principles and Practice of Medicine*). Other text-books quote some statistics of Fagge's making out the age-incidence to be greatest between twenty and thirty, but omit to say that these are (1) post-mortem statistics, and (2) compiled at a hospital where comparatively few children are seen. As Dr. Gee pointed out, statistics might be collected at a children's hospital dealing with a large number of cases, yet making it evident that the disease never occurred in adults at all!

post-mortem examinations I have made on rickety children, who have died of complaints that do not affect the spleen, that organ has never been enlarged, and in the surgical wards, where there are constantly extreme instances of rickety bony deformity, I have never been able to satisfy myself clinically of any enlargement. Thirdly, Dr. Carr has seen at least one well-marked case of splenic anæmia in which there was no evidence whatsoever of rickets. Fourthly and lastly, observations made on simple rickets tend to show that the blood changes are very different; the red blood-corpuscles maintain almost a normal percentage, and the marked anæmia is due to a deficiency of hæmoglobin—a distinct contrast to the condition found in splenic anæmia. This statement again I make with humility and reserve. I have only been able as yet to test its accuracy in one case, and in that the anæmia was so slight that it really, I am afraid, has no value; in fact, though the hæmoglobin was slightly deficient, yet it was well within the normal limits for London children, and the corpuscles amounted to 96 per cent. To sum up, rickets is an almost constant accompaniment of splenic anæmia, but in London that is true of most other diseases occurring in children under three. Rickets itself does not cause enlargement of the spleen; the blood changes are different. Hence my conclusion is that, however important rickets may be as one of the factors in the causation of the disease, it does not stand alone.

Turning now to congenital syphilis, as you probably all know, Dr. Gee was the first in this country to draw attention to enlargement of the spleen as one of the points in this disease. Unfortunately he made the statement at the same time that this enlargement was in some cases the only evidence which was to be obtained. I do not know where his original remarks are to be found, and so I do not know if any qualification is attached to this statement, but I cannot feel that it is an unassailable position. To take one argument only, almost the same statement has been made about rickets by Dr. Dickinson, namely, that enlargement of the spleen is occasionally the only evidence of rickets. Obviously both these statements cannot be true, and I think it quite possible that these cases of splenic anæmia suggested the remark in both instances, for a considerable number of them have some evidence of congenital syphilis. Of the twelve cases one alone was almost certainly syphilitic; two others had a doubtful history, but no symptoms unless the splenic enlargement be accepted. Other statistics give a higher percentage. This question, however, depends entirely upon what is accepted as evidence of congenital syphilis. There are, of course, certain well-ascertained symptoms, but unfortunately these mostly occur in older children,—as, for instance, notched incisors and interstitial keratitis. In children of the age of these patients, when you have gone into the history of the family and the mother's pregnancies, and have admitted certain skin affections, you have got everything which is really undeniable evidence. Parrot's nodes, I believe, are always syphilitic. Many believe them to be always rachitic, and there is, I think, no other clinical evidence which is undisputed. Post mortem there is, of course, certain other evidence, especially the hepatic pericellular cirrhosis, but happily most cases do not die. At any rate, the connection between congenital syphilis and splenic anæmia is decidedly vague.

Another hypothesis—for there is absolutely no evidence on this point—is that the coincidence of rickets and congenital syphilis determines the onset of splenic anæmia. I need do nothing more than mention it, for obviously it is quite impossible to prove or disprove it.

On the whole, therefore, it appears that this "splenic anæmia" of young children is in reality a disease *sui generis*, associated with rickets in the majority of cases, with congenital syphilis in a certain somewhat smaller proportion; the other factors are quite unknown. Some of the cases have been unwisely fed, but that is certainly not an essential condition, for a few have had no history of this source of trouble, and none of them improve so rapidly with a return to proper diet as one would expect if this were the cause. Some of them have been brought up under very bad hygienic conditions; others, again, come from healthy houses, and even some from the country.

Lastly, are the unexplained cases of enlargement of the spleen in slightly older children, seven, eight, and ten years of age, instances of this disease or not? They are very rare, but I have seen one such case at least.

I hope I have not exhausted the patience of the Society by these somewhat scrappy notes; the whole subject is extremely vague and full of difficulty, but it appeared to me that there was a gap at this point in most of the text-books, which I have attempted partially to fill in this paper.

NOTE.—Since this paper was read I have consulted Dr. Dickinson's paper on "Visceral Changes in Rickets," and I think my surmise entirely justified; he was certainly describing cases of "splenic anæmia."

A Case of Poisoning by Oil of Bitter Almonds.

ON April 17th Ralph Joseph N—, aged 23, was brought to the surgery at 1 p.m. in a comatose condition. The history given was that at 10.30 a.m. he had swallowed a quantity of the oil of bitter almonds from a quart bottle; he had vomited, and had been treated outside by subcutaneous injections of ether. When seen in the surgery he presented the following appearance:—He lay on his back in total insensibility, with a livid colour of skin, and a quantity of foam at the mouth strongly suggesting the recent occurrence of an attack of epilepsy. In the absence of all history, however, the cause could not have been mistaken by reason of the strong odour of prussic acid the patient exhaled. The breathing was slow, laboured, and stertorous. On opening the closed eyelids the pupils were found dilated, the corneal reflex absent. The jaw was tightly clenched, and the tongue protruded. The skin was covered with a cold, clammy sweat. The pulse was full, soft, and slow.

The following treatment was pursued:—An injection of half a drachm of ether was given subcutaneously. The stomach was well washed out through a soft tube, and as the respiration continued to be depressed, two ounces of brandy were placed in the stomach previously to the withdrawal of the tube, and five minims of the hypodermic injection of strychnine administered. Under this treatment the respiration and pulse improved slightly, and the time that had elapsed from the taking of the poison being considered, hopes were entertained of his recovery.

Almost immediately, however, upon the admission of the patient to Luke Ward the respiration began to fail, and although artificial respiration was persevered with for some time no improvement took place, and at 3 p.m. he died.

Post mortem both lungs were found engorged, especially the lower lobes. The stomach was considerably injected, and contained greenish bile-stained fluid; some injection of the duodenum and upper part of the jejunum was found.

The pancreas was engorged.

The internal organs smelt strongly of prussic acid; smell most marked in contents of stomach.

The blood was everywhere fluid, and on exposure acquired a bright cherry tint.

The points in the case worthy of note are—

1. The length of time between the actual taking of poison and the supervention of death. This is remarkable, seeing that the case was suicidal, and the amount taken therefore probably large. It was stated that this fluid contained 10 per cent. of prussic acid. Although the patient had vomited, the ultimate washings of the stomach still strongly smelt of hydrocyanic acid.
2. The extreme difficulty of getting the stomach-tube into the mouth owing to the tight clenching of the jaws.

Surgical Notes.

ON January 4th Mr. Willett showed at Consultations a man aged 25 (No. 16, Pitcairn) with a swelling in the middle of his forehead. The patient stated that three months previously he had knocked his forehead severely: he felt the "bone crack," and became very dizzy, but did not lose consciousness. Severe frontal headache followed the injury, and had persisted ever since. Six weeks before admission he noticed a swelling on the forehead, which gradually increased in size. The swelling was from the first very tender to the touch. From the time the swelling was noticed the sight of the left eye became impaired. On admission, situated about the middle of the forehead was a protruding oval pulsating swelling, measuring 2½ by 1¼ inches, with fairly defined margins, firmly fixed to the frontal bone, and exquisitely tender. The overlying skin was normal. The swelling felt hard, but at its summit was a softer spot. An indistinct furrow divided the swelling more or less into two parts. Ophthalmoscopic examination of the left eye revealed well-marked optic neuritis.

As is so often the case, the question was whether the swelling was malignant or inflammatory. There were three points in favour of an inflammatory origin: (1) the swelling had apparently directly followed an injury; (2) the centre was softer than the circumference; (3) under full doses of iodide of potassium the swelling had not increased, but had rather decreased in size. The opinion of the majority, however, was in favour of the view that the swelling was sarcomatous, but there was considerable difference of opinion as to the advisability of any operative treatment.

On January 15th Mr. Willett made a crucial incision into the growth, and removed it. The hæmorrhage was so severe that a thorough removal was impracticable. The cavity was packed. The growth was situated between the inner and outer tables of the frontal bone. Microscopically the growth proved to be a myeloid sarcoma. The patient rapidly recovered from the operation and experienced much relief. Seen on April 5th, nearly three months after the operation, he was in excellent health; was suffering no pain. The cavity between the tables of the frontal bone looked perfectly healthy, and there was apparently no active disease present.

On March 15th Mr. Langton showed a man aged 47 (No. 702, Henry), who for four months had had a swelling about the middle of the anterior aspect of his left thigh. The swelling was about three inches in diameter, not lobulated, with definite outline, and it had not appreciably increased in size since the patient first noticed it. The diagnosis rested between a growth, innocent or malignant, and hæmatoma. The prevailing opinion was that the swelling was solid and fibro-cellular in nature. The view was also expressed that it was fluid, in which case it was probably an abscess or a hæmatoma. Operation and microscopical examination showed it to be a myxosarcoma of the rectus muscle of the thigh. H. J. P.

Notes.

DR. H. M. FLETCHER, Dr. Leonard Guthrie, and Dr. Robert Bridges have been elected to the Fellowship of the Royal College of Physicians.

* * *

DR. SHORE has been re-elected a member of the Standing Committee in the Faculty of Medicine at the University of London.

* * *

DR. C. H. PERRAM has been appointed Assistant Physician to the Bedford County Hospital.

* * *

THE degree of M.D. has been conferred on G. A. Auden, M.A., and those of M.B., B.C., upon B. R. B. Truman, B.A.

* * *

THE Kirkes Scholarship and Gold Medal have been awarded to A. E. H. Thomas; *proxime accessit*, R. L. Thornley.

* * *

THE Brackenbury Medical Scholarship has been awarded to H. T. Pridham.

* * *

THE Brackenbury Surgical Scholarship has been awarded to C. E. West; *prox. accessit*, C. S. Hawes.

* * *

THE Wix Prize has been awarded to N. E. Waterfield.

* * *

E. G. SIMMONDS has been awarded the Rymer Gold Medal and the Prize in Dental Metallurgy at the National Dental Hospital.

* * *

WE understand that the annual prize and scholarship distribution, which has taken place in the Great Hall in June of the past three or four years, is to be omitted in future. The old order of things—awarding the prizes to the successful students *in camera* at a School committee meeting—is to be in vogue again.

* * *

THIS decision of the authorities is disappointing. We had regarded the step from the dull obscurity of the Library on a Saturday afternoon to the publicity of the Great Hall as a distinct advance. The return to the older custom, therefore, seems just as surely retrograde. Of course we had been looking at the affair from the students' standpoint. Perhaps this was a mistake. Curiously enough, we notice in this month's issue of our contemporary, *The St. Mary's Hospital Gazette*, that "the distribution of prizes, which was formerly an annual summer function, is to be revived; and Professor Clifford Allbutt has consented to officiate on an early day in July." We are aware that our sister medical school needs the blessed uses of advertisement more than we do, but is that the whole question involved?

* * *

CONCERNING Decennial Club Dinners: before the probable issue of the next number of the JOURNAL the season for these annual functions will have arrived, so that a few remarks concerning the constitution of the Contemporary Clubs will not be out of place. The Clubs were started during the decade 1815–25, and have been continued in regular series ever since. The First, Second, and Third Clubs have died natural deaths, though we believe there are still a few members of the Third Decennial Club incorporated in the now fused Fourth and Fifth Clubs. The Sixth Decennial Club, under the Secretaryship of Mr. Cumberbatch and Dr. Herbert Taylor, forms, therefore, the second club now in existence.

* * *

THE Seventh Contemporary Club is at present honoured in being represented at the front by its two Secretaries, Dr. H. H. Tooth and Mr. A. Bowlby. But we have been asked to inform the members of this Club that the annual dinner will be held, as usual, on the first Wednesday in July (the 4th). Before leaving for South Africa the Secretaries arranged with Mr. Edgar Willett and Mr. F. C. Wallis to act as temporary Secretaries, in the event of the war preventing them from returning in time to send out the notices for the dinner. Reply post-cards, giving details as to time and place, will be sent out as usual to the members of the Club, and it is hoped that the gathering will be a good one.

* * *

OF the Eighth and youngest Decennial Club we wish especially to speak, because it seems necessary to remind our readers of the conditions of eligibility for membership, and of the advantages of joining the Club. All Bart.'s men who joined the Hospital between 1885 and 1895 and have

subsequently become qualified, or University men of corresponding standing who have also become qualified, are eligible. The full membership, therefore, is obviously not yet complete. Every man ought to try and join, because this Club's annual dinner is the only one where he meets his contemporaries and no one else,—not even guests. Notices of the Club, life membership of which costs 2s. 6d. only, are forwarded to each man on qualification, but owing to several reasons, chiefly connected with changes of address, these notices sometimes fail to reach their destination. Men should acquaint either of the Club Secretaries—Mr. Waring or Dr. Drysdale—with the alteration, if such occurs, or of any other circumstance which may prevent the notice reaching them. The present membership is far below what it should be, considering the number of men who yearly become qualified and leave the immediate precincts of the Hospital. The date of the approaching dinner is June 27th.

* * *

PAST *v.* PRESENT.—CRICKET AND TENNIS.—This annual fixture has been arranged for Wednesday, June 13th, and the Secretaries of the above clubs would be glad if all those Old Bart.'s men who wish to play would send in their names as soon as possible. It is hoped that this year we shall have a larger gathering than we have had in the past; and with this object in view the day has been changed from Saturday to a *Wednesday*. A band will play during the afternoon. Tea will be provided, and we hope that men will not only go down to Winchmore Hill themselves, but also take their friends with them.

* * *

THE Amalgamated Clubs' Dinner will not be held on the evening of the Past and Present matches, as has been customary the last few years, because it has been found that the attendance of students was not what it should be. At the dinner last year the staff was much better represented than the students. This being the case, it can hardly be said that the dinner—as a dinner of the Amalgamated Clubs—was a success. It has been suggested that the reason of there being such a poor attendance of students is that the dinner follows the Past and Present matches, and most of the men in the Hospital imagine that it is only a cricket and tennis dinner; and, not being interested in these, they do not go. The Club Secretaries are of opinion that the Summer Term is not particularly a suitable time for the dinner, for its taking place after the Past and Present match causes a certain amount of inconvenience to those who are playing. Moreover the games have to be stopped earlier than they otherwise would be, to enable the players to be back in town in time for dinner, thus making it almost impossible—at least in the case of cricket—to arrive at a definite result. In addition to this, some men do not care to forego their week-end on the river or in the country for the sake of the Clubs' dinner.

IT has, therefore, been decided that the dinner shall, if possible, be held some time during the first Winter Term, when it is thought that, in addition to getting a larger attendance of men who are now at the Hospital, we shall also see a large number of Freshmen. A Committee, consisting of the secretaries of all the various clubs, has been appointed to discuss whether the annual dinner is to be continued, and if so, to fix a date most suited to the majority.

* * *

WE should like to offer as a suggestion to those who may be appointed to make the necessary arrangements, that the fact of the dinner being held, as it has been, at a restaurant at some distance from the Hospital, to a certain extent makes it far less interesting and attractive than it would be if it were held within the Hospital precincts—say, for example, the Great Hall. We do not know whether it would be possible to have the Clubs' dinner in the Great Hall, but we feel quite sure that if the dinner were held there the attendance would be much larger and the occasion much more enthusiastic.

* * *

IN conclusion, we would point out that the dinner is and has always been essentially meant for *all* of the members of the Amalgamated Clubs, whether Past or Present, and at functions of this kind we would gladly see more men than we usually do, for then we should know that the vaunted *esprit de corps* of Bart.'s men is a reality, and not a myth.

* * *

IN the Medical Golf Tournament, held at Wembley on May 10th, Mr. Percy Furnivall won the first prize in Class 1 with a score of 84 less 8, equal 76; and Dr. J. F. Steedman was second with 85 less 8, equal 77.

* * *

THE following letter has been received by Dr. Andrewes from Surgeon-Captain B. H. F. Leumann, I.M.S., an old Bart.'s man, to whom our Museum was last year indebted for the excellent series of plague specimens which have been mounted. We publish the letter *in extenso*, in the belief that many Bart.'s men will be willing to contribute to such a fund as is therein suggested, not only for the excellence of the cause, but as some response for the efforts which Surgeon-Captain Leumann has made on behalf of the Hospital Museum. Subscriptions will be received by the Editor of the JOURNAL or by Dr. Andrewes, and will be duly acknowledged.

c/o RAILWAY STAFF OFFICER,
PIETERMARITZBURG, NATAL, SOUTH AFRICA;
April 6th, 1900.

MY DEAR ANDREWES,—The copy of the additions to our Museum in 1899, which you kindly sent to my Indian address, reached me yesterday. Very many thanks, and for the nice way in which you acknowledge my poor efforts. I came over here as an adviser on plague matters a year ago, but when the war began donned my khaki, and was put in charge of an ambulance train—the first used in this campaign,—and by the time Princess Christian's train arrived I had carried very nearly 6000 sick and wounded from the front to the rear. My experiences have been variable, as you may imagine,—too much so, indeed, to be discussed in a letter.

While no one is gladder than I to note how well the people at home recognise the valour of our Tommies, it is a great grief to me, as an I.M.S. man, to feel that no notice has been taken of the excellent way in which our Indian water-carriers, dhooly-bearers, muleteers, and hospital attendants have worked. The papers have been loud in their praises, but no one has substantially acknowledged them, and so I am trying to get a fund up to help their widows and orphans in India, to get the men still actively engaged warm clothes for the fast approaching cold weather, and extra food.

Their various caste prejudices preclude our giving them food such as we eat, and to a large extent clothes such as we wear; but we can get money for both purposes, and if you will not think me too much of a nuisance, I shall be glad if you will use your best endeavours to help us, *i.e.* the three I.M.S. men out in this war, who are working for our grand Indian followers engaged in it. There are about 1400 of them, and to feed them a bit extra, to give them a sweater and a pair of warm drawers apiece, and a few odd shillings, "baksheesh," when the war is over, we shall require half again as many pounds, while there are widows and orphans to think of in India—dear old more-than-ever famine stricken India. I have practically no relations, and but few friends in England, hence my worrying you. St. Bart.'s has sent forth many of her sons to India, some of whom have made their mark; will she help another of her sons to do good to those who have worked hitherto unrewarded, and always badly paid, and have endured fire and shell—even to death—for the brave sahibs they serve?

If you can get us anything—*e.g.* sweaters, to keep them warm—send them to me at the above address; but I would suggest, in order to save carriage fees and likelihood of miscarriage in their destination, that the money to purchase these and other articles be sent instead, and I will undertake to provide what is necessary, and render you an account of what you send.

Excuse this begging letter, but I love my Indians, and I want them to feel that our people at home do recognise their worth.

With kind regards to all who may remember me,

Yours sincerely,

B. H. F. LEUMANN

* * *

AN old house physician has sent us the following extract from an officer at the front, which we print on account of the interest attaching to the names introduced:

Officers' Ward,
No. 1, General Hospital, Wynberg.

When I got down here I had a long consultation with Mr Bowlby regarding my rupture. After he had explained to me the chances of an operation for radical cure being successful, I decided to have it done; and he very kindly promised to come over from the Portland Hospital, Rondebosch, and do it for me.

Bowlby did the operation three weeks ago, and I have not been allowed to get up until to-day. But I am feeling extremely well, and they tell me I have been quite a record case in getting well and healing up so soon.

Sister Smith, who belongs to St. Bartholomew's, is nursing me, and was present at the "slaughterhouse" (as we call it). She is tremendously popular in the hospital here, and has been awfully nice to me. I am sure she has helped a great deal to make me fit so soon, since there is nothing like a good Sister to put one right in a short time.

Watson, also of Bart.'s, has been looking after me since the operation. What a nice fellow he is!

* * *

THE University of London cannot as yet be congratulated upon its new abode at the Imperial Institute. Presentation Day this year was not nearly the success it usually is, despite the distinction the presence of H.R.H. gave to the function. The room was badly chosen, and contrasted very unfavourably with the theatre at Burlington Gardens. But a most ludicrous situation arose in the matter of refreshments, leading to the students being locked out by the caterers at the Institute, whose syndicate seems to have the sole right to supply refreshments in the buildings. An affair so badly managed as this was augurs ill for the future management of the "new University."

* * *

MARK TWAIN was the chief guest at this year's View Dinner. He replied to the toast of "The Visitors" in a speech which had to be seen as well as heard to be properly appreciated. Mark Twain is just as inimitable in an after-dinner speech as he is in a tramp abroad. In the course of his humorous remarks, he referred to St. Bartholomew's as one of those "small corner-lots" which need not fear coming to grief financially. He spoke of his village doctor fifty years ago on the Mississippi, who treated him as Galen would have done,—gave him prescriptions made up of the weeds, rubbish, and brickbats of the middle ages. A man was safe until he got into his physician's hands, and when he got there the insurance company put on more risk. He read an account of the treatment adopted by a surgeon fifty years ago for headache: "I, being called, did cause vene section in the arm, leeches to the vessels of the nostrils, forehead, temples, and regions behind the ears, cupping glasses with scarification to the back. The patient was bleeding from every pore, and notwithstanding these precautions, he died. If any surgeon skilled in arteriotomy had been present, I would have advised that operation also." What a godsend the guillotine would have been to that doctor! The speaker pointed to the picture of Henry VIII at the head of the Great Hall, and spoke of him as a practitioner with an extensive experience, though there was no doubt it was attended with fatalities.

* * *

WE have received a copy of *League News*, the new journal of the League of St. Bartholomew's Nurses, which is to be issued twice yearly. We congratulate the League upon this its new venture, and wish it all success. The Editorial relates the history of the formation of the League, and sets forth its objects. We learn that the League was founded to encourage that feeling of *esprit de corps* among the nurses which "among the male students (*sic*) is fostered and satisfied by associations among themselves." The objects of the League are three:—"By union to encourage the members to maintain a high standard of work and conduct; for mutual help and pleasure; to promote the establishment of a fund for the relief of former nurses of the Hospital who are in distressed circumstances." We are glad to see that one of the original suggestions of the provisional Committee, that the League should "enquire into, and lay before the members when necessary, any case of misconduct which may come under its notice," has no place in the present programme. As we pointed out, such an inquisitory function could but endanger the success of the Club.

* * *

Our flattering contemporary the *Nursing Record* assures us that "the motto of the Hospital" is "Nulli secundus." We did not know it, but are always glad to be taught. In

spite of this, however, we do not think the spirit which leads the editor of *League News* to say that "among Bart.'s nurses the sense of comradeship and unity is more strongly felt than among the members of most training schools," is a wise one to encourage.

* * *

We have found that the journal is not without humour; for what else can the editor have in mind when, describing the "at home" of the members of the League at 30, Bruton Street, recently, she says, "There was a delightful sound of animated conversation throughout the evening"? And printed under the head of "Marriages" is a paragraph with the rather quaint information that a certain member of the League "arrived in England on March 26th, bringing a small son and daughter with her." The journal gives excellent promise for the future, and can scarcely help proving a great success. The names and addresses of the 284 members of the League are inserted. The secretary is Mrs. Walter Spencer, 35, Brook Street, W.

* * *

A FOURTH year's student recently took a friend to see the senior eye surgeon of his hospital. On quitting the consulting room quoth the student, "Do you think, sir, my friend had better see an *oculist* about glasses?"

* * *

As we go to press the results of the Final F.R.C.S.(Eng.) Examination are to hand. The following have been successful: Messrs. Dyson, Harmer, Hyslop, Millward and Rawling.

Annual View Day—May 9th.

VIEW DAY comes every year like Christmas, and with about the same regularity; moreover, judging by the reports of the reckless *abandon* to which the Hospital on this day gives way (see each volume of the JOURNAL, about page 120), one View Day is very like another. It was to the above-mentioned archives we confess we turned when the Editor—in other respects humane,—thoughtless of the consequent explosions in our grey matter, called on us for an account of View Day, 1900. In former years we had always "slid off," fearful of the results of the orgie, and not wishing to be a compounder in unseemly revelry. We hasten to assure those who, like ourselves, have been misled, that there was nothing criminal or indecent in the day's proceedings, which apparently differed little from those of other "Views."

At half-past two the Treasurer, accompanied by some four or five Governors, and preceded by the Senior Beadle, bearing the mace, and whose robes of office were our envy, inspected the dispensary and out-patient departments, and thence proceeded to the wards.

'Tis a thrilling spectacle, as it may be witnessed in Coburn, when the Beadle enters and announces "The Treasurer, Almoners, and Governors." The surgeons rise, armed with a list of their cases; the visitors stand with expectant deference, and a sudden hush envelops all. The Steward calls the name of the ward and the number of the bed; the surgeon in charge of the case responds with the name of the occupant, the nature of his disease, and the length of his stay in hospital. On this day cases that have hitherto defied diagnosis resolve themselves with a beautiful assurance into simple terms. Were View Days more frequent, autopsies might be abolished, and the pathologists' office become a sinecure.

"*Quis custodiet ipsos custodes?*" But it struck us as an excellent opportunity for extending the *vivâ voce* system of examination, and we could not help indulging in unholy speculation and visions of the Senior Surgeon being "ragged." When each patient is duly accounted for, the Treasurer asks for an expression of confidence or complaints (if any) from the surgeons and nursing staff—the lowly office of dresser alone being unrecognised,—and the Steward's "Would any of the patients like to say anything?" is the signal for the Governors' rapid retreat.

But these ceremonies form only a small portion of the whole. Visitors parade the square, and inspect the library, laboratories, and theatres; they are shown the Roman sarcophagus on the school stairs, and shudder as with awe they enter the museum and catch sight of the dried contents of Case F on one side and an abdominal tourniquet on the other. Nor is this all; the junior staff appears in frock coats and patent leather boots, the porters' buttons shine again, and the lift attendants wear belts as insignia of their high calling. The fountain plays in the square, and the solubility of pot. permang. is graphically illustrated. This year counter-staining with methylene blue was attempted, but the result was more suggestive of amyloid disease than a rich harmony of colour.

The wards were resplendent with emblems of patriotism and floral decorations, to which no eye, however hypercritical, could take exception. Some had new quilts, and though all the patients were kept in bed, yet they good-naturedly forbore to complain, and appeared to enter into the spirit of the thing quite readily.

On the babies and children, as usual, lavish attention was bestowed, and their appearance upon this occasion must have enhanced their value even to their mothers' eyes. One we noticed wore a white smock, feather-stitched in crimson silk (this is no rash hazard, for we took the trouble to confirm our impression). Open house and tea in the wards brought the proceedings to a close. Visitors departed; routine and rest reigned once again.

The Annual View Dinner.

THE Annual View Dinner was held in the Great Hall on May 9th. The Hall was as well filled as is usual, the Treasurer being in the chair. After the loyal toasts had been drunk, Sir Trevor Lawrence proposed "Prosperity to the Hospital, and Ease and Health to Poor Patients." He gave the customary yearly statistics of income and expenditure, and made the customary allusions to the Christ's Hospital negotiations. Sir Trevor then read a letter from Mr Bowlby at the front, and referred to the work of the Bart.'s Sisters in South Africa. Reference was then made to the recent deaths of Sir James Paget, Sir Richard Thorne Thorne, and Mr. Parsons. The rating of hospitals was touched upon; also the action of the School Board in regard to the testing of children's eyesight.

Mr Justice Bigham proposed the toast of "The Medical and Surgical Staff," coupled with the names of Dr. Church and Mr. Willett, who respectively replied.

Mr. Sidney Holland proposed the health of "The Treasurer and Governors." He confessed that he belonged to that large class who have nothing for dinner, and dinner for nothing. He alluded to the management and abuse of hospitals, and thought that medical staffs might give more assistance in dealing with the latter grievance. He referred to the hostility of anti-vivisectionists, and the consequent withdrawal of hospital subscriptions as the result of their propaganda. He thought that the Government ought to help hospitals, yet hoped that the time was far distant when that help would be necessary.

The Treasurer returned thanks, and spoke of the difficulties of bringing St. Bartholomew's up to date, owing to its having been built 150 years ago.

Mr. Miles responded for the Governors, and proposed the toast of "The Visitors," coupled with the name of Mr. Clemens (MARK TWAIN), who responded in a speech to which we have referred elsewhere.

Mr. Charles Burt proposed the health of "The Scholars and Students of the Hospital," coupled with the name of C. J. Thomas (Brackenbury Medical Scholar), who responded in appropriate terms.

The various speeches were relieved by a musical programme, which was much appreciated.

A Letter from South Africa.

BLOEMFONTEIN, O.F.S.

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

A few days ago I received the January and February numbers of the JOURNAL, and at the sight of them was reminded of the promise I made to write and let you know what I saw here.

As soon as I reached the Cape I was sent to No. 3 Stationary Hospital, at De Aar. The journey from Cape Town to De Aar took about thirty hours. The train was comfortable, but intensely hot; the view was execrable, nothing but arid wastes, occasionally relieved by kopjes. I was told that all the farmers make large incomes out of the land, but the desolation of the scene hardly encouraged one to believe it. At De Aar the stationary hospital was really intended and equipped for 100 beds, but by the energy of the medical officer in charge, Major Perry Marsh, R.A.M.C., it had been enlarged at the time I was there to 300 beds. This number was necessary to the work. The patients were a mixed lot, wounds and medical cases. The cases making the longest stay in hospital were the medical. There were four large tin and wood huts provided with beds, very comfortable and well ventilated, and tents and marquees for the less urgent cases. The whole hospital had been grouped round a brick school-house, which was used for the worst cases of enteric.

Most of the surgical cases we got were doing extremely well. Flesh wounds by the Mauser bullet healed up generally in a few days, stiffness of the tissues traversed remaining sometimes for weeks. There was little operative surgery. Some few bullet extractions, one or two amputations, operations for hæmorrhoids, radical cure of hydrocœle, and a couple of cases of perityphlitic abscess represented a month's work.

I had charge of nine bell tents, two marquees, and a tin hut, which contained twenty cases of enteric. In relation to enteric, it is interesting to note that at De Aar spots were very numerous, enlarged spleen a constant and fairly early sign, the cases with the most copious spots often running a very rapid course to convalescence. The cases which had been inoculated, and we had several, were all slight, and convalescence was very rapid. They were often fit to return to duty six weeks after coming into hospital.

Lord Roberts visited this hospital on his way up to the front. He left the train at midnight to come and inspect the arrangements. His visit was quite a surprise, as it was only late in the evening that we heard he was passing through De Aar by special train.

I had settled down to the routine work when on February 22nd, just a month after reaching De Aar, a wire was received calling for medical officers for Paardeberg. We four civilians left at 5 a.m. the next morning, and arrived at the Modder River in the evening. There we were detained to assist in attending to a convoy of wounded, which was expected to arrive from Paardeberg through Jacobsdaal. About eight hundred wounded came in next morning, and we were all kept pretty busy looking after them. The arrangements made for their reception were excellent. Within a few hours several hundred had been dressed, fed, and started by train down the line, the worst cases going by ambulance train, the less serious in ordinary trains, under the charge of a medical officer. Many of the wounds were slight, and most of the flesh wounds were already healing up. I was struck here by the frequency with which injury to the musculo-spiral nerve goes with flesh wounds of the upper arm. Quite a number of nerve injuries from Mauser bullet-wounds were seen, and I am sorry that owing to the press of work only a rough note could be taken of the cases. In the evening six of us medicals (all civilians) left in an ambulance wagon on our journey to Paardeberg. The wagon was drawn by ten mules, and we had two native boys as drivers. The roads were very heavy—it is incorrect to call them roads—a track across the veldt marked out by the ruts formed by previous traffic is a more correct description. Their bad condition was due to the very heavy rains of the two previous days. We reached Jacobsdaal at 8 p.m., and started again at 3 a.m. in a heavy downpour of rain. Through Klip Drift and Klip Kraal we went, finally reaching the outposts of the camp at Paardeberg about 10 p.m. All along the track kept getting worse, often a sheet of water. The wagon was continually getting stuck, or lurching over great stones in a manner which made us think it was going to turn over every minute. Many dead cattle by the roadside informed us of their presence in no equivocal manner. The darkness for the last few hours of the journey, and the difficulty of finding our way, all tended to make the journey not a very desirable experience. Next morning we reported to headquarters to Colonel Stevenson, R.A.M.C., and were soon all sent in different directions. I was sent to the Seventh Co. Royal Engineers. They were engaged the same night in the trenches in the attack of the Royal Canadians. We were at work dressing the wounded during the early hours, and at daybreak got the grateful news that Cronje had surrendered. I rode over the laager during the morning. I am sure you have read excellent descriptions in the newspapers of the extraordinary sight it was, and I have no wish to renew the impression of the horrors it presented. Among the Boer sick and wounded left behind in the laager I saw one man who was completely paralysed from the effect of a lyddite charge detonating close to him. He could only move his head; his breathing was diaphragmatic; but there was no wound on him.

After a few days at Paardeberg we moved on to Macaw's Drift, and later, on the 10th of March, started from Poplar Grove for the march "on Bloemfontein." The water of the Modder River, which we were obliged to drink here in default of better, was very muddy, and of a peculiar taste. A small Berkfeld filter failed to help us in the difficulty. What water it did let through was beautifully clear, but it was necessary after each ounce filtered to remove the inner tube, and scrub it before it would work again. Of course the time required put the use of it out of question. The Boers have chosen the name of the river well—Modder—the muddy river.

At Driefontein the division I was with were not engaged, but the Sixth Division were very successful. From there we marched through Asvogel Kop and Venter's Valley to Perreira's Siding. It was most pleasant to see the railway line again after our isolation on the veldt. The march was most trying; the hot sun, the relative scarcity of water, and the nature of the ground, caused one to tire quickly. I was mounted, but even on horseback the journey was very trying, as one had to keep at a walking pace the whole time. The ground was very "tussocky" in parts, but the men came along grandly, and, owing to their previous marches, it was the exception to find them footsore. Cases of true sunstroke, by all accounts, were rare. Faintness, through weakness following

on diarrhœa—probably caused by the poor water—was fairly common. The drug available—Tinct. Opii mix in water, generally checked the diarrhœa. On the morning of the 15th March we marched into Bloemfontein, or rather to a camp on the outskirts of the town. It is a beautifully level bit of ground, and was used by the Free Staters as a rifle range. In the afternoon I went into the town, and was very agreeably impressed by it. It nestles in a hollow between two hills. There are plenty of trees about the streets, and one or two small dams of water near the outskirts. We got a pretty good rest here for a few days; but a large number of the troops began to feel the effects of the heavy strain put on them by the long marches and poor food.

On the 21st I was sent to help at a hospital which was being formed at the "Industrial School." A R.A.M.C. captain was in charge. When we got to the place, we found a very spacious building, very well ventilated and well built. It had been built to accommodate sixty boys, but when we got there there were only four left. The caretaker or master (he appeared to be a little of both) informed me that most of the boys had left at the beginning of the war—he believed to fight against us. We had a few orderlies, and the equipment of a bearer company was handed over to us. We were also told to purchase freely in the town things required for the treatment or comfort of the patients. Next day fifty wounded men came in, carried in buck wagons, who had been lying in a field hospital at Driefontein. Most of them were healing up very well. Here for the first time I saw a good many men wounded by shrapnel. Up to this time it had been exceptional to see either shrapnel or shell wounds, perhaps because the shell wounds are much more commonly fatal. There were several fractures that needed careful putting up after their long journey. Two compound fractures of the thigh, high up, due to shrapnel wounds, especially caused some anxiety. One of them had a big exit wound behind the thigh, freely discharging pus. The man, however, had little or no fever, and by careful syringing of the wound with a solution of Iodic Hydrarg. 5ijss he rapidly improved. The dressing of the wound rather interfered with the rest of the limb, but a large amount of callus rapidly formed round the site of the fracture. The shortening in both these cases was reduced to between one and one and a half inches, which was very satisfactory considering the very serious nature of the injury. All the fractures were laid on mattresses on the floor, as the spring beds were too soft, and we had no back boards available. Curiously enough, in spite of explanations of the reason, this was a cause of slight grievance to the men. As a whole, however, they were very good and patient, and very thankful for any attention paid to them. A very interesting case was a gunner, who had been touched on the right forearm by a pom-pom missile. When seen a few days after the injury, he had a large ulcer about half an inch deep, and five inches across, and both bones of the forearm were broken. He did very well. As our wounded improved, and were sent out either to duty or to the base hospitals, their places were taken by cases of fever, many of which turned out to be enteric. Most of the cases were very severe, and several cases died with hæmorrhage from the bowel, followed by peritonitis, a day or two after coming in. Evidently the moving of them was the cause of the trouble. Four days after opening the hospital, four army reserve nurses came to help. They were invaluable. The quickness with which they straightened up the wards was remarkable, and one had to be quite strict with them to prevent them overworking. At first the accommodation for them was rough—one big room being partitioned off to form a bedroom and sitting-room—but soon better arrangements were made.

On the night of the 30th I was suddenly told to rejoin my unit, and early on Saturday morning we marched out to Waterval, a long march of about twenty miles. During this march I was with a bearer company, the officers of which were down with sickness. There was a small engagement at the end of the day's march, but our division had only two or three slight casualties from bullet wounds. We, however, were kept busy collecting wounded men from the morning's fight, in which General Broadwood's Taba 'Nchu force had engaged. Two of the cases we got were men shot through the abdomen. One of them was shot a hand's breadth below the left costal arch in the nipple line, the bullet coming out behind just above the left iliac crest. He was very pale and in considerable pain when I got him. The apertures of the wound had been rapidly dressed by a comrade with his first field dressing. I gave him an injection of morphia, but was hardly surprised to hear later that he had died. The other man was shot through the liver on the right side just below the ninth rib. He had signs of considerable hæmorrhage. I heard he was alive and doing well a week later. Another case was a man shot through the left chest, close to the sterno-clavicular articulation. As far as one could see the bullet must have penetrated between the first and second ribs. There was a swelling the size of an orange when I saw him, pulsating, and emphysema over the front of his chest and spreading up his neck. He was taken into an ambulance wagon, and I heard was left on the veldt in charge of an orderly for a few hours, as it was feared the jolting was too dangerous. I did not hear how he did eventually, but he was got safely back to a field hospital later on in the day. I was in the saddle this day from 4.45 a.m., till after 10 p.m., with two biscuits and a water-bottle full of water as nourishment. The biscuits are ration biscuits, about the size of a Spratt's dog biscuit, and very hard, but very satisfying. They have a fatal effect on one's teeth, especially when these are largely artificial. The next day (1st of April) we returned to Boshman's Kop, where a field hospital had been rapidly established. About ninety wounded from the previous day's action were brought back from the Waterworks in buck and ambulance wagons. Many of them were shot in two or three places. They got into camp about 9 p.m., and it was hard work unloading them, getting them settled, fed, and dressed by the dim light of lanterns. Considering the many difficulties I think the work of the R.A.M.C. is done magnificently. Three men had died during the short journey from the Waterworks to Boshman's Kop. Every wounded man was got under cover, either in tents or farmhouse buildings, in a very short time; and it was most fortunate we were able to get them sheltered, as in the early morning a heavy rain came on. Among the wounded was a Dutch military attaché on the Boer side, who was shot in the neck, and had evidently had his spine injured, as he was paralysed below the waist. Next morning every man's wounds, whether slight or severe, were attended to, great care being taken not to disturb the first dressings next to the wound except when absolutely necessary. The successful healing of the wound greatly depends on this. The presence of dirt all around the bullet opening appears to do little harm. As soon as they were all attended to they were placed in ambulance and buck wagons and sent back to Bloemfontein. In the evening we moved to Springfield, where we camped for the night, and next morning returned to Bloemfontein. The next day (4th April) the division again went out for a two days' reconnaissance in force. Its chief interest to me was the fact that on the second night we had a very heavy downpour, which wetted me through to the skin, and as we were camped on swampy ground, when one did lie down, it was in about half a foot of mud. Luckily rheumatism is practically unknown here, the few cases I have seen being very slight and in men who have had previous attacks. Since then I have been doing duty in a field hospital. A few slightly wounded from General Gatacre's force and cases of fever are what I have seen. The cases of fever are many. Some of them turn out to be enteric, but many, after a week of temperatures ranging from 102° to 104° rapidly improve and get well. One is sorely tempted to attribute these cases to an influenza epidemic, but all respiratory symptoms are conspicuous by their absence. I have seen several old Bart.'s men in Bloemfontein. H. K. Palmer, R.A.M.C., is with the cavalry brigade. Scott, R.A.M.C., was doing duty with a town hospital; I am sorry to say he is very ill with enteric at present. It is rather a pity that he has not been inoculated. No. 9 General Hospital arrived on the 9th April (I think). I have seen J. C. S. Dunn, H. G. McKinney, and C. G. Meade, who are part of the *personnel*. I am sorry to say the two first are at present ill with dysentery, luckily not severe. Yesterday (14th April) I met Mr. Bowlby in the town—he was looking very well—and as soon as I can get away from camp I hope to make a trip to the Portland Hospital. Fletcher, R.A.M.C., is in medical charge of three batteries of field artillery in the Ninth Division.

ALEX. GRANVILLE.

The Rahere Lodge, No. 2546.

AN ordinary meeting of the Rahere Lodge, No. 2546, was held at the Restaurant Frascati on Tuesday, 8th May, 1900, the W.M., W. Bro. R. J. Reece, in the chair. Bro. H. E. Thompson, M.B., was raised to the third degree in freemasonry. W. Bro. Walter Gripper, M.B. Cantab., F.P.G.D. (Surrey), was unanimously elected W.M. for the ensuing year, W. Bro. Clement Godson was re-elected Treasurer, and Bro. P. F. Madden was elected Tyler. The brethren and their guests afterwards dined together to the number of thirty-five.

The next meeting of the Lodge will be held (by the kind permission of the Treasurer and Almoners) in the Great Hall of the Hospital on Tuesday, 12th June. As it is the Installation meeting the usual goodly muster of members of the Lodge is expected.

Amalgamated Clubs.

BALANCE-SHEET, 1898–9.

	£	s.	d.
To Members' Subscriptions	807	11	0
,, Grant from Medical School	100	0	0
,, Profit on the JOURNAL	6	14	9

Audited and found correct according to vouchers and bank pass-book.

H. MORLEY FLETCHER.
LOUIS BATHE RAWLING.
REGINALD BIGG.

2nd May, 1900.

£914 5 9

By Grants to Clubs:	£	s.	d.	£	s.	d.
Rugby Football Club	12	8	6			
Association Football Club	15	14	0			
Boxing Club	23	13	0			
Shooting Club	22	4	0			
Swimming Club	17	9	0			
Lawn Tennis Club	20	5	0			
Hockey Club	6	5	0			
Cricket Club	26	12	7			
Athletic Club	41	8	0			
				185	19	1
By Abernethian Society, 101 members at £1 1s. ...				106	1	0
,, Musical Society				20	0	0
,, Maintenance and Reserve Fund				602	5	8
				£914	5	9

MAINTENANCE AND RESERVE FUND, 1898–9.

	£	s.	d.
To Balance from 1897–8	189	18	5
,, Funds as per General Account	602	5	8
,, Sale of Refreshments	9	17	7

Audited and found correct according to vouchers and bank pass-book.

H. MORLEY FLETCHER.
LOUIS BATHE RAWLING.
REGINALD BIGG.

2nd May, 1900.

£802 1 8

By	£	s.	d.
Rent of ground	300	0	0
,, Rates, taxes, and water	43	3	3
,, Coal, &c.	8	2	0
,, Refreshments, &c.	19	6	0
,, Wages of ground-men and boy, keep of horse, and general maintenance of ground and pavilion	143	8	4
,, Band, Past & Present	5	5	0
,, Cheque Books	0	8	4
,, General Secretary's petty cash	5	6	6
,, Wages of clerk	5	0	0
Balance at bank	272	2	3
	£802	1	8

CRICKET CLUB.

President.—Dr. Church.
Captain of 1st XI.—H. E. Scoones.
Secretaries of 1st XI.—H. E. G. Boyle, H. B. Hill.
Captain and Secretary of 2nd XI.—J. Corbin.
Committee.—H. W. Pank, J. C. Sale, H. Whitwell, C. F. Nicholas, H. E. Stanger-Leathes, C. A. Anderson, T. H. Fowler, G. G. Ellett.

MATCHES.—FIRST XI.

Date.	*Opponents.*	*Time.*	*Ground.*
Wed. May 2	Trial Game		Winchmore Hill
Sat. ,, 5	Beckenham	11.30	Beckenham
Sat. ,, 12	M.C.C.	11.30	Winchmore Hill
Wed. ,, 16	Hornsey	11.30	Winchmore Hill
Sat. ,, 19	Henley	11.30	Henley
Sat. ,, 26	Richmond	11.30	Richmond
Sat. June 2	Barnet	2.30	Winchmore Hill
Sat. ,, 9			
Wed. ,, 13	Past and Present	11.30	Winchmore Hill
Sat. ,, 16	Addlestone.....	11.30	Addlestone
Sat. ,, 23	Heath Asylum	11.30	Bisley
Wed. ,, 27	Kensington Park	11.30	Winchmore Hill
Sat. ,, 30	Dunstable Grammar Sch.	11.30	Dunstable
Sat. July 7	Hampstead	11.30	Hampstead
Sat. ,, 14	R.I.E.C.	11.30	Cooper's Hill
Sat. ,, 21	Surbiton	11.30	Surbiton

SECOND XI.

Wed. May 2	Trial Game		
Sat. ,, 5			
Sat. ,, 12	London Hospital	2.30	Edmonton
Sat. May 19	Mary's Hospital	2.30	Winchmore Hill
Wed. ,, 23	Guy's Hospital	2.30	Honor Oak Park
Sat. ,, 28	Blackheath School	2.30	Blackheath
Wed. ,, 30	St. Thomas's Hospital...	2.30	Chiswick
Wed. June 6	St. Mary's Hospital	2.30	Winchmore Hill
Sat. ,, 9			
Sat. ,, 16	Hospital Employés	2.30	Winchmore Hill
Wed. ,, 20	Blackheath School	2.30	
Sat. ,, 23	St. Thomas's Hospital...	2.30	Winchmore Hill
Wed. ,, 27	Banstead	11.30	Banstead
Sat. ,, 30	Virginia Water.....	11.30	Virginia Water
Sat. July 7	Guy's Hospital	2.30	Winchmore Hill
Wed. ,, 11	Claybury	11.30	Claybury
Sat. ,, 14	London Hospital	2.30	Winchmore Hill
Sat. ,, 21	Merchant Taylors' Sch. .	2.30	Winchmore Hill

ST. BART.'S *v.* BECKENHAM.

The first match against Beckenham was played on Saturday, May 5th, at Beckenham, and ended in a win for the home team. Beckenham, who had an exceedingly strong side, batted first, and we soon began to feel the want of some good bowlers. "More bowlers and better bowlers" has been our cry for some time, and this year it is more so than ever. Beckenham eventually declared, having made 340 for 5 wickets, and we were left with about three hours to bat; during this time we made 232, which, all things considered, was a very creditable performance. For the Hospital Ellett, who made 39, batted exceedingly well. Nealor and Boyle also did well; the former, whose first match this was for the Hospital, made 81, and is to be congratulated on the very excellent commencement he has made in hospital cricket. Boyle made 65, and it was unfortunate that both Nealor and he should have been run out, as,

when they were together, there seemed every possibility of a draw. Eventually our last wicket went down three minutes before the time for drawing.

SCORES.

BECKENHAM.		ST. BART.'S.	
C. O. Cooper, c Nealor, b Anderson	47	H. E. Scoones, b W. B. Baker	12
A. A. Torrens, st Fowler, b Nealor	70	C. A. Anderson, c P. C. Baker, b A. A. Torrens	3
P. C. Baker, c Scoones, b Nealor	50	G. G. Ellett, c Todd, b W. B. Baker	37
W. M. Torrens, c Anderson, b Ellett	91	W. S. Nealor, run out	81
W. B. Baker, c Anderson, b Boyle	17	T. H. Fowler, b W. B. Baker	5
J. H. Todd, not out	32	H. E. G. Boyle, run out	65
A. A. Baker, not out	24	C. F. Nicholas, b A. A. Baker	0
T. K. Stenning, C. M. Baker, A. Williamson, R. Curwen } did not bat.		H. D. Hill, c P. C. Baker, b Curwen	3
		H. T. Wilson, b A. A. Torrens	12
		J. Corbin, b A. A. Torrens	0
		C. H. Fernie, not out	0
Extras	9	Extras	14
Total (5 wkts.)	*340	Total	232

* Innings declared.

ST. BART.'S *v.* M.C.C.

This match was played at Winchmore Hill on Saturday, May 12th, and ended in a win for the M.C.C. by 31 runs. The M.C.C. batted first, and made 117. This total we ought to have exceeded, but the wicket was bad, and Brown's fast deliveries jumped about in rather an awkward way, and we were all out for 86. For the Hospital Anderson bowled well, as his analysis, 6 wickets for 26, shows.

M.C.C.		ST. BART.'S.	
C. G. Hulton, b Boyle	7	H. E. Scoones, c Carlin, b Moorhouse	6
Carlin, c Boyle, b Anderson	13	G. G. Ellett, b Brown	17
Major Greenway, c Scoones, b Boyle	7	C. A. Anderson, b Brown	5
Brown, c Wilson, b Anderson	1	C. F. Nicholas, c Brown, b Moorhouse	4
N. H. Balfour, run out	0	T. H. Fowler, c and b Brown	9
P. Lofts, st Fowler, b Anderson	29	H. E. G. Boyle, c Hulton, b Brown	14
B. S. Cave, c Fowler, b Anderson	32	H. B. Hill, b Brown	7
F. J. M. More, b Anderson	0	H. T. Wilson, b Moorhouse	16
Moorhouse, not out	13	L. V. Thurston, not out	5
G. C. Ives, c Holbrook, b Anderson	0	F. Connor, c Brown, b Moorhouse	2
W. Meyrick, b Boyle	1	H. Holbrook, c Carlin, b Moorhouse	1
Extras	8	Extras	0
Total	117	Total	86

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
C. A. Anderson	17	4	25	6
H. E. G. Boyle	15	2	45	3
C. F. Nicholas	3	0	8	0
F. Connor	5	0	30	0

UNITED HOSPITALS' CRICKET CLUB.

The following is the draw for the Cup Ties for 1900:

First Round.

St. Mary's (Holders) *v.* Guy's.
St. Bart.'s *v.* King's.

Second Round.

Westminster *v.* Charing Cross.
University *v.* Middlesex.
St. Thomas's *v.* London.

First Round to be played on or before June 1st.
Second " " " " " 15th.
Semi-final " " " " " 29th.
Final " " " " July 13th.

LAWN TENNIS CLUB.

President.—Howard Marsh, Esq.
Captain.—C. M. Pennefather.
Hon. Secretaries.—E. H. Hunt, A. O'Neill.
Committee.—G. V. Bull, L. E. Hughes, L. Toswill, C. L. Nedwill, J. K. N. Marsh, H. Walker, F. E. Murray, H. Whale.

MATCHES.

Date.		*Name of Club.*	*Where Played.*
Sat.	May 5	Practice	Winchmore Hill
Wed.	" 9	Practice	Winchmore Hill
Sat.	" 12	Wanstead L.T.C.	Wanstead
Wed.	" 16	Hornsey L.T.C.	Winchmore Hill
Sat.	" 19	N. Kensington L.T.C. 2nd	North Kensington
Wed.	" 23		
Sat.	" 26	Balliol College, Oxford	Oxford
Wed.	" 30	Wimbledon Park	
Sat.	June 2	Wanstead L.T.C.	Winchmore Hill
Wed.	" 6	Albemarle L.T.C.	Winchmore Hill
Sat.	" 9	N. Kensington L.T.C. 2nd	Winchmore Hill
Wed.	" 13	Past *v.* Present	Winchmore Hill
Sat.	" 16	Cooper's Hill L.T.C.	Egham
Wed.	" 20	Winchmore Hill L.T.C.	Winchmore Hill
Sat.	" 23	Bromley L.T.C.	
Wed.	" 27	Connaught L.T.C.	Chingford
Sat.	" 30	Dulwich L.T.C.	Dulwich
Wed.	July 4	Connaught L.T.C.	Chingford
Sat.	" 7	Tufnell Park L.T.C.	Winchmore Hill
Wed.	" 11	Cooper's Hill L.T.C.	Egham
Sat.	" 14	Albemarle L.T.C.	Beckenham

MATCHES.

ST. BART.'S *v.* HORNSEY L.T.C.

Played at Winchmore Hill on May 16th, and resulted in a win for the Hospital by 6 matches to 1.

Doubles.—E. H. Hunt and H. Whale—
lost to E. E. Adamson and J. Lewis, 8—10, 5—7.
beat A. E. Duncan and L. Tubbs, 6—0, 6—1.
beat T. W. Sloper and D. C. Bryer, 6—1, 6—2.
J. Stirling-Hamilton and F. H. Wood—
beat Adamson and Lewis, 7—5, 4—0, 0—2.
beat Duncan and Tubbs, 6—3, 6—0.
L. E. Hughes and F. E. Wood—
beat Duncan and Tubbs, 6—3, 4—6, 6—1.
beat Sloper and Bryer, 6—4, 6—4.

ST. BART.'S *v.* NORTH KENSINGTON L.T.C. 2nd.

Played at North Kensington ground on Saturday, May 19th, and resulted in a win for the Hospital by 7 matches to 2.

Doubles.—E. H. Hunt and A. O'Neill—
beat W. H. Beall and A. W. Andrews, 6—2, 4—6, 6—0.
beat H. D. Brown and M. Cottam, 6—0, 5—7, 6—4.
beat S. Simond and H. B. Gourlay, 6—, 7—5.
C. L. Nedwill and H. Whale—
beat Beale and Andrews, 6—4 (retired).
beat Brown and Cottam, 6—3, 2—6, 6—2.
beat Simond and Gourlay, 6—0, 6—3.
J. Stirling-Hamilton and L. Furber—
lost to Beale and Andrews, 2—6, 2—6.
lost to Brown and Cottam, 4—6 (retired).
beat Simond and Gourlay, 6—4, 6—3.

BOAT CLUB.

It is now ten years since there has been an active boat club at the Hospital, and one year more since we have been represented in the United Hospitals' Cup.

At the end of the year 1893 the club was re-formed and officers were appointed, but there the attempt to re-start rowing ended.

On May 9th a meeting was held with the object of reviving the boat club, and it was decided to make an attempt to get together a crew to represent the Hospital in the Cup, and that rowing at the Hospital should otherwise be encouraged. The following officers have been elected:

President.—H. T. Butlin, Esq, F.R.C.S.
Vice-President.—W. Bruce Clarke, Esq, F.R.C.S.
Captain.—H. U. Gould.
Committee.—F. G. Nokes, J. G. Slade, W. V. Wood.

Practice was started on May 9th. The services of Mr. R. B. Etherington-Smith, ex-president of the C.U.B.C., who we hope will be able to row for us next year, have been obtained as coach, and under his able tuition the crew is improving steadily. The men are at present rather rough, and not so well together as might be desired; they are, however, a fairly strong lot, and, all having done a good deal of rowing before, should render a good account of themselves in the race. The crew is composed as follows:

Bow, J. G. Slade; 2, H. E. Graham; 3, F. G. Nokes; stroke, H. U. Gould; cox, W. V. Wood.

The other hospitals competing are the London, St. Thomas's, and St. George's (the holders). The boats seem to be a very level lot, and the race on Saturday, May 26th, should be well contested. It is to be rowed from Putney to Hammersmith, starting at 11.15 a.m. The steamer starts from the Old Swan Pier at 10 o'clock. Application for tickets should be made to the captain at once.

The following club races are to be rowed, probably on June 30th. Scratch fours, ¾ mile; scratch pairs, ¼ mile; and handicap sculls, 1¼ miles. It is hoped that there will be good entries for these events, and that all who take an interest in rowing will do their best to make them a success.

The club dressing-room is at Thompson and Bower's, Putney. Boats for practice can be obtained daily, and those wishing to row should let the captain know at once, so that crews may be made up, and coaches arranged.

Reviews.

EXPERIMENTS ON ANIMALS, by STEPHEN PAGET, with an Introduction by Lord LISTER. (London: T. Fisher Unwin, 1900. Price 6s.)

A most opportune little work, and by an author whose credentials for the essay he undertakes are beyond dispute. Mr. Paget's experience whilst Secretary of the Association for the Advancement of Medicine by Research not only enabled him to attain a wide familiarity with the history and efficacy of animal experimentation, but also acquainted him with the working of the Vivisection Act. The *motif* of the book is admirably suited to all who are looking out for an honest and deliberate statement of the facts connected with the subject, and the author's rigid avoidance of the many argumentative side issues which create the confusion found in too many minds, even amongst our own profession, will doubtless be fraught with excellent results.

A calm perusal of these 200 pages must inevitably settle once for all, in the mind of the most prejudiced reader, the question of the utility of vivisection. So that to argue the matter on any other than purely ethical grounds becomes mere waste of words. To have gained even this much is something to be thankful for. We most strongly recommend the book to our readers both as a fascinating record of the various steps in the progress of medicine, preventive and curative, and as a fund of facts wherewith to meet the anti-vivisector.

The sections dealing with serum treatment and preventive inoculation are brought fully up to date, and the text of the Act relating to experiments on animals is given for reference.

THE STUDENT'S HANDBOOK OF THE SURGERY OF THE ALIMENTARY CANAL; being an abridged and amended edition of the author's treatise on the same subject, by A. E. MAYLARD, M.B Lond. (J. and A. Churchill, London. Price 8s 6d.)

The alimentary canal is treated of in four parts,—the œsophagus, the stomach, the small and large intestine, and the rectum. The various diseases affecting each part are preceded in each case by a short but accurate discourse on the anatomy and physiology of the particular viscus in question. This in itself is an obvious advantage, which might well be copied in other and larger works. Taken as a whole, this book affords interesting matter, and will repay reading, not only by the student, but also the general practitioner. The author has condensed into a small volume a great deal of information, including many extremely rare diseases of this part of the system. Most of the larger subjects are ably described, but we may perhaps single out those on carcinoma of the œsophagus, appendicitis, and intestinal obstruction as being the best. Each section is well up-to-date and concise. Two objections we have, however, to the book. Firstly, the operations might very well be further condensed, some of them being so rarely performed that they might with advantage be left out in an abridged edition. For instance, the operations of internal œsophagotomy and gastrectomy would not be missed, and Howse's method of performing gastrostomy might well be inserted in their place. This latter operation, though very frequently done, is not mentioned. The second objection is that the paper used for the book is bad. This is a fault which is too common in the cheaper editions of medical works, and a great disadvantage to those who are accustomed to making side-notes. Otherwise the book is well got up, and the illustrations are good.

LETTER-, WORD-, AND MIND-BLINDNESS, by JAMES HINSHELWOOD, M.A., M.D., etc. (London, H. K. Lewis, 1900. Price 3s.)

A permanent issue of five very interesting lectures upon this subject which have appeared in the *Lancet*. Chapter I on "the visual memory" is as good an account of this important factor in brain physiology as we remember to have seen. The cases quoted in the succeeding chapters are worth careful study, both for their intrinsic interest and on account of the admirably lucid manner of their description. We commend them as models for this most difficult subject of clinical note-taking. Their importance as actual cases is no less great to the physician than to the ophthalmologist. The book is very neatly bound and well printed.

A MANUAL OF GYNÆCOLOGICAL PRACTICE, by Dr. A. DÜHRSSEN, translated by Messrs Taylor and Edge. (London: H. K. Lewis. Price 6s.).

This, as a guide to the practice of midwifery, is one of the very best of the minor text books. It is eminently practical and sound; wherever the treatment differs from the usual method as obtains in England, it is only because that treatment is now the one recognised in Berlin.

The translation of the text is excellent, and we must congratulate the joint editors on their work, especially as we suffer so much nowadays from Americanised German work.

The book will will be found of the greatest value to the general practitioner on account of the exact details given for the various methods of treatment, and also for the lucid way in which the reasons for any special line of procedure are explained.

NOTES ON MIDWIFERY, by T. A. GLOVER. (Edinburgh: E. and S. Livingstone. Price 2s. 6d.)

This small book of 100 pages, intended as an introduction to the subject for students, can hardly be recommended on account of the indefiniteness of its instruction, together with the inaccuracy of its facts.

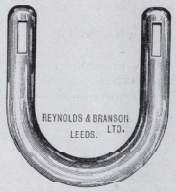
Some chapters, especially those on abortion and the management of ordinary labour, are instructive and well written, but the remainder of the work is almost unsafe in students' hands.

Thus eclampsia, that awful accident to a pregnant woman, is dismissed without any mention of the word urine throughout the chapter; the treatment is given just at the last line in these words: "As a general rule labour may be left to take care of itself." Puerperal fever is dismissed in a page and a half, whilst phlegmasia alba dolens is called the most common of all the puerperal diseases. No mention of absolute rest is made in its treatment, and quinine, iron, and iodine ointment gently rubbed in are given as the main indications. Many of the diagrams are old and incorrect,—to wit, the heights of the uterus at the different months of pregnancy, copied from Playfair; whilst the text itself is frequently not free from blame. Thus "scybalæ" for fæcal masses, "cartilaginous" as applied to the texture of a cervix, etc., are scarcely correct. The pathology is weak, and the treatment frequently heroic or old-fashioned.

New Productions.

MR. HAMILTON WHITEFORD, of Plymouth, sends us an account of a horseshoe which he has recently introduced, to be used instead of a straight rod for enterostomy or colostomy. Mr. Whiteford claims to "have found the horseshoe far more useful than the straight

metal or glass rod usually employed in performing enterostomy or colostomy. The rod nearly always impinges on some bony prominence, such as the crest of the ilium, and very easily slips out. The horseshoe is easily retained by winding gauze round it and the



bowel, or by tapes, and lies comfortably away from all bony points. In those cases of distended abdomen or short mesentery in which it is impossible to bring the bowel *outside* the abdomen, by allowing the ends of the horseshoe to tilt, the bowel can often be kept in apposition with the parietes, which cannot be done with a straight rod. Where a large portion of intestine has to be fixed outside the abdomen, as in the case of a new growth, both ends of the horseshoe may be passed through the mesentery, the ends pointing towards the umbilicus. The horseshoe has been made of German silver by Messrs. Reynolds & Branson, Limited, of Leeds; price *2s. 6d.* each.

Examinations.

UNIVERSITY OF CAMBRIDGE.

Third Examination.

Surgery and Midwifery.—J. G. Cooke, R. L. V. Foster, N. Maclaren, A. S. Mellor, S. C. Newman, G. H. Orton, H. H. Riddle, J. C. A. Rigby, L. B. Scott, R. H. Urwick, H. Walker, W. W. Wingate Saul.

Medicine.—S. Bousfield, G. V. Bull, W. S. Darby, W. M. Fletcher, J. Gutch, J. W. Malim, W. M. Willoughby.

Examination in Sanitary Science.—H. W. P. Young.

UNIVERSITY OF DURHAM.

Third Examination.—R. Walker.

Final Examination.—H. R. Ellis.

CONJOINT BOARD.

First Examination.

Chemistry and Physics.—W. H. G. Thorne, W. T. Williamson, A. H. Bloxsome, A. F. C. Pollard, L. F. Chambers, A. H. Muirhead.

Practical Pharmacy. F. Harvey.

Elementary Biology.—W. H. G. Thorne, W. T. Williamson, E. R. Aylward, R. C. P. Berryman, P. V. Bhatt, W. R. Collingridge, P. A. Dingle, W. S. Edmond, C. Elliott, W. E. L. Fowler, F. H. G. Gosse, J. P. Griffin, C. B. Hambling, E. W. D. Hardy, C. D. M. Holbrooke, A. M. A. James, T. A. Killby, H. J. S. Klimbell, E. B. Lathbury, C. Loddiges, T. O'Neill, E. W. M. Paine, H. H. Rolfe, H. B. Scott, C. O. O. Williams.

Second Examination.

Anatomy and Physiology.—W. E. Lee, W. A. H. Moses, G. E. Aubrey, R. J. P. Thomas, F. M. Bishop, A. F. Forster.

The following have completed the examination and received the Diplomas of M.R.C.S., L.R.C.P.:—T. S. Arbuthnot, H. C. Adams, C. S. Hawes, C. H. D. Robbs, W. C. Douglas, H. St. Clair Elliott, S. Hey, W. M. James, A. H. Bostock, H. W. Illius, G. J. A. Leclizio, A. J. W. Wells, C. C. C. K. White, F. M. Howell, S. Neave, H. M. Pearce, R. J. Morris, P. Tatchell.

First Fellowship Examination.

H. Burrows, J. D. Hartley, N. E. Waterfield, H. V. Wenham.

Appointments.

BREWER, A. H., M.R.C.S. L.R.C.P., appointed Assistant House Surgeon to the Royal Infirmary, Leicester.

* * *

DUNN, W. E. N., M.B.Lond., M.R.C.S., L.R.C.P., appointed Surgeon to the P. & O. ss. 'Nubia' (hospital ship).

* * *

EVERINGTON, H. D., M.B.Lond., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the Royal Hospital for Women and Children, Waterloo Road.

* * *

ILLIUS, H. W., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Royal Southern Hospital, Liverpool.

* * *

MAIDLOW, W. H., M.D., B.S.Dunelm, F.R.C.S.Eng., appointed M.O.H. Ilminster Urban District.

* * *

PEKKAM, C. H., M.D.Lond., M.R.C.S., L.R.C.P., appointed Assistant Physician to the Bedford County Hospital, *vice* T. Hammerton Edwards, M.D.Cantab., resigned.

* * *

ROBBS, C. H. D., B.A.Oxon., M.R.C.S., L.R.C.P., appointed House Physician to the Royal Free Hospital.

* * *

STAWELL, R. DE S., M.B.Cantab., F.R.C.S.Eng., appointed Medical Officer to Shrewsbury School.

Birth.

CLARKE. On April 18th, at Nottingham, the wife of F. A. H. Clarke, M.R.C.S., L.R.C.P., of a son.

HORTON-SMITH.—On April 27th, at Upper Westbourne Terrace, W., the wife of Percival Horton-Smith, M.D., F.R.C.P., of a daughter.

Marriages.

COLBY—BRYANT.—On the 1st inst., at St. Mark's Church, Surbiton, Francis E. A. Colby, Esq., M.B., F.R.C.S., son of W. Taylor Colby, Esq., M.D., of Malton, Yorkshire, to Elsie, daughter of the late Arthur Charles Bryant, Esq., and Mrs. A. C. Bryant, of Oak Hill Lodge, Surbiton.

JOY—CONEY.—April 18th, at St. James' Church, Birkendale, by the Rev. C. V. Wansbrough, M.A., Rector of High Bickington, assisted by the Rev. R. Stephenson, M.A., vicar of the parish, Norman H. Joy, M.R.C.S., L.R.C.P., of Bradfield, Berks, to Ethel Mary, younger daughter of the late Herbert Coney, of Haselor, Warwickshire.

ACKNOWLEDGMENTS.—*London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review, The Practitioner, University College Magazine, The Student, The Hospital, League News, Transactions of the Students Society of Dental Hospital.*

St. Bartholomew's Hospital Journal.

VOL. VII.—No. 9.] JUNE, 1900. [PRICE SIXPENCE.

NOTICE.

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

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

All communications, financial or otherwise, relative to Advertisements ONLY, should be addressed to J. H. BOOTY & SON, *Advertising Agents, 30, Holborn, E.C.*

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

St. Bartholomew's Hospital Journal,

JUNE, 1900.

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

THE Council of the Metropolitan Radical Federation has tendered its memorial to the Committee of the Prince of Wales' Hospital Fund, the latter has replied, and a further rejoinder has been added by the Federation, which apparently still remained unconvinced. A more or less detailed report has lately appeared in the daily papers, from which we feel sure that the public must recognise the Federation's assertions to be as groundless and untenable as they are calumniating.

With reference to the charge brought against the medical schools of appropriating the hospital funds: "for ourselves," as a morning paper remarks, "we are inclined to regard a medical school as an essential part of a hospital." And, indeed, a distinct line between the two would be hard to draw. The school depends on the hospital for many demonstrations, and a large part of the hospital work is performed gratuitously by dressers and clerks—what would happen, we wonder, should these one day elect to strike? *Quod dii avertant.* But it would be an overwhelming argument against many of the Federation's allegations. Again, the hospital is dependent on laboratories for many diagnoses to which treatment is subservient. However, quite apart from these arguments the following quotation from the Report is a conclusive answer to this accusation:

The utmost that can be made of the charge is that some minute unascertained portion of a grant for general purposes may have percolated under the administration of the hospital concerned into a medical school or laboratory. But even this has been guarded against, and, so far as the committee can ascertain, no such percolation has actually occurred.

The awards made by this fund to the hospitals have been made with certain conditions, following as nearly as possible the recommendations of the visitors who have inspected and reported on them; and these awards, and the objects for which they were made, are stated in the annual reports of the fund, and have also been published in the public press. In no case can there be found in these reports an award given for a medical school or laboratory. Nor can it be fairly said that the hospital authorities have, in fact, used any part of such grants for medical schools and laboratories.

In administering this fund the committee have endeavoured in all cases to aid the hospitals in the manner best suited in the case of each hospital to benefit the sick and suffering poor of London, and they have no reason to believe that the eminent authorities who are associated with the large and important hospitals that have medical schools have done otherwise than act to the best of their ability in promoting the highest interests of the hospital patients.

But even with this direct language the Radical Federation is not satisfied. It apparently either disbelieves or disregards the report, and concludes its rejoinder by the following peroration:

That the medical schools and the laboratories licensed for vivisection which publish no accounts should be subsidised by grants out of funds subscribed by the charitable for the tending of the sick remains, in the opinion of the Federation, one of the gravest scandals of our time, against which, as representing a very large body of working men, they feel bound solemnly to protest.

That the committee of the Prince of Wales' Hospital Fund should make no effort to discountenance this scandal, but should even fail to fulfil a definite pledge made by His Royal Highness that his Hospital Fund should be free from it, cannot but be a matter of serious concern to every one who regards the interests of the patients as paramount in our hospitals.

But the profoundest regret of all is felt by every member of the Federation that His Royal Highness should allow the pledge he gave in this matter to be openly disregarded by his committee, and should

suffer the great influence of his name and person to be employed in defending the diversion of money by hospital managers in London to purposes for which it was not contributed.

Thus, then, the matter at present stands, and we are gratified to reflect that by their verbose anxiety to substantiate their grievance, and their refusal to admit the Executive Committee's report, they have cut the ground from under them.

We are not alarmists, and we should imagine that lay opinion is quite sufficient to cope with this outbreak of ignorant bickering. Indeed, as Sir Thomas Smith remarked in his opening address to the Abernethian Society in 1898, "the prejudice that existed against hospitals among the poor has entirely disappeared; they no longer regard a hospital as a place 'where they cut you up'—a common expression in past time. The difficulty now-a-days is to keep them out of a hospital, and this applies especially to those whose social position scarcely justifies them in availing themselves of hospital treatment." Medicine has lived down, or is living down, bone-setters, homœopathists, *et hoc genus omne*, and is now quite convalescent from an attack of Christian Scientists. It may be trusted to resist the inroads of the Council of the Metropolitan Radical Federation also.

A Letter from Mr. Bowlby.

PORTLAND HOSPITAL,
BLOEMFONTEIN;
May 19th, 1900.

WE have now been established here since April 15th, and have had a pretty busy time of it. During the last part of our stay at Rodebonsch there was but little to do, as for at least a month before we left there had been no fighting of importance, and we were glad to move to the front, where there was promise of more work. The packing up of a hospital is not a very simple matter, but everything was ready when the day arrived for our sixty tons of tents, wooden cases, and packages to be taken to our special train. We were then delayed by an unforeseen accident, for the large traction engine which was sent to fetch us broke through a bridge close to our camp, and carried away the whole road into the bed of a small stream with steep banks. This would not have been the cause of any delay had it not been that there was no other road into our camp, and it was forty-eight hours later before the engine was got on level ground, and we got our things to train. Dr. Tooth and I went on by the mail, and arrived here in time to mark out a site for a camp before our equipment arrived three days later. The journey was interesting, taking us past Arundel and Rensberg, where there has been so much fighting, and then over the river at Colesberg, where the big bridge has been so effectually blown up at a place where the Orange River is about as wide as the Thames at Richmond, though not so deep. At Springfontein we were warned that the train might be attacked, and took an escort of 200 men to be prepared for emergencies; but the night passed quietly, except for a severe thunderstorm, and we awoke in Bloemfontein Station.

This is a pretty little town of about 5000 inhabitants, with some wooded kopjes at its northern side, on the slopes of which some of the newly-built houses have been erected. On the east, west, and south are grass plains, extending for many miles, and sloping down to the town, so that the latter lies in a hollow. There are pretty villa-like residences, with flowers and trees, and a wide central street, with a market square, and containing some very good buildings, many of which are now used as hospitals.

We found a suitable site for the hospital on some rising ground a mile from the edge of the town on its south side, and near to two good deep wells, which were the chief attraction, for owing to the occupation of the Waterworks by the enemy, water is both scanty and bad in and near the town, and has to be carted to all sorts of distances for troops and hospitals. We got our own tents and some tents for orderlies pitched, and then on Saturday, April 14th, we unloaded our train at a siding, and sent some of our goods up by traction engine and various mule waggons, but the bulk of them were delayed till the evening for ox transport. It was most unfortunately a dark, rainy night, and at about 9 p.m. shouts in the distance announced the arrival of a train of waggons, each drawn by sixteen oxen, and spreading over a distance of about half a mile. We had these drawn up around the camping ground as best we could in the darkness, and then for about two hours unloaded the cases and packed them under tarpaulins, but, of course, lots of things got wetted. Next night was also wet, and the night after my own tent was wrecked in a hailstorm, and the mess tent narrowly escaped a similar fate. But as the days were fine we got our camp pitched, and dried our damp blankets and mattresses, and were soon ready to receive patients. From that time onwards there has been continued fine weather, brilliant, clear, sunny days, a fresh breeze, and cold nights, and yet, as I shall tell you, a terrible lot of sickness.

When we arrived here there were yet no general hospitals at work, because of the impossibility of getting their equipment past the broken bridges at Colesberg and Bethulie; the sick in consequence had to be accommodated in buildings in the town, and in the tents of the field hospitals. One man undoubtedly brought typhoid fever with him from the Modder, so that soon after their arrival here enteric broke out and spread with terrible rapidity, all the more because the men were without tents in wet weather, short of proper clothes and boots, and often on short rations. There were no doubt other reasons for our army remaining here, notably want of horses and stores, but the fulness of the field hospitals would alone have kept them, for not one of them could move. Equipped to hold 100 men on mackintosh sheets, and meant for temporary use in the field, these hospitals had to take 300 or 400 men without any increase in the number of orderlies and of medical officers, and had sometimes more than 100 cases of enteric sleeping five or six in a nine-foot bed tent. It could not easily be helped, but it emphasises the trouble an enemy can do by blowing up bridges and stopping supplies, and when Nos. 8 and 9 general hospitals got to work each of them had to expand from 500 to 1500 beds to take in the accumulation of the last few weeks. The result was that when on May 1st our army moved north there were 4000 sick left behind, including 1100 typhoids, and funerals were sometimes as numerous as twenty a day, or even more. In addition to enteric there is a great deal of diarrhœa, to which every one seems subject, and a certain amount of fever of a nondescript character, but which sometimes turns out to be typhoid. You will have some idea of the amount of sickness when I tell you that within ten days of our troops moving north more than 700 of them came back here sick to our already overcrowded hospitals.

So much then in general of Bloemfontein and its sick, but I must tell you a little also about its wounded. Fighting recommenced about April 20th, and soon after that Makins (who was staying with us at the time) and myself went out to the scene of the fight at the Waterworks, twenty-three miles to the east. We had a very interesting time in an Indian Tonga, of which twenty have been presented to the army for the wounded, and on our arrival found that Major Marshall, commanding "Marshall's Horse," and three of his officers and various men had been hit, as well as some men from other regiments. One man had been hit by a bullet in front of the left ear, and the skull on the right frontal region was broken but not penetrated, so we advised operation, and Makins, after opening up the bone, found the bullet in the subjacent brain. The man came on here afterwards, but died in ten days' time without recovering consciousness. We sent the rest of the wounded straight here. One officer had been shot through the middle of his sacrum and out through the abdomen, two inches above and to the left of the pubes. We left him alone, giving no food by the mouth except sips of broth for several days. He had no bad symptoms at all at first, but in a fortnight's time he had an attack of some abdominal pain and signs of localised peritonitis, which gradually passed away; he is now convalescent. We next took in about thirty wounded from the cavalry division fights near Thaba-'Nchu, and among them were three men shot through the lower end of the femur and the knee-joint with only drilling of the bone and no complete fracture. All their joints were full of fluid, but all did well. We had also a compound fracture of the femur, and various men shot through the chest and extremities. Most of the chest cases have hæmothorax, and in most of them there is a regular fever of a week or even a fortnight's duration, the temperature often reaching 102°, and making one think of suppuration; yet of twenty or thirty such cases I have seen only one that has suppurated, and where by operation the chest has been opened to let out the blood many cases have gone to the bad. In one case I saw at the Cape an officer had been shot through the chest, and the bullet was lodged under the skin, where it proved too tempting to the surgeon, who removed it at the field hospital, with the result that suppuration ensued and a very bad empyema followed. It is impossible to secure complete asepsis in the field and in the ox-transport, which is liable to take up the next three or four days. The bullet might well have been left or else removed later when the pleura was shut off. Then we had six Boers, one of whom had a bad compound comminuted fracture of the lower end of his femur, and another cellulitis of the leg after a bullet wound. They all did very well. After that came more officers and men of the cavalry, so that I had about fifty wounded in a very few days. Another of the last arrivals was also hit through the knee-joint, and one of them was hit through the ulnar nerve, the bullet passing on and lodging in the abdomen, but causing no symptoms. After that, a couple of days later, fifteen wounded arrived one night at 11 p.m., together with twenty sick. One man, a trooper in "Kitchener's Horse," was one of twenty-five men who came all the way from Argentina at their own expense, providing horse and saddlery and all kit and enlisting here on arrival. This man was first shot through the fleshy part of his shoulder, then through the right buttock whilst lying down firing, then through the left buttock, whilst finally his firing was stopped by a bullet smashing his forearm; but he is doing very well.

In another case, a man from the same regiment had been shot through the forearm with a so-called "explosive" bullet. The wound of entry is quite small and on the radial side, but the wound of exit is six inches long and nearly four inches wide, and through it protrude masses of muscles and fascia with fragments of bone embedded in them, the whole looking rather like a huge ulcer caused by a breaking-down malignant tumour. You would have supposed that no bullet could possibly have done such damage; it looks like the work of a large shell fragment. The ulnar vessels and nerves are shot away, but I am trying to save the arm.

Injuries of nerves.—These have been very numerous, and I think I have now seen examples of injury to all the nerves of the extremities amongst the fifty or sixty patients I have had the opportunity of examining. In the first place it must be pointed out that contusion of nerves or partial severance is infinitely more common than complete division of them, so that I have hardly seen a single case in which the symptoms clearly pointed to actual complete

division. It is very important to note that no value can be attached to loss of sensation or of power during the first few hours or days succeeding to this injury, for in very many cases an apparently complete paralysis rapidly passes away, and in many others improves to a quite remarkable extent. It can, therefore, never be the right thing to cut down at once with the object of suturing the injured nerve. In the next place, it must be noted that where after some weeks there is still an apparently complete paralysis, careful examination will show that the retention of power or of good sensation in some part renders it certain that the nerve is not really divided, and it is the fact that in many such cases when surgeons have cut down on the nerve they have not found it severed. Such cases get well if left alone, though they may take several months to do so. Thirdly, in some cases the contraction of the scar where the bullet has passed causes symptoms of paralysis. Here, also, as the scar atrophies the symptoms pass away, and in these cases massage is often of great use. Comparatively few surgeons seem to be able to realise the length of time which is usually required for the recovery from a nerve wound, and are in far too much hurry to do operations when none are needed. In only one or two cases of nerve injury have I seen the severe burning pain to which Weir Mitchell specially called attention after the American Civil War, and in some cases the pain complained of is certainly functional.

I saw one man whose sciatic was supposed to have been wounded, and who suffered agonising pain. The surgeon cut down upon it, and freed it from the scar tissue, but without benefit, and the patient screamed except when under morphia, and could hardly bear the limb looked at. I said I thought his troubles were mainly functional or hysterical, and advised stopping the morphia absolutely. A few days later he had a violent hysterical fit, and when this was over his pain had gone.

Another patient was quite deaf and apparently dumb, without any external lesion, and numerous suggestions of possible brain lesions were made, but one day on the voyage home he quite suddenly recovered completely. It is very evident that the mental condition induced by the excitement, mental tension, and even terror caused by the surrounding sights and sounds, and also, perhaps, by the shock of an injury, is of exactly the nature which might be expected to predispose to those functional disturbances which have so often been noticed in connection with railway accidents; but as a matter of fact these functional disturbances are really rare. Neurasthenia is, on the other hand, common. It would be tedious to detail cases of nerve injury at length, but I may mention that one of our patients was evidently hit on the left pneumogastric, for the bullet passed through the neck above the level of the cricoid cartilage, and left him with a completely paralysed and atrophied left cord, which had not altered at all four months later. The bullet had entered the right eye, passed through the mouth, and then, missing the vessels in some extraordinary way, emerged through the left sterno-mastoid.

In another man the cervical sympathetic had been struck, and he showed the typical diminished palpebral fissure, and a pupil incapable of complete dilatation.

Wounds of the brain.—I think that the events of this war have hardly modified at all the views of surgeons on brain injuries. Most of these are, as heretofore, rapidly fatal, and in many cases the brain is injured far from the track of the bullet. In some cases, however, for reasons impossible to determine, the passage of a bullet through the brain causes infinitely less injury than is usual. Here are some examples of this fact:

(1) A child aged seven was shot at Kimberley at a range of about a mile, the bullet entering above the right orbit, and emerging in the left Rolandic area high up. Paralysis of both lower extremities and of the right arm immediately ensued, but the child recovered consciousness, and when I saw him three weeks later he was mentally quite well, and power was returning in the right leg and in the arm.

(2) A man was shot from the vertex, behind the Rolandic area, and out at the left mastoid. He recovered with hemianopia and partial aphasia and amnesia, and was still improving when I last saw him—six weeks after the wound.

(3) A Seaforth Highlander was shot at Paardeberg from one temporal region to the other, and in five weeks rejoined his regiment, and went with them a march of twenty-four miles and fought the next day. After that he suffered from headache, and was sent to the base. He walked half a mile into camp directly after the accident, and then went three days in a bullock waggon before he got to hospital. At no time was he unconscious according to his own account.

In other cases, unfortunately, even when death is not instantaneous, the brain is so much damaged that no operation is of service. I very recently saw an officer who was shot through the temporal region two days previously. I advised enlarging the wound and removing loose fragments, but he died thirty-six hours later, and a post-mortem showed an extremely lacerated brain.

Gutter fractures of the skull.—This form of fracture requires special care, for the subsequent injury is very liable to be overlooked, and the necessary treatment omitted. It may be laid down as a rule that if a bullet travelling at high velocity touches any part of the cranial vault so as to leave even the slightest groove or "gutter" on the bone, then the inner table will be found splintered. It may be added that the dura mater will often be found injured and the brain lacerated. Here are two typical cases:

(1) A man was admitted to the Portland Hospital four days after a "gunshot wound of the scalp." Mr. Wallace, on examining him, found a gutter fracture at the bottom of a suppurating wound, and the man had severe headache and a temperature of nearly 102°. The patient was promptly trephined, and a splintering of his inner table over an area the size of half a crown was found with laceration of the subjacent brain. Recovery after operation was uninterrupted.

(2) An officer was shot across the forehead right at the level of the eyebrows, but he regarded it as a flesh wound, had it bandaged, and walked on as if nothing had happened. Some days later headache and delirium and other cerebral symptoms caused one of the civil surgeons to open up his wound, and then to trephine where there was a fissure in the outer table, the operation revealing an extensive comminution of the inner table. The patient made an excellent recovery.

Many similar cases have been noticed by various surgeons, and I think there are probably some patients now in England who may yet develop symptoms due to an overlooked "gutter fracture," and a subsequent pachymeningitis.

In consequence of the demand for accommodation Lady Roberts has opened the ball room at the Residency for the reception of the wounded under the charge of Dr. MacMunn, one of the Physicians to the Wolverhampton Infirmary and a Major of Volunteers, who is now out here, and I have been asked by him to see the cases in consultation with him. There are now about twenty patients, and you will be interested to know that one of the two nurses in charge is Miss Beadsmore Smith, who was so recently one of our sisters at St. Bart.'s. I saw there this morning a case of bad wound of the forearm, caused by an "explosive" bullet, two cases of slight injury of the nerves of the upper extremity, and one of injury of the external popliteal, as well as several interesting cases of gunshot wounds of the neck and trunk; but if I once begin to tell you of interesting and curious cases of injury this letter will never come to an end.

I am glad to say that we all keep well, in spite of the illness in all the camps around us; but the work on the medical side is extremely heavy just now, and the nurses and orderlies are at times much overworked. Only this afternoon we have admitted twenty-seven very bad cases of typhoid, the worst out of 200 in a field hospital, so you may imagine they are bad—so that now we have about seventy enteric patients out of a total of 160. You can well believe, therefore, that Dr. Tooth and Mr. Calverley have their hands pretty full.

As to the war, it seems that everything now goes on well, and I hope that we may be in Pretoria by the end of June or July, and perhaps sooner. I trust, therefore, that before the winter season begins the war may be over, and in any case we intend to return before that time.

Selecta ex Scriptis.

II.—PHYSICAL.

WE are indebted to Mr. Womack for a further selection of novel but interesting opinions upon matters scientific, this time dealing with certain problems in Physics. Again we refrain from comments, leaving the sentences in their native beauty and simplicity. We strongly suspect a gleam of genuine humour as the source of one or two of the answers, but this makes them none the less delightful.

Question.—State in precise terms why it is that smoke from a fire is drawn up the chimney with a considerable draught.

Answer 1.—The reason is that the air in a room wishes to find an outlet. As the fire grate is generally the only opening, it forces its way out there, and carries the smoke with it.

A. 2.—Because the air gets down the chimney and has to get back again, and so it takes the smoke back with it.

A. 3.—The air in a room is continually moving about looking for an outlet by which to escape. [The devil goeth about like a roaring lion seeking whom he may devour somebody.—A. W.]

A. 4.—There is a vacuum at the top of the chimney, and the wind passing over the top acts as a sort of magnet.

A. 5.—Carbon has such an affinity for oxygen that the carbon moves up the chimney with some force to get to the oxygen outside.

Q.—What is a "second" of time? Explain carefully how it is connected with the time of revolution of the earth on its axis.

A. 1.—By a second of time is meant the time which a body takes to fall the distance of 32 ft. per second. This is known as the uniform acceleration of time per second.

A. 2.—Time is something that everybody understands, but nobody can define.

A. 3.—A second is the smallest portion of time conceivable to human beings without artificial means.

A. 4.—The time the earth takes to make a revolution on its axis is a little over twenty-four hours, but as it is much more convenient to have an exact number of hours in calculating time, the time over is not counted.

A. 5.—A second of time is the unit of time which a unit of mass takes to pass through, by, or over a unit of distance. But of course a body composed of two or three units' mass might pass through two or three units of space in one unit of time. [Convenient for stout people in a hurry.]

A. 6.—The earth rotates more slowly now than it used to because there are more people living on it. This partly accounts, also, for the greater ages of the patriarchs.

A question on the buoyancy of sea water as compared with fresh water produced the following:

A. 1.—A person may swim or float much easier in the sea than on land. Thus a ship draws less water in the sea than on land.

A. 2.—If we were to bathe in a sea of mercury we should flounder about like a fish on dry land, for we could get no hold on the ground.

A. 3. The ducks are bedecked with much down on the belly to allow them to displace much water and swim more easily.

The remaining excerpts will possibly explain themselves :

Bodies in a vacuo have no "weight," but only mass.

There are three scales of temperature—

The Farenhight (used in England).
" Centigrade (used in France, etc.).
" Rotograde (used in Russia).

The ohm is the current maintained at the ends of 18 feet of wire ('034 diameter), the size of the cell being one quart.

A steam engine, when at work, gives out steam through its chimney, which propels the engine forward.

When little chicken feel cold they flock together in a heap to get warm. Just in the same way, if we may use the illustration, do the tiny, tiny drops of invisible water vapour, on feeling cold, rush together into a heap for shelter and warmth, as it were ; and if too heavy to float, they fall as rain.

To find the amount of heat given out by a rabbit in six hours, wrap the rabbit in flannel for six hours and quickly removing the flannel wrap it round a metal vessel full of water. Find the heat thus imparted to the water.

Put the rabbit in a vessel containing broken ice for six hours and determine how much ice is melted.

Shave the rabbit and apply a thermopile at different points of the body and take the average reading.

The volume of a pound of the liquid is twice as heavy as an equal quantity of water.

That motion generates heat is seen in the instance of a man running.

When first getting into a bath it may seem very hot but it soon seems to get cooler, but to any one else it would seem just as hot. This shows the great speed with which heat travels.

The following appeared in reply to a question as to the temperature of the water at the bottom of Niagara being higher than at the top :

The water at the bottom of a waterfall is nearer the centre of the earth, which is molten.

If the lower layers of water are warmed the water at the bottom expands and rises to the surface, and hence a waterfall is the result.

In 1 c. ft. water there are 1000 oz.
height of 1 c. ft. of water is 1 foot.
∴ 87,000 ft. pdls. raise to 1° C.

∴ water at height of 160 feet in falling will be raised 160 × 87,000 degrees of temp.

∴ temp. at bottom of waterfall = 13,920,000 degrees.

As water comes out from the earth it will be put out with the heat in the interior of the earth, but as it has arisen higher the heat has been absorbed by the air and scattered through the air. So the bottom is hotter than the top of the waterfall.

A question on the temperature of the infusion obtained by pouring boiling water on to tea leaves in a cold silver tea-pot, elicited the following :

The temp. of the tea is $\frac{0.0 \pm 0.2}{0.2 0^{\circ} 8}$

$= 96^{\circ}\ 21'\ 56'' \frac{0.2 8}{1.5 8 7}$

A *viva voce* reply to a question as to the definition of the equator was "a menagerie lion running round the earth."

Daniell's cell was described as a pit in the earth, about twenty-four feet across and twenty feet deep, and full of roaring lions.

Specimens of spelling are atmostphere, sucksion, visa vesa, hot coakes, buoncy, hygroscopicity of the air.

But we have kept "the good wine till now." A question concerning the meaning of the Toricellian vacuum produced this :—

"Nature avoids a vacuum." The Pope is an old gentleman who lives at Rome in a vacuum.

Experiences in the Life of an Army Doctor in England.

A Paper read before the Abernethian Society, October 12th, 1899,

By W. E. LEE, M.D.Lond.

WHEN your Secretary did me the honour to ask me to read a surgical paper to you to-night, the question of a subject arose, and it seemed to me that I should be able to interest you more by giving you an account of medical life in the Army, than by reading you a paper on a more distinctly surgical subject.

The position and life of medical officers in the Services should be known more fully than it is at the hospitals, for they form in their proper state an exceedingly good and useful sphere for many members of our over-crowded profession.

The Services need medical officers, and offer them a sphere where they can be both useful and happy, and where their future is assured. I feel sure that the time is not far distant when the Army Medical Service will once again attract many of the best of the younger members of our profession, with advantages to the profession and the army.

On joining, after receiving his commission, the young officer is always sent first to a big station to learn the routine of his duties, and be under the supervision of his senior medical officers. I was sent to York, which is the headquarters of the North-Eastern District. The Principal Medical Officer of the district is stationed there, and is on the staff of the general commanding the District. The P.M.O. of a district is either a surgeon-general or a full colonel of the Royal Army Medical Corps. The P.M.O. is the executive head of the R.A.M.C. in the district ; has no direct charge of cases, but inspects the hospitals and other parts of the medical machine ; sees that it is in working order, and that patients are doing as well as they should be ; if not he has the power to alter treatment, and make suggestions, and give reprimands. The first duty of every officer on arriving at a new district is to report his arrival to the P.M.O. of the district in a formal signed report, and if there are any officers his senior in the station to report his arrival to the officer in charge of his hospital station, etc. The North-Eastern District is a first-class district as an army command, and a second-class district as a post of P.M.O. ; that is, there is not a general hospital at headquarters, but a large station hospital.

This is the place, I think, to make a few remarks on army hospitals in general, which are in five sections.

1. *The Royal Victoria Hospital at Netley*, which is the chief and largest army hospital in the Services. There all surgeons on probation both for the Royal Army Medical Corps and the Indian Medical Service go for a four months' course of instruction immediately after passing their examination for entering the Services. After the four months' course there is another examination in which definite improvement in professional knowledge during the probationary period must be shown. The list for priority of commission is based on the combined marks gained in the two examinations, and on a man's place in the final list depends his seniority during the rest of his service, unless he is specially accelerated for meritorious conduct, or retarded for inability to pass his further examination for the ranks of captain and major.

2. *General Hospitals*, which must have at least a hundred and fifty beds. The best known of these is the Cambridge Hospital at Aldershot, which those of you who belong to the Volunteer Medical Staff Corps know all about. To the Cambridge Hospital all officers of the R.A.M.C. go for a course of instruction in drill immediately after leaving Netley and receiving their commissions. The members of the Indian Medical Service receive their drill instruction at Netley. Other general hospitals are at Portsmouth, Chatham, etc.

3. *Station Hospitals.*—A hospital is attached to every military station, and has beds which vary in number according to the importance and number of troops on the station. At York the station hospital is commanded by a lieutenant-colonel R.A.M.C., with eight officers of the R.A.M.C. as his staff, nominally two majors, two captains, and four lieutenants. There was not this complement when I was there, or there would have been no need for me, but, as you all know, the army is deplorably short of medical officers. This state of affairs is much to be regretted, for although a general can take an army into the field without doctors, he can't bring it out without them, except at a terrible cost in lives thrown away, and suffering needlessly borne. The combatant officers regret this condition, but none of them have as yet stated the true causes, some of which I hope to refer to later on.

4. *Camp Hospitals.*—These are practically station hospitals in a camp. They differ from station hospitals in that they are housed in huts or tents, and not in permanent buildings, and that their equipment is less complete than that of station hospitals, while they are also allowed to empty their beds by transferring their patients to the nearest station hospital three or four times a week.

5. *Field Hospitals* are housed in tents ; they move every time the force they accompany moves. They are the most advanced part of the medical organisation, with the exception of the bearer companies actually concerned in picking up the wounded on the field during and after an engagement. A field hospital must empty every day to the nearest station or other receiving hospital ; when it cannot do this it becomes a station hospital on the line of communications. If unable to empty, it is obvious that it can't move with a moving column. The field hospital usually supplies dressings, does urgent operations, attends the wounded immediately after an action, so that it is a more surgical place than the other hospitals, in which many more men are found suffering from disease due to exposure and infection than wounds, even on active service.

The *daily routine* of life in a home station is as follows. Attend the hospital, which should be reached at 9 a.m. in summer—1st April to 1st October ; 10 a.m. in winter—1st October to 1st April. After morning hospital the medical officer is free until the following morning unless on orderly duty, or detailed for special work, or exceptionally busy.

On arriving at the hospital in the morning he reports himself to the senior medical officer, and shows that he is there in time. Next he reads the Orders of the Day, Detachment first, then Garrison, then District Orders, to find out if he is allotted any special work for that or some other day. Having read Detachment Orders he initials them, to show that he has read them, and proceeds to his wards. The special duties may be to sit upon an invaliding board, examine recruits, attend courts-martial, proceed to other stations, attend sanitary inquiries, or boards for localising the place for erection of camps, new buildings, etc. The medical officer has to give his opinion on these points, and it is worth while here to point out that the best result may in many cases be attained not by finding the ideal spot for health from a sanitary point of view, but to take the best spot for that purpose that will give an equally good military position, for an ideal camping place may be much exposed to the enemy's fire, give the men an unusual and excessive amount of exertion, be too far from the nearest station, etc. On all these points it is important that the medical officer should base his opinion, so that it may be valued and sought by the combatant branch. Due care in these particulars will often ensure smooth unity of action between the medical and combatant branches, and so conduce eventually to the health and comfort and enjoyment of the medical officer himself.

The *ward routine* is much the same as in all hospitals. All patients able to be out of bed stand to attention on the entry of the medical officer, and hold their diet boards in their right hands, the ward master follows with the prescription book and the ink bottle, while the orderlies fetch and carry anything they may be told to. The patients being seen, the bath rooms and lavatories are inspected, and the tidiness of the ward seen to ; the kits of the men must be noted for any incompleteness—of that portion they are allowed while in hospital—boots, razors, caps, blacking and hair brushes, etc.

The men who are allowed to smoke are supplied from the canteen on presentation of chits signed by the medical officer. Stationery, stamps, and other articles are also supplied in the same way. The signature guarantees that the right man is supplied, and also that he pays, for without it the canteen sergeant could not draw the payment from the man's pay.

A comparison of the chief difference between civil and military hospitals may interest you.

CIVIL.

a. Usually both an in- and out-patient department.
b. In-patient is usually a severe or an interesting case.
c. Clinical notes in full are taken and kept of all in-patients.
d. The civil hospital is complete in itself.
e. Instruments are abundant, and if not, are usually obtained at short notice.
f. Elasticity is the rule in civil hospitals, and any hospital which fails to move with the times gets a bad name rapidly. Surgery is done at all places with as much skill and enthusiasm as is possible.
g. History of cases unreliable and discontinuous.

MILITARY.

a. Practically no out-patient department.
b. The majority of in-patients have only trifling complaints. Small wounds needing bandage which show, or a graze from riding, send a man into hospital, for a soldier is fit for his whole duty or none at all in the piping times of peace.
c. Clinical notes are taken only of cases which require extras beyond the ordinary diet, and then a daily note must be taken to cover the extra. Extras are soda-water, chicken broth, lemonade, eggs, &c. There is practically no limit to what the medical officer can order as extras.
d. The military hospital is part of an organisation. The organisation is complete, but parts of it may be sadly lacking in particular things, which have to be requisitioned from headquarters for the purpose.
e. Instruments are few except at district headquarters and other headquarter stores, and everything except the simplest must be obtained from these.
f. A military hospital is rigidly bound by traditions. New drugs, new instruments, new methods, appear very slowly, and they are always behind the times at home, especially from a surgical point of view, though there seems to be a little more progress recently. Surgery is very much behind the times. Radical cure of hernia is hardly done at all, though much needed, and its efficient performance would save a large amount of invaliding.
g. The history of cases during men's term of service is very reliable and continuous. A medical history sheet is supplied to each man on joining, and at each admission to hospital an entry is made of the number of days he is in hospital, the disease, its cause, and any special details that may be of interest or use in the future.

Orderly duty.—All medical officers below the rank of major, and a good many of them owing to the scarcity of officers, have to do orderly duty, which means that they have a day on duty in rotation, in the same way as the surgeons and their house surgeons are on duty for their half week in rotation at Bart's. The routine is this. Reach hospital at 8.45 a.m. Inspect rations of all men in hospital, and the detachment or company of the R.A.M.C., and the rations issued to married men on the strength. Look at meat, fowls, etc., weigh them if they look short weight, or else do it as a routine to keep the butcher up to the mark. If sound and fit pass them, if not reject,

and reinspect what is substituted for them. Taste the bread to see if it is sweet, and inspect barley, eggs, milk, etc., to see if they are fit for food for sick men.

After inspecting rations attend hospital in the ordinary way. All new cases arriving at the hospital between 10 a.m. and 9 a.m. the following morning are seen by the orderly medical officer. At 12 noon the sanitary inspection of troops and barracks is carried out, if it is the day for sanitary inspection. At 12.30 comes inspection of dinners, with inquiries for complaints as to quantity and quality of food from all patients, finishing with inspection of the dinners of the N.C.Os. and men of the detachment R.A.M.C.

Then comes lunch, after which the orderly medical officer is free, but must be within call until 3 o'clock. At 3 o'clock he visits the hospital, sees all urgent cases, and inspects discharged patients to see that they are clean, their kits in order, and that a N.C.O. from their own regiment is present to conduct them back to barracks.

The men for night duty in the wards then parade and are inspected, after which the day's work is done except for emergencies. Emergencies are usually accidents in barrack rooms, drunks, etc. Fires must be attended by the orderly medical officer in case of scalds, burning, and other injuries. There is in some stations a room appointed for the officer on duty, in most he remains in or near his own quarters.

At 8.45 a.m. on the following morning he signs a printed report to the effect that he has efficiently performed his duties, makes a note of any unusual occurrences, such as the outbreak of scarlet fever among the troops, etc. (three cases were brought into barracks by the militia battalions while I was in York), and hands it in to the senior medical officer, and then does his ordinary hospital and other duties until his next time for duty arrives. Mine came round about once in four days in York.

The officers, their wives and children, and the women and children on the strength are medically attended by an officer detailed for this work either alone or in addition to his other duties. He calls on officers in their quarters, their wives and children in their homes, when informed that they need attention. The women and children he sees at 10.30 a.m. in a room in barracks set apart for that purpose, and visits them in their quarters when too ill to attend at the inspection-room.

The chief duty of an army doctor is to keep the troops under his care well and in fighting order, and both in peace and war this must depend as much on sanitation as it does in civil life, or more so.

A routine sanitary inspection of troops, barracks, latrines, cook-houses, married quarters, lavatories, latrines, etc., is carried out once a week by the orderly medical officer.

Other sanitary inspections of barracks are—

1. P.M.O.'s, who makes a yearly inspection.

2. If any special point is called attention to by the commanding officer of a regiment, a sanitary inspection is made at once by a medical officer detailed for that purpose.

To take the troops first. The men fall in by companies, tunics off, boots and socks off, shirts unbuttoned and opened over their chests, with their arms stretched out with the backs of the hands up and fingers open. The inspecting officer walks up and down the ranks and keeps an eye open for dirty legs and chests, scabies and skin rashes, with a view to the early detection of infectious diseases, especially syphilis. Many men prefer not to report themselves sick with venereal disease, for if drawing extra pay on any account they will at once lose this while in hospital.

Barracks are next inspected as to ventilation, cleanliness, warmth, etc. The private is drawn mostly from a rank of life in which warmth is preferred to fresh air, and a proper supply of that necessity is secured by frequent inspection—the daily one by the subaltern of the day, the weekly one by the medical officer, and others by other officers, staff, field, and medical.

Cook-houses are inspected, dinners looked at in process of cooking, and cleanliness and good cooking maintained or ordered. Undue burning of meat is common, as the large joints, pies, etc., for a company need big fires to cook them, so burning of meat is easy. The army cook is usually an exceedingly good one, and can turn out a meal under difficulties that would prevent any other cook in the world from having anything ready to eat at all.

Canteens, wet and dry, are inspected carefully, everything supplied is sampled occasionally, and the quality of Tommy Atkins's beer can be tested personally to see that it is not watered or unduly bittered, or otherwise tampered with.

The drains are best inspected on a wet day, when deficiencies in the making of barrack squares and stopped drains are more obvious than when there are no puddles to reveal them.

Saturday is the regulation day for sanitary inspection, and 12 noon the hour for starting all the world over; if there are many troops, a few medical officers' inspections may be made on other days. At York Wednesday is the day for the cavalry barracks, Thursday for the depôt of the West Yorkshire Regiment, and Friday for the infantry barracks, which were occupied first by the Black Watch and then by the York and Lancaster Regiment.

Social duties.—The medical officer, in common with all others, finds himself confronted on joining with a round of calls, which he must pay or be ostracised. First comes the commandant, at a headquarters station the general commanding the district, the colonel if a regimental station, etc. etc. This is a ceremonial call, and consists in walking into Government House and writing one's name in a book kept for the purpose, and coming out again. The regiments in garrison or camp next claim attention. These are very enjoyable calls; you go in, have tea or a drink and a chat, and come away again, having met an exceedingly nice set of men. Such you will always find the combatant officers if only taken the right way, which is not to toady to them or to try and make yourself out a very superior sort of person, but the much more useful and little-used way of not treading on other people's toes and doing your duty with a cheery face, even if it involves a little personal discomfort.

Next come the married officers and their wives. This is usually a walk round shooting pasteboards. Having done these duties, I found myself invited to a round of dinners, dances, at-homes, tennis parties, and all the other functions which were going.

Cricket and football are always to be had in their season, and one has the chance of playing for one's own corps, or the garrison, camp, or any other team one may be associated with. The York Garrison team was a fairly strong one, and beat the Yorkshire Gentlemen.

Cycle polo was the rage last summer, and was excellent sport in all ways. The rules against dribbling were severe, and so a minimum of accidents ensued.

Military duties.—The purely military part of a medical officer's duties are to know stretcher drill, ambulance drill, and company and battalion drill. He must also be an efficient horseman.

The drill portion of these duties I had very little to do with, but I had a driving course in the cavalry riding-school, and thoroughly enjoyed it. The method of giving a firm seat consists in a graduated series of exercises, in which the length of time without stirrups is slowly increased, riding without reins introduced, graduated jumping practised, and finally a series of physical drill exercises on horseback undertaken, before the recruit is allowed to use a sword or lance. Sword, lance, and carbine practice are taught on the square, and when the recruit can do his drill on the square and ride a horse, he is introduced to the combination of arms and a horse, and finally turned into an efficient cavalryman.

The average length of a recruit's training in a cavalry regiment is from one hundred to one hundred and twenty days. Dull recruits take longer, sometimes a good deal longer; but it is very rare for a man to leave the ranks of the recruits under a hundred days.

The cavalry seat is essentially a sticky seat as opposed to the balance seat of the hunting-field, for man and horse must be one unit to be effective in action; the result of a charge depends less on the arms of the soldier than on the combined impact of man and horse. The other uses of modern cavalry are for a shield to screen the movements of the infantry and for scouting purposes.

Camp life.—After being in York for a month I was sent to Strensall Camp. Strensall is the chief musketry station in the north-eastern district, and there also the officers and men from York, Leeds, Sheffield, Pontefract, Richmond, and Beverley go for their musketry instruction.

The summer camp is an annual camp of exercise, and the regiment in garrison at York always goes there for field training from the beginning of May until the commencement of the autumn manœuvres. A militia brigade also goes into training there for a month every summer.

I was supplied with a tent and a servant at the camp hospital and attached to the Black Watch, who made me an honorary member of their mess, and were most kind and hospitable to me in every way. Camp life is the healthiest and most enjoyable way of spending the summer that I know of. Plenty of fresh air, comfortable quarters in a good rain-proof tent, and a first-class mess at most moderate charges, together with the best set of fellows I ever met as companions, and a fair amount of work and plenty of exercise, make a most delightful set of surroundings for any man.

The work in camp was rather different from that in garrison, for there were many more men to look after, and the militia brigade gave a great deal of work in examining their men for different purposes, such as re-engaging in the militia, enlisting in the Line from the militia, enlisting in the militia reserve.

A surgeon-major and I were in medical charge of a camp of 1000 regulars (Black Watch), detachments from other regiments for musketry purposes numbering 300 to 400 men, and about 4000 militia.

The routine of *recruit inspection* may be of interest to you.

The recruit strips absolutely, then steps on to the measuring standard, after which he is weighed and his chest measured. Then his heart and lungs are listened to, and his muscular efficiency tested by making him go down on his knees and toes, raise himself without the help of his hands, etc. Then his arms, hands, and feet are looked at to see that he has no deformity which would prevent him from using a rifle and marching. Lastly, his eyes are tested to see that he can see sufficiently well to see the foresight of his rifle, and that he is not colour-blind. Teeth are important, for if a man has not good teeth his digestion will give out in campaigning, and he becomes more liable to dysentery and diarrhœa.

When a junior officer is in sole charge at a small station, such as Leeds, his duties are more varied and somewhat different; there is less medical work and a great deal more routine and executive work to do. Senior officers do the executive work and supervise the medical work done by their juniors at big stations.

The executive portion consists in issuing detachment orders, inspecting all things, seeing that rations are properly issued, hospital and barracks kept in proper order, the non-commissioned officers and men of the detachment R.A.M.C. properly drilled, accoutred, and instructed in their duties and their work done, attending courts martial, writing weekly, monthly, and other reports to headquarters, requisitioning stores and issuing them, etc. The number of times in a day that the medical officer in charge signs his name is astounding; everything must be written down and signed.

The first duty when in charge of a hospital is to inspect the men, reporting sick, and examine them. Most are admitted, some detained for observation for a day, and again inspected, and a very few given a dose of medicine and sent back to duty.

The work is more continuous in a small station, for if there is only one doctor he is on perpetual orderly duty, and must always be findable, especially if attached to a cavalry regiment, for casualties are more common with them than in an infantry regiment; they are more rare after five o'clock, as stables are then over for the day, and horse-kicks, horse-bites, etc., form the staple of such emergencies.

Medical matters.—On home service cases are few, and generally of an ordinary kind, for it is obvious that there ought not to be much sickness among 800 or 1200 specially selected healthy men, living a healthy life, with plenty of good food and plenty of exercise. There are, if the regiment is recently home from foreign service, a number of cases of tropical diseases.

I saw four abscesses of the liver, all secondary, the primary one having in each case occurred while the regiment was in Burmah. Three were extremely simple to open, for the liver was adherent to the anterior abdominal wall, and a simple straight incision through the anterior abdominal wall and a small portion of liver substance opened the abscess, which then drained freely. The fourth was more difficult, and I subsequently opened and drained it through the pleura, when the case did well.

I also excised a considerable number of varicose veins, and did a trephining for a depressed fracture caused by a fall from a horse.

There is always an excess of venereal disease, greater in some places than in others. York is an exceedingly clean place in this respect, Leeds and Sheffield very bad, and there the type of disease is usually severe. The most common type at Leeds was a triple infection, gonorrhœa occurring in from three to four days after infection, extensive ulceration in from six to eight days, and a hard Hunterian chancre in eighteen to twenty-eight days. So general was it to find men who had been infected in a particular quarter of the city to be suffering from the three forms combined, that if any man was known to have caught his disease in that quarter, I always put him on mercury as soon as admitted, with greatly improved results.

The use of mercury intra-muscularly is extremely useful in the army, for it makes a certainty that the patient gets his medicine. Many men put the pills given them in a hollow tooth, and then spit them out when unobserved, either because they want to stay in hospital, or from a fear that they will be given too much medicine.

I used the intra-muscular method in nearly all cases where there was a chancre, and got excellent results with it; the sore softened more rapidly, and the secondary symptoms were slighter, than in cases not so treated. Certainly it is, for army purposes, the most useful method there is, for men can attend once a week to get their injections, and do their duties in the interval, when they would otherwise be off duty altogether, for it would be impossible for a man to attend three times a day, and yet do his duty, and it is against regulations to supply privates with a stock of medicine. Besides, the men would never turn up again after a first attendance unless obliged to. All cases with a rash or with a chancre must be taken into the hospital, for "a man is fit for his whole duty as a soldier or for none at all" is the maxim of the army.

Avian Tuberculosis.

By J. GRAHAM FORBES, M.B.

NOTES based on the case of a hen which died in the pathological rooms after a very short illness in April, 1899.

Post-mortem.—Much wasted externally.

Neck.—An enlarged gland composed of calcified material.

Thorax—Heart.—Pericardial effusion and œdema of visceral layer of pericardium.

Lungs.—Healthy.

Abdomen. Liver enlarged, soft, and friable; surface scattered with small white growths, some the size of a pin's head, others irregular, nodular, the size of a raspberry, situated on the under surface.

Spleen not enlarged, crowded with small, hard, yellow nodules of chalky material.

Intestines—Crop and gizzard.—Natural.

At intervals in duodenum, small and large intestines, were scattered five or six irregular hard nodules, the size varying from that of a pea to a walnut; similarly the cloaca was affected.

The growths presented a very rough, black, and depressed surface to the lumen of the gut, and were as hard as cement. The smallest nodules, the size of a pin's head, bore small depressed ulcers on the mucous membrane, and on section were found to be composed of hard gritty material.

The uterus and Fallopian tubes were also involved by growths of a like nature.

Kidneys and ovaries were free from growth.

Microscopically in all the affected areas typical appearances of tubercle were found on section, but giant cells were very scanty, and areas of necrosis were extensive. Tubercle bacilli were found abundantly in all the organs diseased.

Features of the Disease.

1. *Ætiology, i.e.* source of the infection with tubercle, is not definitely known. There are recorded cases in which fowls have been infected by eating sputa of phthisical patients, and one author claims to have produced the disease by feeding fowls on tubercular sputa.

Infection from one fowl to another may readily occur through the excreta, which in diseased birds abounds in tubercle bacilli.

Heredity is considered by some to play a strong part in transmitting the disease. Taking into view the fact that the ovaries, Fallopian tubes, and uterus are by no means unfrequently diseased, the chances that the ova may become infected seems highly probable, and so the disease be directly transmitted from one brood to the next.

2. *Mortality* is estimated by one author at 10 per cent. among fowls which die a natural death.

3. *Symptoms* are of short duration. Progressive emaciation. Loss of redness in the bird's comb. Refusal of food.

4. The characters of the lesions, notably the intestinal in this fowl, were quite unlike anything found in mammalian tuberculosis, and were very striking. The large, hard, cretaceous masses in the intestinal walls are not of frequent occurrence in avian tuberculosis. Mention has been found of a similar condition in fowls only, though not to the same extent, and never as the result of inoculation.

The intestinal lesions following inoculation usually take the form of a deposit of minute tubercles in the intestinal walls and on the peritoneum.

The liver and spleen are the organs most commonly attacked, are usually much enlarged, and the descriptions of the tubercular deposit resemble the condition presented by this case.

Lungs are not often diseased, the kidney very seldom. Testicles and ovaries are said by some to be not uncommonly affected.

Cases are described in which the tubercular disease is confined to the bones and joints—femora, tibiæ, and vertebræ particularly.

5. *Transmission* of avian tuberculosis to mammals, and of mam-

mallan and human tuberculosis to birds has been hotly disputed. As the result of a long series of experiments the following facts have been discovered by foreign writers.

(*a*) *Fowls* inoculated with avian tuberculosis acquire the disease in a general disseminated form.

(*b*) *Rabbits* inoculated intra-peritoneally die of general tuberculosis in the great majority of cases.

(*c*) *Guinea-pigs* are more resistent to inoculation, in many cases not affected at all, or only to the extent of a localised abscess; in a few cases minute scattered tubercles are found in the viscera insufficient to prove fatal. Very rarely general tuberculosis occurs.

(*d*) *Dogs* are entirely resistent.

(*e*) *Fowls* only when inoculated both intra-venously and intra-peritoneally. On being killed forty to sixty days afterwards, were found to contain minute tubercular deposits in the viscera.

(*f*) Mention of only one case of direct infection from bird to man has been found—that of a woman said to have died of phthisis after eating a fowl, which had acquired the disease by ingestion of phthisical sputum.

(*g*) Human tubercular material inoculated into dogs and guinea-pigs nearly always causes a general tuberculosis.

(*h*) Two cases are recorded of fowls reacting very powerfully to injections of tuberculin. On post-mortem, avian tuberculosis was found.

The bacilli of avian and human tuberculosis have been differentiated as follows:

1. The avian tubercle bacillus is larger, more granular, and grows more easily on artificial media than the human. The colonies of avian are described as soft, flat, and glistening; those of human tubercle as dry, warty, and firm.

2. *Resistance.*—Avian bacillus more hardy; grows at 43° C., and resists to 65° C. *Human* grows at 41° C., and dies 65° C.

3. *Vitality.*—Avian bacillus remains active after ten months, and the human dies after six months.

4. *Staining reactions* are identical by Ziehl-Nielsen method with carbol-fuchsin.

Possible Sources of Dissemination of Avian Tuberculosis.

1. *By the excreta,* which have been found to abound in tubercle bacilli.

2. *By the ova*—

3. By ingestion of infected fowl. } Doubtful source of danger to human beings.

1. Transmission of disease from one brood to the next.

2. Ingestion of infected ova. }

Conclusions.—Though the two bacilli present some differences as regards culture, resistance, vitality, and morphological appearances, they are not sufficient to justify the conclusion that they are two entirely different organisms, but that they are two different varieties of the same species.

This conclusion is supported by the fact that, as the result of experiment, tuberculosis has been produced in the lower mammals, such as guinea-pig and rabbit, by inoculation with avian tubercle, and in birds, fowls, and pheasants by inoculation with the human tubercle.

It is impossible to estimate the amount of danger, if there is any, to which a human being is exposed by the ingestion of a diseased fowl, or of the eggs of a diseased fowl.

To own that the avian and human bacilli are identical is to add a further source for the inroads of the tubercle bacillus on the human race. Hitherto the identity of the two is not established.

Notes.

THE midsummer address to the Abernethian Society will be delivered on Thursday, July 5th, at 8 p.m., in the Anatomical Theatre, by Sir Dyce Duckworth. Sir Dyce's subject is "The Pursuit after Novelties in Medicine."

* * *

THE Summer Concert (Resident Staff and Musical Society) will be held in the Great Hall at 8 p.m. on Tuesday, July 17th.

DR. HUBERT ROBERTS has been appointed Physician to In-patients at Queen Charlotte's Lying-in Hospital.

* * *

MR. E. C. CRIPPS, of Cirencester, has been elected President of the Gloucestershire branch of the British Medical Association for the ensuing year.

* * *

THE following reappointments have been made:—Demonstrators of Operative Surgery, Messrs. D'Arcy Power and Waring; Senior Demonstrator of Anatomy, Mr. R. C. Bailey; Assistant Demonstrator of Anatomy, Dr. Christopherson; Demonstrator of Pathology and Assistant Demonstrator of Practical Medicine, Dr. Drysdale; Demonstrator of Chemistry, Dr. Orton; Assistant Demonstrator of Chemistry, Mr. Hurtley; Assistant Demonstrators of Biology, Messrs. E. C. Williams and White.

* * *

THE following appointments have been made:—Assistant Demonstrator of Practical Medicine, Dr. T. J. Horder (*vice* Dr. P. Horton-Smith); Assistant Demonstrator of Physiology, Mr. Bainbridge (*vice* Dr. Horder).

* * *

A BRANCH Yeomanry Hospital is being arranged for Johannesburg or Pretoria, to consist of 400 beds, and with a staff of 40 nurses. It will be under the supervision of a military commandant and a chief surgeon from Deelfontein. Dr. W. Langdon Brown has been appointed physician in charge, Mr. H. Williamson second surgeon, and Mr. S. F. Crowther-Smith and Mr. Howell Davies assistant physicians.

* * *

THE Lawrence Scholarship and Gold Medal have been awarded to C. J. Thomas.

* * *

THE Skynner Prize in Pathology has been awarded to F. C. Shrubsall.

* * *

THE Sir George Burrows Prize in Pathology has been awarded to C. E. West.

* * *

THE Matthews Duncan Gold Medal has not been awarded; the Prize has been awarded to R. H. Parramore.

* * *

IN response to Mr. Leumann's appeal for a "stretcher fund," made in our last issue, the following subscriptions have been received, which we gratefully acknowledge:

	£	s.	d.
Edgar Willett, Esq.	3	3	0
Lady Macleay (per Miss Armitage)... ...	2	2	0
Sir Hermann Weber	2	2	0
Lady Weber	2	2	0
Dr. F. Parkes Weber	2	2	0
Dr. F. Andrewes	2	2	0
Dr. Morley Fletcher	2	2	0
Miss Armitage...	0	10	0
Total.....	£16	5	0

* * *

THE Eighth Decennial Club dinner was held at the Café Royal on June 27th. There was a very good gathering, about

70 members being present. Mr. H. J. Waring was in the chair. (Detailed reports of the Decennial Club gatherings do not appear in this or any other paper, for reasons that are as discreet as they are obvious.) The following members of the Eighth Decennial Club are at present in South Africa:—Dr. Christopherson, Messrs. Jameson, Granville, P. Wood, H. D. Parker, Ellacombe, S. R. Scott, Rowe, C. G. Watson, P. E. Adams, Cuddon-Fletcher, H. K. Palmer, Laming Evans, and Worthington.

* * *

WHAT is amiss with Bart.'s men in Yorkshire? Hearing of an advertised Bart.'s dinner at Leeds, we asked Dr. C. P. White, who was organising the affair, to let us know how successful it was. We have received the surprising news that out of 108 invitations sent out only 11 favourable replies were received, and over 40 did not reply at all! We are glad to hear Bart.'s men are kept so busy in Yorkshire. Yet we cannot help thinking that the busiest practice, if it will not admit of a meeting with other old Bart.'s men, should at least leave time for courtesy.

* * *

WE are glad to publish another letter from Mr. Bowlby. The account of nerve injuries is specially interesting, and adds yet another to the surgical revelations the war has made.

* * *

MR. DERWENT PARKER also writes to us again; his letter deals with some aspects of the war in a lighter vein.

No. 6 GENERAL HOSPITAL, NAAUWPOORT; *May 10th.*

SIR,—I am not quite sure whether it was Boston or Chicago that used to be the "hub of the universe," but now it is Naauwpoort. It also combines the beauties of Port Said. If you sit tight in Naauwpoort, everybody you ever knew or heard of passes through sooner or later. Mr. Bowlby and Lord Kitchener, several Bart.'s Sisters, Rudyard Kipling, Dr. Tooth, the Director-General of the Medical Department, Boer prisoners, lots of mules, guns, horses, Jameson, and Calverley are a few who occur to me just now. I had the pleasure of seeing Calverley drink a bottle of soda water. I was unfortunately unable to show any hospitality to the others. It is curious living under martial law. Generally one forgets that one is living under any particular form of law, but it gives a peculiar thrill to read in the 'Order Book' that you are liable to penal servitude if you stand Tommy a drink. The method of taking a railway ticket is also novel. Your commanding officer gives you authority to move your place of abode. You take that permission, or rather order, to a railway staff officer who writes it out again on another paper and retains the first. You take that paper to the ticket office and receive a third paper, the booking clerk retaining the second. Then the pleasurable part comes; you find there is nothing to pay for all this and your ticket is marked first-class; then you look for your compartment, and find that there are only trucks. Then you perceive that the War Office were not wasting time by their elaborate methods, but were leading up carefully to the climax of their joke. This was the start of a little excursion I had to make to Rensburg, but better things were to come. When I got to Rensburg I found that I was medical adviser to three camps ten miles apart. I had only been on a horse for about twenty-seven seconds once before, and when they asked me at the War Office if I should describe myself as a rough-rider I had said, "Certainly not." They then said "Could I ride at all?" And I had to say I didn't know, as the only horse to which I had made proposals had refused to let me try. I will not describe those rides; for a long time it was a painful subject. I had to ride near the line—the horse would walk, if undisturbed; I schemed not to be riding near the line when the train passed. At last I was caught. I took a firm hold of the pommel and prepared for the worst. I spoke soothing words to him; I would have patted him if I had had a free hand; the train passed, he was still walking,—I was saved. I now wear spurs when going round my tents.

WAR from a hospital point of view is depressing. The men keep pouring up in trucks or first-class carriages, as their luck may be, but they dribble back to us, generally in the night, dirty, and thin, sick or wounded; each, no matter how ill he is, still clinging to all his wordly possessions in this country. Kipling maligned Tommy when he said he'd left a lot of little things behind him. As a matter of fact, he clings to his belongings to the last. Indeed, Kipling has much to answer for. A volunteer here told me he was prepared to shoot him at sight, and this volunteer was a prosaic barrister at home. He had spent all day picking stones off a pathway and piling them in a heap. His cause of complaint seemed just. He said he had made an exhaustive study of Kipling, and nowhere could he find any account of fatigue parties, whereas really they were the most prominent feature of military life. It is really curious how absolutely different everything is from what one expected. Men who have come down wounded and have been in many engagements say they have never seen a Boer. I have seen no surgery except a case of hæmorrhoids; but of enteric fever I have seen over a hundred cases.

The Mauser bullet seems a harmless, inoffensive enough little thing, but the insanitary condition of the country where Boer camps have been, and where our men have to follow, will cause a most terrible death roll. Some militia regiments on lines of communication, who have never been within miles of a Boer gun, must have as heavy a percentage of deaths as many a fighting regiment. No men will have better earned their medals than the orderlies who nurse enteric cases. There seems to have been no news now for weeks. It is a puzzle how the London papers will have filled their columns—evening papers too. Are the boys reduced to shouting results of cricket matches and winners? I think when I last wrote my only complaint was that there were no Bart.'s men here; that is now removed. Geach has come up from De Aar. He also is doing unmitigated enteric. I have Sister Hope as Sister of three of my marquees. I feel that by coming out here I have almost held the post of house physician to Dr. Gee. I think I ought to be able to put it in the 'Medical Directory.' Old Bart.'s men would recognise its value.

* * *

ATMOSPHERIC acquiescence favoured us this year for our annual foregathering at Winchmore Hill, although the æsthetic temperament of the Weather Office, with an eye to counter-effects, could not forbear to throw in an occasional shower, which did not, however, materially hamper the play, nor the enjoyment of the visitors. The ground looked quite as attractive as we have ever seen it; in many points, indeed, improved, amongst which may be mentioned the flower-bed at the gate, and the utilisation of the strip at the south end right up to the "stables." On the other hand, though a difficult and stony path is allegorical of the approach to success, still we think that the rolling of the road to the pavilion would save both anathema and shoe leather. As to the building, why has not the suggestion of creepers, which we remember seeing some time back in a letter, been adopted? The isolated oak at the opposite side of the ground appears to be dying whilst still short of his prime; hither, O Demonstrators of vegetable biology, seek the cause—apply the cure. With regret we noticed arising on our western march—*horribile visu*—villas of brick and mortar overlooking our acres, blotting out our view. Do justice and incendiarism sleep? Yet one more defect—and this, too, well knowing the cares and troubles of the Finance Committee—would it not be possible to obtain an entrance at the back of the pavilion? Only a footpath, or even a right of way, would suffice. This would save almost half the distance to the station, and improve the value of the property not a little.

"PITY these things aren't better attended," said the casual cynic; we assented. "Ah," and the casual cynic shook his head, "Bart.'s never had any *esprit de corps*, and is composed of cliques and corners." Now to this altogether we did not assent, and when our friend went on to allude to the scant attendance at cup ties (a time-worn cry) and lack of enthusiasm, we felt his remarks were becoming irrelevant, and that cup ties and social reunions were not parallels, nor was *esprit de corps* necessarily comparable to enthusiasm, and that, moreover, neither allegation was justified. However, tea, tobacco, and desire not to damage each other, preserved the peace and prevented bloodshed. But to revert to the subject. We have always maintained that any social function of the hospital—of which, indeed, there are but few—should be supported, and amidst the sordid aims of everyday life little chance is lent to every one to meet every one else. Yet fewer opportunities are afforded for "past" men to see their old friends, whether the latter are themselves also swallowed up amongst the "past," or still patronise the fountain's rim, and fill the coffers of examining boards.

* * *

ONE of the best chances for this is, perhaps, the occasion of the annual "Past *v.* Present," when also men can bring their friends, and the nursing staff, last but not least, are graciously pleased to accept our invitation. Now in the attendance of these functions we submit lie the seeds of *esprit de corps*, and that these chances seldom occur is the more reason for a greater attendance. Cup ties, on the other hand, are a matter for certain picked men themselves to decide; and though a crowded touch-line may be pleasant to see, yet the issue is independent of the audience, and a small attendance does not necessarily imply a lack of enthusiasm. Cup ties happen comparatively often, therefore all men cannot afford to give up so much time. Besides, they should be looked upon more as a matter of general routine—reverses taken stoically, successes indeed noted, but exuberant exultations, springing rattles, and blowing penny trumpets smack more of hysteria and cerebral congestion, and detract from the value of achievements. And therefore we do not consider that our perhaps small attendance on these occasions is a fair criterion.

Past *v.* Present.

IT was unfortunate that the day chosen for these annual fixtures, which have quite become one of the social functions of the Hospital, should have been marred by a heavy downfall of rain just at the time when most of the visitors had arrived, yet we should be thankful that this did not happen an hour or two earlier, as it would have kept away many of those who were present. As it was the attendance was decidedly good, if anything better than that of last year, and although the Staff were scarcely so well represented as on that occasion we are sure they had the best of reasons for their absence. Professional duty has ever been the first consideration with the Staff of St. Bartholomew's Hospital.

On the other hand, we were glad to see so many of the Sisters and Nursing Staff on the ground, and we hope that future occasions will see them in still greater numbers, as it is proverbially impossible to have too much of a good thing.

Soon after lunch the visitors began to arrive, Dr. Church being the first of the Staff to appear, and was shortly followed by Mr. Langton, Dr. Garrod, Dr. West, Dr. and Mrs. Calvert, Mrs. Butlin, and others.

We were pleased to see more of the students and their friends, but we might mention that the ground is capable of accommodating still larger numbers.

The band, furnished by the police, played exceedingly well during the afternoon, and last, but not least, we would mention the tea, which in our opinion made up for any slight discomforts entailed by the weather.

Amalgamated Clubs.

CRICKET CLUB.

ST. BART.'S *v.* HENLEY.

This match was played at Henley on May 19th, and ended in a win for the home side. For the Hospital Nealor played another very good innings, and had any one stayed with him we must have won. Scores:

HENLEY.	
M. Molloy, c Nicholas, b Boyle	8
G. L. Bush, c Nicholas, b Nealor	15
Eustace, b Nealor	0
R. O. Schwarz, c Elliott, b Nealor	71
H. R. Blaker, b Boyle	1
C. H. Surtees, l b w, b Nicholas	18
H. Sutton, b Connor	7
L. Henby, not out	27
E. G. Fryer, b Ash	9
L. Cortauld, b Sale	1
Packer, b Boyle	0
Extras	18
Total	175

ST. BART.'S.	
H. E. Scoones, c Fryer, b Molloy	16
C. F. Nicholas, b Eustace	19
J. C. Sale, b Eustace	8
W. S. Nealor, not out	61
T. H. Fowler, b Eustace	3
H. E. G. Boyle, b Eustace	26
B. N. Ash, c Cortauld, b Eustace	5
H. T. Wilson, c Schwarz, b Eustace	0
C. Elliott, c Blaker, b Eustace	0
H. S. Ward, b Molloy	4
F. Connor, c Sutton, b Molloy	0
Extras	24
Total	166

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
H. E. G. Boyle	14	1	44	3
W. S. Nealor	12	1	58	3
J. C. Sale	5	1	16	1
C. F. Nicholas	3	0	19	1
F. Connor	2	0	12	1
B. N. Ash	2	1	5	1
H. E. Scoones	1	0	2	0

ST. BART.'S *v.* RICHMOND.

Played at Richmond on May 26th. Bart.'s batted first, and compiled 291 runs for the loss of 8 wickets. Ellett, Nealor, and Nicholas were the chief scorers, and all batted well. The match ended in a draw, as Richmond made 173 for the loss of only 2 wickets. Scores:

ST. BART.'S.	
H. E. Scoones, b Denham	6
C. F. Nicholas, c Healing, b Griffin	47
W. S. Nealor, l b w, b Griffin	57
J. C. Sale, c Lloyd, b Denham	20
G. G. Ellett, c Groves, b Lyons	69
H. E. G. Boyle, c Leigh, b Denham	5
C. A. Anderson, c Bowns, b Groves	27
T. H. Fowler, not out	16
L. Orton, run out	15
H. T. Wilson, G. H. Adam } did not bat.	
Extras	32
Total (8 wkts.)	*291

* Innings declared.

RICHMOND.	
G. J. Groves, not out	118
G. G. F. Griffin, c Ellett, b Nealor	14
F. W. James, c Orton, b Nealor	6
J. Leigh, not out	19
T. C. Roper, G. Lyons, A. G. Lloyd, H. B. Denham, J. A. Healing, P. Bowns, Greenfield } did not bat.	
Extras	16
Total (2 wkts.)	173

ST. BART.'S *v.* BARNET.

This match was played at Winchmore Hill on Saturday, June 2nd, and ended in a draw. Unfortunately most of the regular team were away, and consequently we did not have as good a side as usual. Greaves, who played for Barnet, made 96, which, considering the state of the wicket, was an excellent performance. Scores:

BARNET.	
J. R. Pank, b Boyle	4
J. de Winton, b Boyle	4
H. S. Greaves, b Sale	90
C. de Winton, c Sale, b Turner	32
W. P. Williams, b Turner	15
P. Thornburgh, not out	17
C. S. Higgs, not out	4
H. W. Pank, H. E. Pearce, S. Higgs, A. T. Martin } did not bat.	
Extras	7
Total (5 wkts.)	*179

* Innings declared.

ST. BART.'S.	
H. E. Scoones, l b w, b Pearce	30
H. Whitwell, c C. de Winton, b Thornburgh	20
J. C. Sale, b Thornburgh	4
C. F. Nicholas, b Thornburgh	7
H. E. G. Boyle, c C. de Winton, b Pearce	0
L. Orton, not out	16
C. H. Turner, c H. W. Pank, b Pearce	19
G. H. Adam, not out	3
H. B. Hill, H. S. Ward, T. M. Body } did not bat.	
Extras	10
Total (6 wkts.)	109

PAST *v.* PRESENT.

This match was played at Winchmore Hill on Wednesday, June 13th, and ended in a draw. Unfortunately the Past team did not contain anyone who had been away from the Hospital for any considerable time; this was probably owing to the fact that the older men evidently found it difficult to get away. Several were written to, but in the majority of instances they did not reply, and some who promised to play did not turn up for the match.

The Past batted first, and made 194; of these H. S. Greaves made 70, and batted in his well-known style. Nunn and Turner also batted well, the latter playing very free cricket. The Present began with Scoones and Orton, and after a quarter of an hour's play it began to rain heavily; this considerably handicapped the bowlers, as after the rain they could hardly hold the ball. Stumps were drawn later than usual, the Present having made 102 for 4 wickets. Scores:

PAST.	
J. W. Nunn, b Boyle	37
L. B. Rawling, b Boyle	0
J. A. Willett, run out	23
H. S. Greaves, b Stanger-Leathes	70
F. F. Rose (capt.), c sub., b Stanger-Leathes	0
C. H. Turner, b Stanger-Leathes	43
H. W. Pank, c Stanger-Leathes, b Anderson	2
A. H. Bostock, c Fowler, b Anderson	1
T. M. Body, b Stanger-Leathes	4
W. E. Lee, not out	2
C. O'Brien, b Anderson	0
Extras	12
Total	194

PRESENT.	
H. E. Scoones, not out	38
I. Orton, c Rawling, b Pank	19
W. S. Nealor, b Pank	7
G. G. Ellett, c Turner, b Greaves	28
C. A. Anderson, b Rose	5
H. E. G. Boyle, not out	11
T. H. Fowler, H. T. Wilson, H. S. Ward, J. Corbin, H. E. Stanger-Leathes } did not bat.	
Extras	4
Total (4 wkts.)	104

CUP TIES.

First Round.

ST. BART.'S *v.* KING'S COLLEGE HOSPITAL.

We were drawn against King's College Hospital in the first round of the Inter-Hospital matches. This match was played at Chiswick Park, and resulted in an easy win for Bart.'s. We lost the toss, and our opponents decided to bat first on what proved to be a good wicket. Clapperton, Stuttaford, and Hawkins were the only ones who made scores for them; the rest were soon disposed of, and we got them all out for the total of 140. Our start was not brilliant, as the first wickets fell rather quickly, but by an excellent innings of 64 by Sale, and a score of 34 by Ellett, we managed to pass our opponents' score. A very good stand was made by Boyle and Fowler, the latter scoring 85 in a very short time. The feature of the game was a century by Boyle, who is to be congratulated on the performance. He made his runs very quickly, punishing the bowling severely. Sale and Boyle did the greater part of the bowling, the former getting 4 wickets for 44 runs. Scores:

KING'S COLLEGE HOSPITAL.	
T. J. M. Clapperton, c Fowler, b Sale	30
A. T. Marshall, b Sale	3
J. Napper, c Scoones, b Anderson	7
W. J. Stuttaford, b Boyle	26
W. L. Hawkins, st Fowler, b Sale	35
F. W. Holland, b Boyle	0
J. G. Pritchard, b Anderson	19
F. Carlé, c Fowler, b Sale	0
R. H. Lee, c Ellett, b Boyle	0
G. Read, run out	6
C. T. Cheatle, not out	1
Extras	13
Total	140

ST. BART.'S.	
H. E. Scoones, b Stuttaford	18
C. F. Nicholas, b Clapperton	2
W. S. Nealor, c Holland, b Clapperton	30
J. C. Sale, b Napper	64
G. G. Ellett, c Holland, b Carlé	34
C. A. Anderson, c Carlé, b Clapperton	25
H. E. G. Boyle, run out	104
T. H. Fowler, c Carlé, b Pritchard	85
H. B. Hill, b Napper	0
H. T. Wilson, b Napper	4
L. Orton, not out	4
Extras	23
Total	401

Second Round.

ST. BART.'S *v.* ST. MARY'S.

This match was played at Chiswick on the 15th, and ended in a win for St. Mary's. St. Mary's were all out for 200, which, all things considered, we ought to have been able to beat; but chiefly owing to the bowling of Sedgwick, 5 wickets for 31, we were all out for 118. H. E. Stanger-Leathes bowled exceeding well for us, taking 7 wickets for 47 runs. Scores:

ST. MARY'S.	
G. B. Norman, c Orton, b Stanger-Leathes	61
F. C. Hobbs, c sub., b Stanger-Leathes	13
W. G. Cheatle, c Orton, b Stanger-Leathes	52
E. P. Causton, c Fowler, b Stanger-Leathes	0
R. R. Cruise, lbw, b Anderson	32
A. V. Sedgwick, c sub., b Anderson	15
C. Carey, c Orton, b Stanger-Leathes	10
W. S. Mitchell, b Anderson	0
F. D. Nicholson, c and b Stanger Leathes	8
T. H. Ollerhead, not out	4
W. Finlayson, b Stanger-Leathes	0
Extras	10
Total	200

ST. BART.'S.	
H. E. Scoones, c Causton, b Sedgwick	28
C. A. Anderson, c Hobbs, b Mitchell	4
W. S. Nealor, c Cruise, b Causton	14
J. C. Sale, b Sedgwick, b Causton	10
G. G. Ellett, b Sedgwick	0
H. E. G. Boyle, c Causton, b Sedgwick	0
T. H. Fowler, c Finlayson, b Mitchell	24
L. Orton, c Norman, b Sedgwick	30
C. F. Nicholas, b Sedgwick	3
H. T. Wilson, not out	0
H. E. Stanger-Leathes, c Finlayson, b Causton	0
Extras	5
Total	118

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
J. C. Sale	23	7	44	4
H. E. G. Boyle	16	4	53	3
C. A. Anderson	8	2	20	2
W. S. Nealor	4	1	10	0

SWIMMING CLUB.

WATER POLO MATCHES AND TEAM RACES.

St. Bart.'s v. Glasgow University.—This match was played at St. George's Baths on Wednesday, May 20th, before a very enthusiastic attendance. In the Team Race Bart.'s fared badly, the Scotsmen being a very fast lot. In the Water Polo the Hospital defended

the shallow end first. Soon after the start Thorne scored for the Hospital; then within a few minutes Bloxsome added another goal for us. Just before half-time Thorne scored again. On changing ends the score was—St. Bart.'s 3 goals, Glasgow *nil*.

On resuming Thorne added two more goals. Now Russell scored for the 'Varsity. With some good combination by the Hospital the ball was again passed to Thorne, who, with a grand shot, scored again. Just before time Dempster scored for Glasgow, Bart.'s winning by 6—2.

In the Team Race the following represented the Hospital:—L. B. Scott, W. H. G. Thorne, A. H. Bloxsome, and D. M. Stone.

The Water Polo team were—C. Dix (goal); L. B. Scott (capt.), M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, and V. J. Duigan (forwards).

St. Bart.'s v. *South London Harriers*.—The above match was played at St. John's Hill Baths, Clapham, on Tuesday, May 29th, and resulted in a win for the Hospital by 4—1.

Bart.'s won the toss, and defended the deep end first. A few minutes after the start, after some give-and-take play, Thorne scored the first goal for us, the result of a good piece of combination by the forwards. On restarting play became very fast, the South London Harriers making several good attempts to score, but were unsuccessful. Just before half-time Thorne registered another point for Bart.'s, and the teams changed ends, Bart.'s leading by 2—0.

In the second half play settled down in front of the Harriers' goal, and for a little time nothing was scored; but at last Duigan was able to add another goal after some good passing between the forwards. The Harriers then attacked strongly, and were enabled to score by a very hot shot. A few minutes later Thorne added a fourth goal, and play ceased with the above result.

Team: C. Dix (goal); L. B. Scott (capt.), M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, and V. J. Duigan (forwards).

United Hospitals v. *Cambridge University*.

This match was played at Cambridge on June 6th, the United Hospitals being but weakly represented, owing to the members from Guy's and London Hospitals scratching on the day of the match. The game was never very fast, on account of the extreme coldness of the water. Cambridge, winning the toss, elected to play up-stream. After a few minutes, as the outcome of some pretty combined play, Powell scored their first goal. The Hospitals now assumed the offensive, and several shots were sent in, which Davidson successfully cleared. The teams changed over, and, the Medicos getting away with the ball, Thorne was enabled to score. L. B. Scott was now obliged to leave the water owing to cramp. Werner, being unmarked, at once increased the 'Varsity lead by two more goals. This is all that was done, Cambridge winning by 3—1.

The following members represented the United Hospitals:

Goal	C. Dix	St. Bart.'s.
Backs	V. B. Nesfield (capt.)	St. Mary's.
	L. B. Scott	St. Bart.'s.
Half-back	A. H. Bloxsome	St. Bart.'s.
Forwards	O. Ievers	St. Mary's.
	M. B. Scott	St. Bart.'s.
	W. H. G. Thorne	St. Bart.'s.

United Hospitals v. *Cambridge University*. (*Return Match.*)

The Light Blues, now on a water polo tour, opposed the United Hospitals at St. George's Baths, Buckingham Palace Road, on June 14th. The Hospitals' forwards were first on the ball, but Beale, the Cambridge captain, upset their attack. A pass back by Nesfield was badly taken by Newby-Smith, who, playing out of place, did not show to advantage. Powell, getting the ball, scored with an excellent shot. Following the throw-in the Hospitals again attacked, but the Cambridge backs proved too good, and nothing resulted. Half-time was now called, Cambridge leading by 1—0.

After change of ends the Hospitals' combination went to pieces. A bad pass let in Powell, who sent the ball on to Beale. The latter, artfully swimming wide of his man, promptly scored. The Medicos now played up pluckily, and from a good pass from Scott to Bloxsome and on to Thorne the latter was able to score; but soon after Dixon, with a neat side screw shot, got an excellent goal. Though outplayed through lack of practice together, the United Hospitals were not disheartened, and some very fast play ensued. Powell, however, again getting away, added another point for Cambridge. Shortly after this the match ended, the Light Blues winning by 4—1.

The following represented the United Hospitals:

Goal	C. Dix	St. Bart.'s.
Backs	V. B. Nesfield (capt.)	St. Mary's.
	L. B. Scott	St. Bart.'s.
Half-back	A. H. Bloxsome	St. Bart.'s.
Forwards	R. Newby-Smith	London.
	O. Ievers	St. Mary's.
	W. H. G. Thorne	St. Bart.'s.

LAWN TENNIS.

ST. BART.'S v. BALLIOL COLLEGE.

Played on the Balliol Courts on Saturday, May 26th; resulted in a win for the Hospital by 7—5 matches.

Singles.—C. L. Nedwill beat G. D. Rudkin, 3—6, 6—3, 9—7.
A. O'Neill lost to C. Moore, 1—6, 1—6.
E. H. Hunt lost to M. Singh, 1—6, 2—6.

Doubles.—E. H. Hunt and A. O'Neill—
beat A. C. Carré and C. Moore, 6—3, 7—5.
beat O. A. Hunt and M. Singh, 11—9, 6—4.
beat H. Tawney and L. Beveridge, 6—4, 6—3.
C. L. Nedwill and H. Whale—
lost to Carré and Moore, 2—6, 5—7.
beat Hunt and Singh, 6—3, 7—5.
beat Tawney and Beveridge, 6—4, 6—1.
J. Stirling-Hamilton and H. Walker—
lost to Carré and Moore, 2—6, 3—6.
lost to Hunt and Singh, 3—6, 4—6.
beat Tawney and Beveridge, 9—7, 6—3.

ST. BART.'S v. WIMBLEDON L.T.C.

Played at Wimbledon Park on Wednesday, May 30th. A weak team from the Hospital was defeated by 6 matches to 2.

ST. BART.'S v. WANGTEAD L.T.C.

Played at Winchmore Hill on Saturday, June 2nd. The Hospital was again beaten by 7 matches to 2.

ST. BART.'S v. ALBEMARLE L.T.C.

Played at Winchmore Hill on Wednesday, June 6th. Another weak team from the Hospital was beaten by 8 matches to 0.

ST. BART.'S 2ND TEAM v. LONDON HOSPITAL 2ND.

Played at Winchmore Hill on May 26th, resulting in an easy win for St. Bart.'s by 9 matches to 0.

CUP TIES.

ST. BART.'S v. LONDON.

First round June 13th.

Singles.—C. L. Nedwill beat R. C. Mott, 6—1, 5—7, 6—1.
E. H. Hunt lost to L. Bousfield, 4—6, 6—4, 3—6.
A. O'Neill beat L. Brenan, 10—8, 10—8.
H. Whale beat J. E. Frere, 6—3, 6—3.
J. S. Hamilton beat H. R. Fisher, 6—4, 4—6, 6—4.
L. E. Hughes beat A. B. Wilson, 5—7, 6—2, 6—4.

Doubles.—C. L. Nedwill and H. Whale—
lost to Bousfield and Frere, 2—6, 12—14.
beat Wilson and Fisher, 6—4, 7—5.
E. H. Hunt and A. O'Neill—
beat Brenan and Mott, 6—4, 6—3.
beat Bousfield and Frere, 6—2, 6—2.
J. S. Hamilton and L. E. Hughes—
beat Wilson and Fisher, 6—4, 6—2.
beat Brenan and Mott, 6—4, 6—1.

Result—St. Bart.'s won 10 matches, London 2.

ST. BART.'S v. GUY'S.

Second round June 14th.

Singles.—C. L. Nedwill beat E. M. Jupp, 6—1, 6—2.
E. H. Hunt beat H. B. Wedd, 6—2, 4—6, 6—2.
A. O'Neill beat H. K. Lacey, 6—4, 6—1.
H. Whale beat H. Bacon, 6—1, 6—3.
L. E. Hughes beat M. Winckworth, 6—4, 6—4.
J. S. Hamilton beat L. Cooke, 6—4, 6—2.

Doubles.—C. L. Nedwill and H. Whale—
beat Lacey and Jupp, 6—2, 6—3.
E. H. Hunt and A. O'Neill—
beat Bacon and Wedd, 6—4, 6—2.
beat Lacey and Jupp, 6—3, 6—1.
L. E. Hughes and J. S. Hamilton—
beat Cooke and Winckworth, 2—6, 6—3, 6—3.
beat Bacon and Wedd, 6—4, 6—2.

Result—St. Bart.'s 11, Guy's 0.

The Rahere Lodge, No. 2546.

Installation Meeting.

THE Installation Meeting of the Rahere Lodge took place in the Great Hall of St. Bartholomew's Hospital (kindly lent for the occasion by the Treasurer and Almoners) on Tuesday, June 12th, 1900. Bro. J. H. Drysdale, M.D., of the Alliance Lodge No. 1827, was elected a joining member; Bros. the Rev. Sir Borradaile Savory, Bart., and W. H. Cross were re-elected members of the Standing Committee, and Bro. A. W. Izard was elected a member of this Committee. Bro. Reece, the outgoing W.M., installed his successor, W. Bro. Walter Gripper, M.D., P.P.G.D. (Surrey), as W.M. for the ensuing year, the ceremony being in part musical, Bro. Samuel West rendering able assistance, whilst Bro. G. H. Robinson presided at the organ.

W. Bro. Gripper then invested as his officers for the ensuing year Bros. R. J. Reece, Phin. S. Abraham, G. H. R. Holden, Rev. Sir Borradaile Savory, Bart., Clement Godson, D'Arcy Power, Ernest Clarke, J. H. Gilbertson, W. Haig Brodie, F. Swinford Edwards, G. H. Robinson, Mus. Bac., A. G. R. Foulerton, H. D. Lauchlan, M. J. Anderson, J. Valérie, and P. F. Madden.

A Past-Master's jewel was unanimously awarded to Bro. Reece for services rendered to the Lodge during his year of office. It was presented by Bro. Gripper, and Bro. Reece responded in suitable terms. Bro. Gripper also presented a P.G.J.D. jewel to Bro. Secretary, as a present from the Lodge on his appointment by the M.W. the Grand Master, to office in the Grand Lodge of England. Bro. Secretary thanked the Lodge for the honour thus done to him, and for the friendly and masonic feeling which had prompted the gift. The report of the Audit Committee was received and adopted. It showed that the Lodge had given in charity a sum of £153 11s. during the past year.

The banquet was taken at the Frascati Restaurant, where covers were laid for upwards of 100, and a very pleasant evening was spent, the brethren and their guests being entertained by the marvellous dexterity of Dr. Byrd Page.

A Botanical Excursion.

TO Dr. Shore's kind invitation almost the whole of the Preliminary Scientific Class responded, and met at Kenley on Saturday afternoon, the 23rd ult., with the object of studying Botany in Nature's own Biological Laboratory. A more perfect day for the excursion could not have been chosen, and the locality was alike eminently suitable for the expedition. Scarcely had the party left the station when *Solanum dulcamara* (bittersweet) revealed itself in a hedge, and the characteristics of the order *Solanaceæ* were pointed out by Dr. Shore. Next *Bryonia dioica* (bryony) occupied the attention, and many other flowering plants were gathered on the way up the lane to Kenley Common. Here the collection received further additions, and finally a halt was made and Dr. Shore gave an informal discourse on the various interesting specimens which had been collected. Among these *Rosaceæ* were represented by *Geum urbanum* (avens), *Potentilla tormentilla*, *Rosa canina*, and *Poterium sanguisorba*, the last-named being particularly interesting on account of its inflorescence with the lower flowers staminate, and the upper pistillate with crimson feathery stigmas; *Leguminosæ* by *Lotus corniculatus*, and several species of *Vicia*; *Stellatæ* by *Asperula odorata*, and others. Altogether some twenty-five or thirty natural orders were got through; and then it was discovered that the body, no less than the mind, needed refreshment. Soon, however, Kenley was reached again, and there the Preliminary Scientific Class were Dr. Shore's guests to a tea which was greatly appreciated and successfully carried through. Presently three energetic photographers in turn commanded the rest of the party to stand and be shot, and then the station was sought, the train arrived, and the expedition gradually broke up as the several members made for their respective destinations. Altogether a most enjoyable afternoon was spent, and the outing was unanimously voted a great success.

Reviews.

ANÆSTHETICS, THEIR USES AND ADMINISTRATION, by DUDLEY WILMOT BUXTON, M.D., B.S. (H. K. Lewis, London. Pp. 308, crown 8vo; price 6s.)

The third edition of this work has been so largely revised and rewritten that it is practically a new book. It forms one of Lewis's valuable "Practical Series." The use of a book on anæsthetics for practical instruction is at the best limited. Skill in the art of administering anæsthetics can only be gained from practical instruction, followed by experience. From books, however, we can become acquainted with the various forms of apparatus used in administering anæsthetics, and the methods of their use, and perhaps we may gain a fuller appreciation of the many dangers and difficulties, and the appropriate treatment thereof, incident to anæsthesia. The author in his preface shows that he fully realises this. Bearing in mind that the book is intended as an adjuvant to, and not a substitute for, practical instruction and experience, it cannot but be of great value to the practitioner and student.

In describing the administration of ether with an ordinary Clover's inhaler, the author directs the moving of the indicator directly from 0 to 1, and after a short space of time to F (full ether), the patient being ready for operation in from ninety seconds to two minutes and a half. Few patients will tolerate such a rapid increase of ether vapour as is here recommended, and as a general rule the patient is scarcely ready for operation until the expiration of five minutes from the commencement of the administration.

The arrangement of the material in the book perhaps leaves something to be desired. For instance, a separate section is devoted to the administration of ether preceded by the administration of nitrous oxide gas. In this section, however, only a short description of the methods are given, and the use is advocated of the old Clover apparatus, while the newer and less cumbrous forms of Clover's inhaler have already been described under the section purporting to refer to the administration of ether only. This want of arrangement somewhat discounts the usefulness of the book for purposes of reference, as the newer forms of apparatus for giving nitrous oxide gas and ether might be easily overlooked. No mention is made of the simple addition to the ordinary Clover, so familiar at St. Bartholomew's, of a small tap for admitting gas to the ether bag, which forms perhaps the simplest and most commonly used apparatus for giving nitrous oxide gas and ether.

The author speaks highly of the practice of giving oxygen with ether. We believe that the credit of having introduced this method is due to the author. We scarcely think he lays sufficient emphasis on the value of this method. From a small experience of it we feel that too much cannot be said in its favour.

In his preface the author rightly calls attention to the importance of dealing with anæsthetics from a scientific standpoint. After this we are surprised to find a statement quoted (p. 303) that when nitrous oxide gas and oxygen are given together acute dilatation of the heart takes place. There is not a shadow of scientific evidence for any such theory. Repeated observations have failed to show that there is any effect produced on the heart by the administration of nitrous oxide gas and oxygen, even if the administration be prolonged. Such a statement should not be recorded in a scientific work. In this connection we may observe that we cannot agree with the remark that there is no advantage in using nitrous oxide gas for prolonged operations. Its safety, pleasantness, and freedom from after effects are strong recommendations.

In dealing with the remote after effects following the administration of ether the author says, "I believe when ether is *properly given* it is rare to find bronchitis, broncho-pneumonia (so-called ether pneumonia), or nephritis following its administration." The italics are ours.

That such complications do follow the administration of ether by a skilled anæsthetist, and in cases where there is no suspicion of septicæmia, will scarcely be denied, and to attempt to attribute such complications to unskilful administration is begging the whole question.

The chapter on the choice of an anæsthetic is full and clear. We doubt the truth of the statement that in patients suffering from severe collapse ether "properly given" is the best anæsthetic. We believe that in such cases ether causes more after collapse than

chloroform, and prolonged stimulation of the ether during the operation makes it difficult to stimulate the patient later on. So that while admitting that, from the anæsthetist's point of view, ether may be the best, and possibly more free from immediate risk, it is not in our opinion the best anæsthetic in the ultimate interest of the patient. Nor can we altogether agree with the statement that "*with management* ether will give almost as good if not better results than chloroform in abdominal surgery." While admitting that it is possible in many cases to obtain as complete relaxation with ether as with chloroform, we believe that anyone who has seen much abdominal surgery will agree that in these cases the bleeding under ether is much more embarrassing to the operator than under chloroform.

In the treatment of chloroform syncope the author, amongst other plans, advises the hypodermic injection of ether. It must be borne in mind that ether thus used is liable to cause sloughing of the skin, and in one case led to gangrene of the upper limb. If used at all it should be injected deeply into the pectoral muscle. It is a remedy that should only be used in desperate cases. The same remark applies to the injection of *sterilised freshly prepared* supra-renal extract. The practical difficulty of obtaining such a solution in an emergency would prevent its use, and in any case the physiological effect is so transitory, and followed by a rapid fall of blood-pressure, that it is difficult to see how the use of this substance would be of much value.

A word of praise must be bestowed on the excellence of the illustrations and the clearness of the letterpress. Both are admirable.

MONA MACLEAN. (Blackwood & Sons. Price 3*s.* 6*d.*)

The cheap edition of this "medical novel" should become very popular. There is a breezy freshness and piquancy about the book, and those who yet possess the originality to enjoy "human nature's daily food" should find its pages full of charm and interest. All the characters are made of flesh and blood, and the authoress takes us through many everyday scenes in a terse and vivid style. It is Mona's strong and high-principled individuality, always so well controlled, which appeals most to the reader. Nothing could be more sympathetically told than the story of her seclusion in a Scottish village, where she "lives her days with all her might" in spite of the chilling influence of sordid, selfish cousin Rachael. Her friendship with Dr. Dudley, who appears cold, dreamy, stoical at first, but strong and earnest withal, ripens into a love story of no ordinary romance, and they marry after many cross-currents and a courtship spent apart so that each may work for the M.B. examination! Doris, the inevitable woman with a mission, is more pleasing than real; and Mona's medical friends form an excellent background to this unique, amazingly self-reliant student of modern days. Some of the chapters are crude, but the story as a whole is powerful, human, invigorating.

(We are compelled to hold over several reviews this month for want of space.)

New Addresses.

C. H. BARNES, 17, Dartmouth Park Road, Highgate, N.W.
C. GODSON, 82, Brook Street, Grosvenor Square, W.
J. HOBDAY, Bridgefield, Muswell Avenue, Muswell Hill, N.
T. P. LEGG, 41, Savernake Road, Hampstead, N.W.
J. S. SLOANE, 7, Highfield Street, Leicester.
G. H. SOWRY, 4, King Street, Newcastle, Staffs.
J. VALERIE, Gothic Road, Devonshire Road, Balham, S.W.
L. A. WALKER, 46, Aberdare Gardens, West Hampstead, N.W.
H. E. WALLER, Bourne End, Bucks.

Appointments.

BOSTOCK, H. H., M.R.C.S., L.R.C.P., appointed Civil Surgeon to the hospital ship "Simla."

* * *

BROWN, W. LANGDON, M.A., M.B., B.C.Cantab., M.R.C.P., appointed Physician to the Imperial Yeomanry Branch Hospital, Johannesburg.

COLLYNS, J. M., M.R.C.S., L.R.C.P., appointed Civil Surgeon to the hospital ship "Simla."

* * *

CROWTHER-SMITH, S. F., B.A., M.B., B.C.Cantab., appointed Assistant Physician to the Imperial Yeomanry Branch Hospital, Johannesburg.

* * *

CURL, H.W., M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

* * *

HOSKEN, J. G. F., M.R.C.S., L.R.C.P., appointed Civil Medical Officer to the South African Field Force.

* * *

IZARD, A. W., B.A.Cantab., M.R.C.S., L.R.C.P., appointed Civil Medical Officer to the South African Field Force.

* * *

MITCHELL, A. M., M.A., M.D., B.C.Cantab., D.P.H.Cambridge, appointed Medical Officer of Health to the Borough of Guildford.

* * *

POYNDER, F. C., M.B.Oxon., has been elected a member of the Medical Staff of the East Grinstead Cottage Hospital.

* * *

ROBERTS, C. H., M.D.Lond., M.R.C.P., appointed Physician to the In-patients at the Samaritan Hospital for Women.

* * *

VINCENT, R., M.B., B.S.Dunelm, M.R.C.P., appointed Senior Resident Medical Officer at Queen Charlotte's Lying-in Hospital.

Examinations.

UNIVERSITY OF CAMBRIDGE.

M.D. degree, taken by Nicholls, Hubert (St. John's).

Anatomy and Physiology.—Cunnington, C. W., Gould, H. V., Hills, W. Hyde, Lee, W. E., Slade, J. G.

UNIVERSITY OF LONDON.
M.B. Pass Examination

First division.—Ede, A. Gordon, Pridham, A. J.

Second division.—Anstey-Charr, T., Frost, C. S., Knight, C. V., Thornley, R. I., Walker, L. A.

Birth.

HOUNSFIELD.—On June 3rd, at Stowmarket, Suffolk, the wife of Sydney Coupland Hounsfield, M.R.C.S., L.R.C.P., of a son.

Marriages.

CORY—REEVE.—June 12th, at the Parish Church, Tenterden, by the Rev. W. H. Cory, brother of the bridegroom, assisted by the Rev. S. C. Lepard, Vicar of Tenterden, Charles George Cory, M.R.C.S., L.R.C.P., of Soham, Cambs, youngest son of the late Rev. E. W. Cory, Vicar of Mildreth, Cambs, to Mabel Emily Hartridge Reeve, only child of the late Walter Reeve, Esq., of Peasmarsh, Sussex.

COURT—PARLBY.—On June 19th, at St. Peter's, South Weald, by the Rev. R. W. Chilton, Vicar of Wormingford, Colchester, assisted by the Rev. Canon Fraser, Edward Percy Court, M.R.C.S., L.R.C.P., of Hambledon, youngest son of Colonel H. S. Court, Madras Staff Corps (retired), to Lillie, eldest daughter of John P. Parlby, of Harold Wood, Essex.

ACKNOWLEDGMENTS.—*London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review, The Practitioner, University College Magazine, The Student, The Hospital, Transactions of the Students Society of Dental Hospital.*

St. Bartholomew's Hospital Journal.

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NOTICE.

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St. Bartholomew's Hospital Journal,

JULY, 1900.

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

The Pursuit of Novelties in Medicine.

The Mid-Sessional Address delivered before the Abernethian Society, July 5th, 1900.

By SIR DYCE DUCKWORTH, M.D., LL.D.

MR. PRESIDENT AND GENTLEMEN,—When I joined this Society in 1862, there were no mid-sessional addresses. I lived in F. 2 in the College, Dr Andrew being Warden. I think I was once a President of this Society, and I remember reading a Paper before it in 1862 or 1863. We met in a building on this site, demolished some years ago. The importance and the usefulness of this Society have steadily increased, and it has always nursed and helped to develop the best spirits that have entered this school. I regard the Society as one of the most valuable adjuncts to this Hospital and its Medical School, as a training ground for public and professional life, an arena in which humble efforts may be roused, and enthusiasm generated even in an easy-going and indifferent student—if such there be in this last year of the century. You learn here to speak and express your thoughts with accuracy, to endure criticism and opposition, to submit to a majority vote with equanimity, and thus you may have, if you will, all your prickles and sharp corners rubbed off, so as to emerge from the ordeals wiser and more level-headed men. No part of your instruction here will better, or indeed so well, accomplish this essential part of your training. And at no time in the history of medicine is it, in my opinion, of such importance as now for students and practitioners of our Art to be level-headed, and to see things in due proportion. The condition of medicine at the moment, I say, appears to demand this particular quality in very special degree.

I propose to point out to you this evening why this is the case, and to do so by a consideration of our Art regarded from its present stand point in comparison with the outlook which presented itself half a century back. What I shall say will not, I trust, justify you in regarding me as a "prescientific fossil,"* or lead you to believe that I am quite out of sympathy with the present mode of prosecuting our studies. Neither will you, I hope, believe that my views indicate the dawn of senility in my mental and bodily powers. I am, alas! on the downward, degenerative grade. As I tell you sometimes elsewhere, that stage supervenes after passing the acme of vigorous life at the age of thirty-five. I have surpassed that happy acme, but am glad to say that, very lately, when on the deck of a great liner in the Bay of Biscay, I felt that I had gone back to those halcyon days, so refreshed and invigorated did I feel when well away from the strain and pressure of my ordinary environment.

You are aware that the changes in medical education which have gradually come about in the last half of this

* A term often used by the late Dr. Andrew.

century are numerous, and some of them so radical that they amount to a complete transformation of the curriculum. There are many reasons for these changes. Not the least of them is the general and astounding advance in all the sciences, and in those especially on which the Art of Medicine is based, by which I mean those of biology.

I hope you have no misunderstanding with respect to the position of medicine itself. It never was, and it never will be, a science; yet it is scientific, and its foundations lie, and must ever lie, on the rock-bed of many sciences. Medicine, as physicians understand it, is an Art, and all good physicians are good artists.* It is possible to be a great medical scientist, and an inferior medical artist. We may hold that true physicians, like true poets, are born and not made, if we safeguard the assertion by adding that their best qualities do not come by instinct, ready made, but are reached only by assiduous study and unceasing accurate observation. There is no royal road to their attainments, however keen their wits or precise their logic. The mental temper which alone befits the pure scientist would never quite become the investigator of disease, or the student of clinical problems, and for this reason, that the latter has to act promptly and make the best of the facts before him, often without attaining the certainty and exactness of the requirements of the physicist. The difficulties and abstruseness in the particular case before the physician may never be entirely cleared up, and these constitute distressing factors which sadly exercise the purely scientific mind, and tend to avert it from the practice of our art. This has indeed often happened, and men who have eagerly taken up our work have found themselves unable to combat with the oft-recurring uncertainties which are inevitable in practice. They have gone off into other fields of research for which their mental qualities were better fitted. We cannot afford to sit down and bewail our inabilities, to shrink from, or calmly reflect upon, the alluring problems which entice us. For what is the reason of our existence in the body politic? Is it not promptly to combat these difficulties, to do our best by the light of fully trained experience to meet them, and to try to bring comfort, relief and restored vigour to the sick and suffering? Are we to look on, or pass by and do nothing, waiting till we can fully disentangle all the problems which present themselves? That cannot be, and so we have to act while we toil on, thinking, trying, studying, comparing, and hoping, too, for that fuller light which is dawning and drawing us on; and assuredly, gentlemen, that light is ever waxing, day by day; we are working by its luminous beams, all of us, whether we realize it or not. We enter into other men's labours, even if we labour not ourselves. We cannot stand still. We are, in our day, the products of our age, and hence our thoughts and practice differ a good deal from those of our predecessors of some fifty years since.

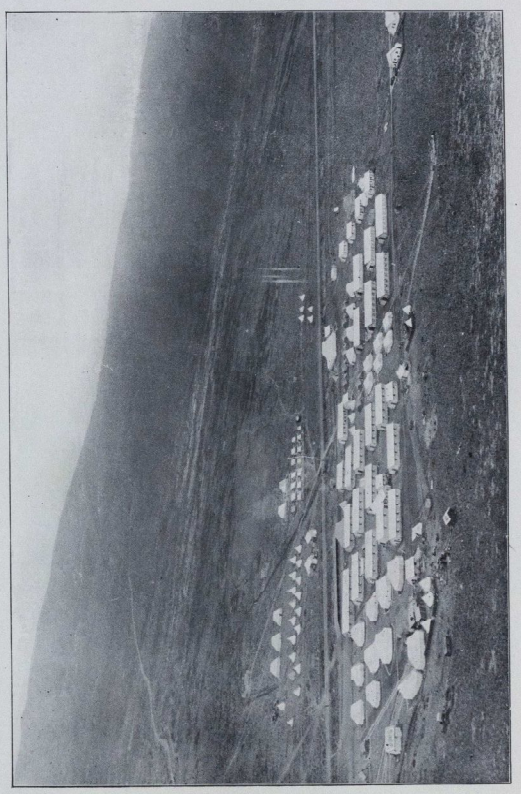
When progress is active in any department of life, we are always apt to think that we have reached a standpoint which puts our forefathers very much into the shade. We regard them as worthy, and as having acted up to their knowledge, but we are prone to believe that we possess higher attainments than they did, that now the meridian is above us, and that we should mightily astonish them if they could now return to the scenes of their former labours and see us at work. Gentlemen, I believe we should indeed astonish them, but I for one should be sorry to be the performer before some of them.

By way of contrast to the plan of study which was pursued forty or fifty years ago, we may note the great increase not only in the subjects to be studied now, but the greater minuteness and elaboration of these subjects themselves. Gross human anatomy was practically perfect at the earlier period, and is hardly more exact now, but histology has become a considerable addition to it, and must be mastered. And what shall I say of physiology as it is recognised to-day in comparison with that taught even in my time? I am, I know, skating on thin ice now, but I will not hesitate to say that this subject now bulks so largely that for the actual possibilities of the student, to say nothing of his comfort and assiduity, it has become a burden very hard to bear. Art is long, and a five years' curriculum too short to enable the increased outspread of this subject to be soundly grasped. We may ask, can nothing be done to adapt the teaching of it more precisely to the actual needs of the majority of future practitioners of medicine? Fifty years ago physiology was taught by the practising physician or surgeon, but now it is rarely, if ever, treated from their stand-point, and is in the hands of pure professors of the subject.

I am none the less of the opinion that physiology is one of the great foundations of our art, and must always be so, but we have seriously to bear in mind that medical students are not all preparing to be scientific physiologists. The development of the biological side has been great during the time I speak of, but I regret to find that the study of botany is now hardly reckoned within the compass of modern medical education. I rarely come across a pupil who knows the natural order of plants, or who could name properly any six of our common hedge-row flowers. I regard this as a lamentable decadence and a distinct loss, since I have always reckoned a training in botany as one of the very best for the future medical man. The mere names and details may be safely forgotten, but the study of specific distinction and differentiation is invaluable as a mental

* "Medicine may and ought to be pursued in a scientific spirit, as ought navigation or engineering, but it is no more a science than these are; it is a practice—an art, that is—which, like all arts, preceded science, but latterly has derived its means more and more from scientific investigation; yet it is by no means restricted thereto, being fed, as I have said, from sheer empiricism as well."—Prof. Clifford Allbutt, M.D., F.R.S., "Medicine and Philosophy," *Medical Magazine*, June, 1900, p. 336.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL, JULY, 1900.



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Medical Magazine, June, 1900, p. 356.

training for future clinical work. So I feel thankful that I had three courses of botanical lectures in my time, and spent some of the happiest days of my life in filling my vasculum in the glorious Highlands of Scotland under one of the greatest masters of his time. These happy chapters of student life are unknown to you, and I can only pity you for the loss you thus sustain. Fifty years ago botany was held to be of importance, and its study, no doubt, did much to encourage accurate appreciation and clear-mindedness.

Chemistry was at that time a comparatively simple science. The development of it in respect of organic matters has been unceasing, and even small departments of it now constitute studies for a lifetime. It is strange to think that the importance and significance of albuminuria were hardly recognised half a century back by the rank and file of the profession, though Bright and Christison, and a few pioneers of animal chemistry, were then disclosing the meaning and associations of it. The stethoscope was scoffed at by many of the foremost men of that day, and pulmonary tuberculosis was still diagnosticated by the pulse, and the tendency to float or sink of the sputa when poured into water. Cardiac hypertrophy, which we regard as a kind act of nature, was then attacked as an enemy, and its vehemence reduced by prostrating drugs. Clinical thermometry was hardly recognised, and its significance unknown. Every hard pulse afforded an indication for venesection. Leeches were used by the hundred. Blistering and counter-irritation were in daily use. An inflammatory process anywhere was the signal for the free use of mercury. People were regularly bled every spring. Aperient doses were very copious, nauseous, and drastic. Fever patients were usually starved; Graves, of Dublin, however, remonstrating against the practice, and desiring for his epitaph the simple sentence, "He fed fevers." I might add to this list did time permit, but I have stated enough to convince you of the mighty changes in the outlook of to-day. And all that I have mentioned went on here, in this, as in other great schools of medicine, at the time I speak of. What shall we say of it? We venerate our predecessors here who carried out these practices. We think we have fallen on better times, and know much that they did not, and could not know. This is the case. But assuredly we are not here now to sit in judgment on the great men who went before us. Times have changed, and we have changed with them. Are we then to believe that much was wrong in medicine in the lifetime of our fathers, and that all is right to-day? Some ardent and sanguine spirits among my auditory and elsewhere may affirm this, but I am prepared to join issue with them. I propose to state my position therefore, and to do so by laying down and contending for two main propositions. First, that our predecessors in the profession were not all ignorant, unobservant, or unwise men; and secondly, that the constant pursuit of novelties in medicine is beset with snares, and that a practice rapidly accommodated to such pursuits is not that of the wise and rightly trained physician.

First, then, it is not to be supposed that the great physicians of the earlier part of this century were ignorant of many of the great truths in medicine. They used the light and the opportunities they had. The plentitude of knowledge that has come to us in the recent past has tended to obscure the fact that many of the clinical problems presented to them were apparently simpler and more readily unravelled than they now appear to us. They set themselves to question these by their unaided senses and well-trained wits, and they did so with an assiduity of observation and attention to details which we are perhaps too apt now to discard. We are almost debauched, if I may say so, by the number of revealing instruments and methods which are available to-day for the prosecution of clinical research, and we are too ready to apply these, and too little disposed to use our wits and unaided powers of observation in individual cases. We make short cuts with instrumental aids to arrive at a diagnosis, and do not always reach the real inwardness of things even then. The experience of the older physicians was great, and they set themselves to follow Morgagni's dictum:—"Nulla autem est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare." We are too apt to forget that many of the practices I have just enumerated, and which are flippantly condemned to-day, contain germs of truth. They were certainly somewhat blindly followed, often in obedience to traditional authority, which is always apt to be dangerous. But it is certain that germs of truth may long lie dormant, and but slowly develop, and their full growth may be reached in very different circumstances from those in which the genius of the discoverer first projected them. Indeed, what is true, was, is, and ever will be true, and no time or fashion of the day can alter it. Moreover, that which is likely to endure is commonly of slow growth, and, not seldom, he who sets forth an original idea to-day may never see the ultimate outcome of his discovery. Again, new ideas, as they are conceived, must always be enshrined in the current thoughts and language of the time they are disclosed. The latter inevitably change with the progress of time. The setting of the jewel may be varied and beautified, but the gem itself remains unaltered.

Hence we have often but to reset the ideas of our predecessors in physic, and to accommodate them to the mode of our own time, or perhaps to recast them, and so render them available for to-day's use. Our temper should, then, not be that of the relentless iconoclast. If we intrude into the old shrines and break up the images we should look carefully for the hidden gems they almost

certainly contain. Let me apply these views, and deal with some concrete instances to make clear my meaning. We find that abuses in practice crept in owing to routine habits, false doctrines, and the tyranny of tradition. The practice of bleeding so prevalent early in this century fell into disuse, and five and twenty years ago was practically abolished. The lancets rusted, and the trade in leeches greatly declined. But, gentlemen, there is a time to bleed, and a time to abstain from it. The prudent and observant physician knows this, and he is quite uninfluenced by any prevalent fashion which either encourages or discourages the practice. The oculist, who sees what he is doing better than the physician, never gave up the practice in deference to those who condemned it as an enfeebling procedure. There were, and there are, and always will be, cases in which it is proper to employ abstraction of blood. There was therefore a not inconsiderable measure of truth underlying this practice of our predecessors. Many of them outran discretion, and the knowledge of their time forbade their recognising the exact conditions in which alone bleeding was a sound practice.

Again, the hard, or, as we should say, the tense pulses, which to them always indicated venæsection, are now recognised by us as sometimes salutary, or as demanding more benign eliminative methods of treatment. But some of the conditions thus manifested were clearly appropriate for the lancet, and were wisely thus treated and with benefit, and the same holds good now, albeit I think there is still too much hesitation to bleed, owing, not a little, to prejudices on the part of the patient or his friends.

With respect to the employment of mercury, we find much the same comment to make. It is true that the great value of this drug has been rediscovered in recent years. It was certainly grossly abused, as was bleeding, and equally stormy disputes occurred regarding its value, especially in relation to its power of reducing inflammatory processes. It was credited with virtues it did not possess, but it did unquestionable good in many cases. We now recognise its usefulness in reducing pulses of high tension, and know that no agent so well and so promptly relieves gastric and biliary catarrhal states. The disuse of mercury led to much continued suffering on the part of patients, and so its several compounds had to be brought back again by those who had been diligently instructed not to employ them. This was my case. In my student days, mercury was largely out of fashion for all ailments, and was, in the Edinburgh School especially, denounced at that time as a remedy for *lues venerea*. With many others I had quickly to unlearn this teaching, and to discover how very wrong it was. So here, as in other cases, we find that a reformation is attended with much that is wrong in itself and undesirable, but good comes of it in the end when the pendulum swings calmly once more. Our predecessors, then, were not altogether in error. They had a modicum of the truth of these matters, and we have been, with further light and experience, enabled to find more clearly wherein the truth lies. (I might here throw out a suggestion that the calomel of our predecessors' days was a more efficient drug than the chemically [perhaps too chemically] pure salt used to-day. It appears to have been more prompt in action, more aperient than ours, possibly owing to some admixture with bichloride of mercury.)

Again, it was formerly the practice to employ purgative medicines to a far larger extent than is now done. As Abernethians, we may here recall the famous prescription of Mr. Abernethy of blue pill and black draught which was greatly in vogue, and which has now been replaced, often inefficiently as I believe, by doses of aperient mineral waters. The fashion set in against purgatives, not improbably because many of them were drastic, griping, and lowering. Modern pharmacy has, however, removed many of the crude qualities of the drugs which were used fifty years ago, and we may therefore now employ them with more certainty, and, as the old doctors said, *jucunde*, for the same purposes our predecessors were wont to use them.

Once more, the older physicians held strongly by the conception of certain bodily habits or proclivities which they termed diatheses. They were impressed by the varied manifestations which attached to particular families or individuals in respect of their tendencies to certain ailments and diseases. They were led, too speculatively, no doubt, after the fashion of their time, to elaborate a variety of these conditions or diathetic states, and they over-elaborated them with an unwarrantable refinement with which we now find it impossible to agree. For many years past, these doctrines have been discarded and forgotten, and members of the human family have come to be regarded by those who oppose these views as so many indifferent units, or items, void of any textural peculiarities or proclivities. Some amongst us, however, have come to see that there was a basis of truth in some of these neglected observations, and that if we honestly use our wits we can find abundant evidence to satisfy us that several diathetic habits of body exist. I will only allude to the scrofulous and rheumatic diatheses, and in respect of these will affirm that the most recent achievements in medicine, those of bacteriology, tend to confirm the truth of the older doctrines in regard to them. The proof lies in a recognition of the fact, for fact I believe it to be, that certain families and individuals are, either by heredity or acquirement, impressed with textural proclivities in the direction of one or the other of these conditions. We recognise the tissues of such persons as being specifically apt to react mischievously, or to be especially vulnerable, to the attacks of microbic parasites, particulate, as in the case of tuberculosis or toxic, as in that of the infection of rheumatism, which I regard as a toxæmic condition due to invasion by some microbe as yet undiscovered. To entertain any doubt on these matters is, in my opinion, to be possessed of slender clinical instincts.

Were they not amongst the certainties of medicine for some of us, it might suffice to remark here and now that our late and ever to be revered master, Sir James Paget, held by these doctrines, and taught them in this school. Thirty years ago they were taught by Laycock, of Edinburgh, who impressed their importance on his pupils, but, as I well remember, his voice was at that time as of one "crying in the wilderness." Those of us who sat under him have long had good reason to bless his teaching, and realise the truth and value of it.

I have tried to show you that some of the best established methods of older times were not altogether wrong or mistaken, but that we have in our day come to improve them, and to find more certain indications for their application. This I believe to be a sound and rational practice, one which helps to establish more firmly the principles of medicine. What we have carefully to do is to learn by observation how to employ the methods which have long been proved to be of value in the treatment of patients' ailments, to master this art, and to equip ourselves soundly with the general principles of successful treatment.

I now pass on to declare, secondly, that this is not what is now being done in the whole field of medicine. A very different plan, indeed, is followed, and, as a consequence, I venture to affirm that our art has not improved so much as it might have done, that many of the acquired certainties and benefits of therapeutics have been lost, and that we do not afford to our patients the full and prompt measures of relief that are possible for them.

What, we may ask, then, is the mischievous element in our modern system of therapeutics? I would express it thus:—A perpetual pursuit of novelties, an untiring effort to produce new remedies, the enjoining new methods of dietary, and with all this the inevitable loss of any well-acquired principles of treatment as founded on long experience of others, or of personal experience laboriously acquired for one's self. When will men learn that what is *new* is not always *true?* I see constantly examples of the employment of remedies which no one has any trustworthy experience of. I meet with prescriptions composed of many drugs of whose existence I have no knowledge, and which are in no pharmacopœias. Every week I am informed from German and American sources of some new synthetical compounds, generally with unpronounceable names, which I am invited to use on the strength of monstrous assertions and the raw experience of some young and imperfectly trained physicians. The documents setting forth the encomiums on these so-called remedies go quickly into my waste paper basket, sometimes with parcels of these strange compounds, but I fear that they enlist the interest of some practitioners who, believing this nonsense, forthwith set to work to try their effects on patients. This is very bad, and unworthy of well-trained practitioners. The state of mind it reveals is lamentable, for it is simply impossible to acquire sound experience in any such way. My position is by no means that of a mere *laudator temporis acti*, and I am not averse from the employment of new methods that distinctly prove themselves to be useful. But I maintain that the mental attitude which is content to be always in pursuit of the latest novelty, and to be expert with the newest product of the chemical laboratory, is not that of the calm and level-headed physician. How can anyone in full practice take note of and keep pace with the new things that are daily foisted on his attention? If he attempts a small part of it, he at once fails in his duty to his patients, he weakens his clinical instincts, and loses hold of well-defined principles which should always be his main guides in practice. And so, I regret to say it, we have frivolous minds amongst us at work in therapeutics. This is the danger of it, and it is high time to rebuke this spirit which has already taken too much hold upon many in our profession.

Gentlemen, I venture to affirm that this is not a St. Bartholomew's temper of mind. You will not, I hope, acquire any of it here. You will go out all over the world fortified with sound principles, many of them worked out within these venerable walls in years gone by, by men of strong intellect and well balanced judgment, and thus will you be fortified against the temptations to pursue new things for the mere sake of their novelty, to let go hardly acquired principles while you with light-mindedness follow each *ignis fatuus* which dances before you. I, at all events, have lived long enough to see how many of these novelties have had their little day, and have vanished; how strange remedies and curious dietaries, which were always useful, we were told, while they were in vogue, have been forgotten. Hence, I often ask myself, when a new drug or a new method is in repute, how will it be in three years' time?

But we have novelties even in the matter of ailments and alleged morbid states. These come, and they go. To-day we find weak hearts asserted to be very prevalent; lately gastric dilatation was perpetually before us, then neurasthenia; next phimosis became of extraordinary frequency, while typhlitis and naso-pharyngeal adenoid growths are heard of on all sides in society. To-morrow there will be something else. What then are we to do in these hurrying, feverish, closing days of this wonderful century? I will tell you as I conclude. We are to be calm, and we are to keep our heads, to be level-headed, to see all things in due proportion, to hold fast by all we have learned to see as most certain and dependable in medicine. We are to expect difficulties, to be patient in our failures, to seek alone for what is true, to be as accurate as we can be, and in and through all to have cheerfulness and strong hope. On these lines we shall do best, and we shall at least not be in danger of frittering away our time and energies in the empty pursuit of novelties.

We are now often told that the young diplomates sent out from the schools are ill equipped for the duties that await them.

If this is true it constitutes a serious reflection on us as your teachers. We do not expect you to be experienced practitioners on the day you are qualified, but we try to furnish you with sound principles and to train you in accurate clinical methods. I certainly do my best to make you see, think, and judge for yourselves while you are with me in my wards, and to train you as practically as possible in the recognition and treatment of disease. I know that my colleagues and your tutors do the same. I can hardly believe, therefore, that the charge I have mentioned can apply to those who study here. In any case let me impress upon you all, that your one object in coming here and studying medicine is to enable you to treat patients with skill and with sympathy. The idea that you are here only to learn to pass examinations is a very base and inadequate one.

If you work in the spirit I have just mentioned, you should find your examinations full of pleasurable interest, mere landmarks on the road of your life studies, in no way to be dreaded, but rather enjoyed.

If I am wrong, the fault can only lie with your examiners, and that is hardly possible, for I suppose good examiners are only concerned to discover what you know, and not what you do not know. They never forget that they were once, like you, students themselves.

Let me say, lastly, that it is a true pleasure to return here to the scenes of former days, to meet the best and aspiring ones in this great school. In a few years, some of you will be carrying on our work here, amid fresh environment, with new seductions and temptations to wander into fields of study and interest which are closed to our present outlook. Indeed, the possibilities that await our Art in the future are enormous. The recent past and the present fully justify such anticipations. But even with such a certain outlook, I will not hesitate to warn you of the risk of discarding the best acquired knowledge of to-day; and I will commend to you, throughout your whole career, a measure of steady conservation which will serve to make both your progress and that of our great Art itself safe and profitable. If you seek what is new, see that it be nothing less than true, and that the novelty is a gem which has only been hidden in the past, and awaiting the genius of him who has unearthed it and laid it bare for the abiding welfare of humanity.

You will then not fail to confer honour and worthiness on the calling you have selected for your life's work. If you are serious cultivators in the great field of medicine, you can follow no other course.

Notes by a Country G.P.

II.

IN a previous number of the JOURNAL I contributed some examples of cases which might be met with in a busy country practice. I venture now to offer for the perusal of any of its readers who honoured me before examples of how the busy G.P. may be deceived *Nemo mortalium omnibus horis sapit.* The good Homer is said to have sometimes slept, and truly all men agree they are human and therefore err, but woe unto the doctor who errs or seems to err, or allows he errs! The doctor must be above mistakes and beyond doubt; he must be certain. Blamed he may be for these, but also blamed whichever way he turns. So let him keep his mistakes to himself, ruminate them, and never make them again. A dear friend of mine never did well in general practice because he would persist in dwelling on the doubts and difficulties of the case at his patient's bedside when he considered that patient "intelligent." The friends are rarely so intelligent, and the patient's intelligence evaporates with increasing discomfort. I much doubt whether we can make our present state of knowledge intelligible to the best-intentioned layman, and we probably still loom large as the magic man. But I rather wander from my subject of "mistakes." I keep carefully noted and carefully locked up my *rôle* of mistakes. I classify them, and try to prevent their recurrence. We do, or ought to, in the present order of the universe, profit by our mistakes. They appear to be the sad experience we must all pass through to the attainment of knowledge *per ardua ad astra;* through countless wrong tracks the road leads to care and more accurate knowledge; and then when we have got it, when our opinion is valuable and we know it is, and when a small—very small—amount has been handed over, we die, and others tread the same painful path, perhaps at a different level, yet still with the same potentiality of error; with a vaster sphere there is a vaster chance. Can any of us but grieve when we think of the "might have been," and what we did do, what we might not have done! Do any of us not see the mocking spectres of those we tried to help—a limbo of pain, scorn, joy, hate, fear!

I have read somewhere a classification of mistakes that the foregoing brings to my memory. The author divided his mistakes into the fact and the cause of the fact. His mistakes arose—(1) from not doing what he should, and (2) from doing that which he should not, and these were due to two causes: (α) from absolute carelessness; (β) from the finite nature of his human knowledge. He apparently had no mistakes from the cause (α), and as these for present purposes may be considered as having no sort of right whatever to occur, I shall confine myself to the relatively justifiable mistakes. But even for the former class there is some justification, for there is such a thing as mental exhaustion, and mental exhaustion would lead to a state of mind which would make the explanation of the mistake overlap another. Still, I think they need not be discussed now; they may be discreetly buried.

A good classification of mistakes should be at once retrospective and prophylactic. Mr. Marsh, writing in the Hospital JOURNAL (January, 1896), gave some valuable headings which have these features. Dr Murray, in a little book entitled *Rough Notes on Remedies*, classifies mistakes into—(1) those which can and ought to be avoided by every intelligent and careful practitioner; (2) those only avoidable by unusual experience and insight; (3) those which no amount of care and experience could avoid.

This classification is mainly retrospective, and is chiefly valuable in giving the mistaker comfort and solace. But it seems to me the best classification is that based on the mind process, which should and does determine and influence, however dimly, all human reasoning, viz. logic. Whatever may be our whims, fancies, and inconsistencies whenever we attempt to reason thereon, we must, to reason safely, knowingly and unknowingly use that all-sufficient and inclusive process. The opposite to the logical is the alogical process of chance. Now much depends on chance, and the results of a mind process which makes no attempt to reason must depend on chance, and on chance also depend results which have no element of reason or reasoning in them. This group must be a large one, and therefore our classification must cover mistakes so depending. Of logic I need say no more; it is the science of all science—the science of the Laws of Thought. But of chance there is a little to be said to explain my use of the term, and may I be forgiven if I appear to wander into the realms of controversy unsuited to the JOURNAL. (I should like to hear some of your readers on these subjects.) It was said by them of old-time and by some now, that there is no such thing as chance in the universe. Every happening or event is capable of reduction to a final cause or law, so that an infinite intellect able to view eternity at a given moment could see the "why." Chance, they said and say, is merely imperfect knowledge. Here we have to do with infinite time and infinite space with infinite matter. Logic only deals with the definite, with form and actuality, not with matter and potentiality. If we knew all things, I suppose they would conform to a rational plan, and nothing would be unaccounted for. Every event happening is conditioned by heaps of other events, themselves conditioned by heaps of other events which might never have happened. We cannot contemplate infinity. Even if I have not made myself clear on the difference between the logical and alogical, yet I have tried to make it clear how I am using the word "chance" for purposes of classification. To give two examples of "chance:" chance exists in the head or tail result of coin tossing. Chance existed in this sequence: journalist A walks down Fleet Street. He is for a few moments obstructed by a bootblack colliding with him, and misses the train at Ludgate Hill. In the next train he meets Editor B, who asks him to write an article on a strike in progress. The particular article leads to an angry controversy, questions are asked in the House, and the ministry falls. Owing to a change in ministry, a European war is precipitated, and the map of the world is perchance altered—by the shoeblack! But then the shoeblack himself was playing marbles, and was angry. Who knows how the shoeblack's character was formed? He was angry over his trivial game. So on to infinity are the conditions and conditioned—quite beyond any human foresight or logic. The subject is far beyond my powers to deal with, but I think the concrete method explains my meaning. Chance, then, is the unforeseen, and what is more, unforeseeable. Here is the classification of mistakes based on chance and logic:

Mistakes are

(A) Alogical, or due to chance.

(B) Logical.

(B) is divisible into terms of premiss * and conclusion, thus:

I. The conclusion is wrong
- 1. Because the premisses are wrong.
- 2. Yet the premisses are right.

1. results because
- (1) Observation is *insufficient*.
  - (i) Due to insufficient hypotheses and no "looking for."
  - (ii) All phenomena not noticed
  - (iii) Phenomena are unnoticeable by present means.
  - (iv) Carelessness, etc.
- (2) Observation is sufficient, but there is bias.

2. results because
- (1) Reasoning is careless.
- (2) Reasoning is unskilful.
- (3) Reasoning is good, but knowledge of it is finite (this borders on A).

* A premiss is a proposition put forward from which we may argue to another called a conclusion, and this conclusion may be arrived at by several mind-processes (reasoning). When we have this power of "concluding" we may be said to have reason. When we arrive at a conclusion almost without using these mind-processes we are geniuses, being "inspired."

II. The conclusion is right and the premisses are right. (This = perfection).

III. The conclusion is right yet the premisses are wrong.

To some examples of these mistakes I shall return on a future occasion.

A Case of Suppression of Urine.

(Reported by H. D. O'SULLIVAN, Esq.)

G—, æt. 65, a gardener, admitted to the Wolverhampton and Staffordshire General Hospital, under the care of Mr. Winter, January 1st, 1900.

Previous History.—Has had severe pain on many occasions in lumbar region (especially on right side) and in small of back, but never typical renal colic.

Recently has experienced some difficulty in micturating, and has taken spirits of nitrous ether "with benefit."

History of present complaint.—On Tuesday, December 26th, 1899, whilst at work, he was taken with pain in hypogastric region. During the day he passed urine "several times and in fair quantity;" but at night the flow ceased entirely and the pain became worse.

During Wednesday and Thursday no urine at all passed. On Friday a "few dark brown spots" passed. Since Friday none at all.

On admission.—Looks ill. Tongue dirty—thick, whitish-yellow fur. Temperature normal. No vomiting. No œdema, save over subcutaneous area of left tibia, where there is a red, inflamed patch, pitting on pressure. There is no obstruction in urethra. Prostate a little enlarged. It was easy to eliminate rupture of bladder. A provisional diagnosis of obstructive suppression was arrived at.

January 2nd.—Condition worse. Temperature 99° F. No urine. After a consultation it was decided to wait twenty-four hours. Pulv. Jalapæ Co. was administered, and the skin encouraged to act.

During the day a catheter was passed and nearly three ounces of bloody urine obtained. This was found to contain an enormous quantity of albumen, many catarrhal cells (polynuclear leucocytes), and an extraordinary number of beautiful transitional epithelial cells. There were no casts, though a most careful search, after centrifugalising the specimen, was instituted.

January 3rd.—No alteration. Operation 10.30 a.m. Gas and ether. Right kidney exposed in loin and brought out of wound, after resection of a portion of rib. On palpation and inspection nothing abnormal was made out concerning the organ.

An incision was made crossing the junction of the ureter with pelvis, and a sound passed into pelvis and calyces. Through this opening a catheter was also passed downwards into the bladder. No stone could be felt, nor was there the slightest obstruction in course of ureter. This incision was then closed with considerable difficulty. The kidney was returned and the wound closed, save for a gauze drain.

The left kidney was next explored, also by lumbar incision. A small hydronephrotic kidney was found, which ruptured during manipulation. There was nothing but a small flaccid sac, and the ureter was thickened and fibrous. The organ was, therefore, removed.

Progress of case after operation.—The patient stood operation remarkably well, but on recovery from the anæsthetic was very restless. At 10 p.m. uræmic symptoms became prominent. Four pints of normal saline solution were injected into a vein. A very remarkable improvement ensued, consciousness returning, pulse improving, and skin acting freely. The man slept little during the night. In the early morning urine was secreted freely, tinged with blood.

January 4th, otherwise uneventful.

On January 5th pulse very good, and condition hopeful. At 10.30 p.m. pulse was failing, the patient almost comatose, and markedly uræmic.

Four and a half pints of normal saline solution injected intravenously. Very little benefit accrued.

On January 6th the patient was quite conscious, but pulse worse. Death took place at 1.30 p.m.

Post-mortem, January 7th.—Right kidney contained no stone. On section it appeared somewhat blurred (thirty hours after death). It was very little if at all enlarged. Right ureter perfectly patent. Bladder normal. Left ureter thickened and fibrous. A No. 3 bougie could be *forced* along its lumen. Sections of left kidney showed vestiges of renal substance surrounded by extensive dense masses of fibrous tissue. Similar microscopic sections of the right kidney were somewhat strange to us. As we could not come to any agreement as to the state of the organ a specimen was sent to Clinical Research Association.

The report was as follows:—"This section shows a considerable increase of the fibrous stroma of the kidney. The glomeruli are not much affected. In one part of the section the tissues are blurred, and the epithelium of the tubules is swollen and granular, as though due to infarction. It is remarkable that there should not be more dilatation of the convoluted tubules in view of the widely spread interstitial fibrosis."

Remarks.—We think this case of sufficient interest to be reported at some length. It obviously presents several pathological problems, whilst on the clinical side the question of diagnosis and operation in such cases is a nice one. At consultation the diagnosis was considered to rest between calculi blocking both ureters, and a calculus in one ureter, the other kidney being functionless.

[One of the several pathological problems that rather readily occurs to us is the question of granular kidney with onset of uræmia. But in the absence of any note as to the state of the pulse, vessels, left ventricle, and fundus of the eyes the question remains unanswered.—ED.]

Correspondence.

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

IMPERIAL YEOMANRY HOSPITAL,
DEELFONTEIN, SOUTH AFRICA;
June 18th, 1900.

SIR,—Perhaps a few details of the life and work in the Imperial Yeomanry Hospital may prove of interest to your readers, judging from my own pleasure in reading Mr. Bowlby's able account of the Portland Hospital. The nursing sisters, who were the last of the staff to arrive, reached Deelfontein on March 17th, and two days later the hospital opened its doors to 100 sick and wounded men. Beginning in this quaint way we now, after three months' existence, accommodate 604, and the work goes on increasing. As in all South African hospitals at this time, the medical cases far outnumber the surgical, and while the physicians are over-worked with attendance on innumerable cases of enteric and dysentery, the surgeons have comparatively very little to do, much to their disappointment. All wounds do remarkably well, and the enteric and dysentery cases are well nursed day and night, though the great difficulty out here is to get a proper and adequate supply of fresh milk and eggs. The type of enteric here is severe, with much hyperpyrexia, delirium, and frequent early heart failure, so that few of the cases, on the whole, are protracted. Many inoculated men have died of it. The hospital accommodation consists of fifteen huts and twenty-seven tents for acute cases, besides convalescent tents holding 250 beds. The larger huts, made in England, and beautifully constructed by Boulton and Paul, of Norwich, hold from thirty to thirty-two beds; the smaller, colonial-built huts, twenty to twenty-two beds. The enteric huts are arranged in a kind of square, and have a special sister and orderly provided day and night, for the work is naturally very heavy, especially if the patients are nursed according to the most approved up-to-date fashion. The tents have an orderly each, and a sister superintending a certain number at each end of the camp, the convalescent patients doing a good deal of the work. We are all under military rule here, and it takes some time to put off the civilian ideas of hospital management and discipline, and adopt as far as possible the military methods. Personally I much prefer the former!

Like Bart.'s we are a parish of our own, and have a church and chaplain, the Rev. J. Blackburne, C.F., who has done good work at the front, and is doing a good deal here, working hard, and being much liked by all sections of this community of over 1000 souls all told.

The church is quite pretty, and the services well organised and attended. Lately it has been the scene of two very sad services, one a Requiem service for Lord Chesham's son killed in action, the other the funeral service for one of the young medical officers who died after a brief but acute attack of enteric fever contracted here.

Beyond the western end of the camp begin the fashionable "suburbs" of Deelfontein, where Lady Chesham, Colonel Sloggett, the Commandant, and Mr. and Mrs. Fripp live in "elegant villas" surrounded by picturesque verandahs, whence kindly hospitality is dispensed at tea-time to wounded officers and the nursing sisters!

Though primarily intended for Yeomanry, a large proportion of the patients, if not the largest, are regulars, and many interesting stories do they tell, and many interesting treasures can they show from Cronje's laager, the siege of Kimberley, and latterly the siege of Mafeking. Our last trainload of sick and wounded came from the latter now celebrated place, but so far our patients have come from Bloemfontein, Fourteen Streams, Nauwpoort, De Aar, and Kimberley, so we are very glad to get them first-hand from Mafeking. More surgical cases have come down in the last three hospital trains than we have had for weeks, and they are officers and men wounded in the recent skirmishes with the rebels about Lindley, Hoopstadt, Kronstadt, and thereabouts, where our D.C.O. and Imperial Yeomanry suffered so severely. A large number of colonials, both officers and men, have been patients here, and one cannot fail to be impressed by their fine physique, extreme courtesy, and chivalry of manner and self-reliance. Even here, where all are worthy of admiration, they stand out conspicuous in these qualities. It is a real pleasure to have anything to do for them.

Your many nursing readers will be interested to hear the work is much harder than the work at Bart.'s or any London hospital, and the hours almost, if not quite, as long. The day nurses breakfast at 7, and go off duty at 8.30, but it is very difficult to get off duty during the day time, owing to the number and severity of the cases, and the fact that the orderlies are off duty (except in the enteric huts) every day at 5 p.m., leaving the sister alone for the rest of the day. Unless the convalescent patients helped a good deal it would be impossible to get through the work at all.

The highest superintendent (which I happen to be at present) has a very interesting post, though it is a tearfully distressing thing to see every night 245 or more enterics in all stages from the dying to the convalescent, many of them mere lads of 18 or 19, and to realize that up and down the whole track of the campaign every hospital, civil and military, is in the same state, and that the cases may actually be numbered by thousands.

Lord Roberts is not allowing any man who has had enteric to return to duty at the front, a most wise and merciful rule, as cases are slow in picking up in this country, and very liable to relapses and attacks of dysentery during convalescence.

The winter has now set in, and the nights are sometimes extremely cold, but the sunny mornings are delightful, and like bright October days in England; moreover the plague of flies has greatly, if not entirely, abated, for which we are most thankful. They worry the patients terribly, and, it is thought, help to spread infection to a large extent, especially as all the worst cases seemed to dislike being under mosquito nets, and so exposed themselves to the torment.

The wards are very fairly warmed by large oil stoves, and keep at a very even temperature, but ventilation in the enteric huts, especially on these bitter nights, is somewhat of a difficulty. I may as well end this rather discursive letter by giving you the statistics for the day, a task entrusted to the highest superintendent for the time being.

Our total number of patients to-day, June 18th, 1900, is 604.

Of these 245 are enteric and 217 more are medical, *i.e.* dysentery, slow continued fever, rheumatism, and what not; the rest, 142, surgical, chiefly bullet wounds.

Mr. Christopherson's friends at St. Bartholomew's will be glad to hear he is in excellent health, and enjoys great sport at buck-shooting, by which the nursing staff commissariat profits greatly. The other members of our alma mater, including myself, are also very well, and enjoying the new experience, but we shall be quite glad to see England again when our work is accomplished here.

Believe me yours sincerely,

ROSAMOND E. ROLLESTON
(Sister Elizabeth, St. B. H.)

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

ETHER ANÆSTHESIA IN COLLAPSE.

SIR,—I have read with considerable interest your Reviewer's remarks on ether as the anæsthetic of election for cases with severe collapse, its use being advocated by Dr. Dudley Buxton in his book on "Anæsthetics, their Uses and Administration." An extensive experience in administration of anæsthetics and private practice has impressed me with the truth of your Reviewer's criticism. In an article on 'One Thousand Consecutive Inductions of General Anæsthesia,' I wrote, apropos of ether given to a collapsed patient, "The one drawback is that I have seen the operation unduly prolonged by the surgeon, who has been quite happy so long as the pulse was strong and the breathing loud. It must never be forgotten that in these cases the patient is going at top pressure, and when a few hours later the stimulus of the ether wears off the resulting collapse is very great, and sometimes fatal. In desperate emergency cases, from the anæsthetist's point of view, ether is invaluable, and has often saved me from having a death on the operation table, although the patient has not infrequently succumbed within the next twenty-four hours."

I am, etc.,

C. HAMILTON WHITEFORD.
Hon. Anæsthetist to the South Devon and East Cornwall Hospital.

Plymouth.

Notes.

THE Shuter Scholarship has been awarded to H. H. Dale (Trinity College).

* * *

THE Bentley Prize has been awarded to E. E. Young.

* * *

IN our notice last month of Dr. Hubert Roberts' appointment as Physician to In-patients at the Samaritan Hospital, we inadvertently substituted Queen Charlotte's Lying-in Hospital for the Samaritan.

* * *

G. J. R. LOWE has been gazetted a Second Lieutenant (dated April 25th) in the 1st Vol. Batt. Lincolnshire Regiment. This notice should have appeared in our last issue.

* * *

AMONG the many Sisters that have left for South Africa during the past six weeks are the following Old Bart.'s nurses:—D. Westbrook, M. Moore, K. French, L. E. Snape, M. May, F. M. Baukes, J. Smith, and F. P. Carruthers. We heartily wish them a successful spell of work and a safe return.

* * *

WE print this month an interesting letter from Sister Elizabeth, describing the work of the Imperial Yeomanry Hospital. We are also indebted to the same correspondent for the birdseye view of the hospital issued with this number.

* * *

FROM a recent issue of the *Daily Mail* we take the following cablegram "from our own correspondent" at New York:

Dr. Frederick Peterson, instructor in psychology at the Columbia University, caused a sensation yesterday by using a paretic from an asylum to illustrate a lecture to the students.

The paretic, who seemed unconscious of the situation, said his name was "Benjamin Franklin George Washington Adams," that he owned the British Navy, and was 80 feet tall.

The Professor explained lesions which caused the condition of the man's mind.

"Sensations" are cheap in New York, evidently, or "our own correspondent" finds "news" with difficulty just now.

* * *

THE *Daily Graphic* supplies us with the following:

WINE VERSUS BEER.

There are prophets among us who are always wishing that our agricultural classes could drink weak wines, as the temperate French do, instead of the heavy beers with which they usually quench their thirst. An article in *Blackwood* by Mrs. P. G. Hamerton may be recommended to their attention. According to Mrs. Hamerton, though the wine does not make the French peasants drunk, it makes them rheumatic and anæmic, and nobody who has ever tasted those wines is likely to doubt the truth of her contention. Their acidity is appalling, as is the acidity of almost all cheap wines everywhere; and of course the weaker the wine the more acid the consumer is likely to get into his system, and acid in the blood is, as we all know, the main cause of many painful ailments which cripple human energy. Bad beer is never quite so bad as bad wine, and there is not so much of it in the market. Very likely this is one of the reasons why, notwithstanding their greater inebriety, the beer-drinking communities lead the van of human progress.

* * *

AND the following extract from the *Evening News* calls forth still another exclamation of "How long, oh British public, how long?"—

DEATH WITH HYGIENIC TREATMENT.

Some sensational evidence was given at Walthamstow to-day in an inquiry into the death of Dorothy Cole, nineteen months, the child of a gasfitter at Acacia Road, who died from alleged neglect.

The medical evidence showed that the body, which looked like a rabbit, only weighed nine instead of twenty pounds, and there was not a vestige of fat present. In the absence of organic disease, death could only be accounted for by malnutrition.

It seems from the evidence of the mother that she strongly objected to "drug" doctors, and had brought up the child under "hygienic rules," and fed it on "Dr." Allinson's food and cows' milk. Until a fortnight before its death the child had not been fed with the bottle.

"Babies' lives were never worth much," significantly added the mother. The morning the child died the mother took it, while in convulsions, from Walthamstow to "Dr." Allinson's house in the West End.

A juror: In that state you should have taken the child to a "drug" doctor.

Witness: The jury don't understand anything about it like I do.

"Dr." Allinson said his food was a patent food composed principally of pearl barley.

In returning a verdict that death was due to improper feeding, the jury censured the mother and father for their neglect, "Dr." Allinson for undertaking the care of a child at so great a distance, and directed the attention of the N.S.P.C.C. to the case.

Amalgamated Clubs.

GENERAL MEETING.

A General Meeting was held on Thursday, July 12th, at 12.30, in the Anatomical Theatre, Dr. Calvert in the chair. Forty-five members were present.

The minutes of the last General Meeting were then read and confirmed.

Mr. S. H. Turner and Mr. L. R. Tosswill then resigned their posts as Senior and Junior Secretaries respectively.

A vote of thanks was passed to the outgoing Secretaries, and the business of electing Secretaries for the ensuing year proceeded with.

Mr. Turner proposed, and Mr. Niall seconded, Mr. L. R. Tosswill as Senior Secretary.

No other proposals being made, Mr. Tosswill was elected *nem. con.*

Mr. Tweedie proposed, and Mr. Tosswill seconded, Mr. C. F. Nicholas as Junior Secretary.

Mr. Nicholas was elected unanimously.

A hearty vote of thanks was passed to Dr. Calvert, and the meeting adjourned at 1 o'clock.

CRICKET CLUB.

ST. BART.'S *v.* ADDLESTONE

This match was played at Addlestone on Saturday, June 16th, and ended in a win for Addlestone. Dr. Hope, an old Bart.'s man, who originally arranged the fixture, kindly made the team his guests for the day, and we had a most enjoyable match. Addlestone batted first, and compiled 308; in reply to this we only made 164, to which Body, Scoones, and Adam were the chief contributors. For the Hospital Nealor was the most successful bowler, taking 6 wickets for 76 runs. Scores:

ADDLESTONE.

Mountford, run out	4
P. H. Darling, c Hill, b Boyle	13
A. E. Darling, run out	42
A. C. Adams, c Wilson, b Nealor	28
Rev. W. Sharp, st Body, b Nealor	14
R. Paine, c Hill, b Boyle	53
J. Gray, c Boyle, b Nealor	0
A. H. Bell, c Scoones, b Nealor	32
F. G. Slade, c Nealor, b Nicholas	6
Rev. W. Williams, b Nealor	12
Dr. Hope, not out	52
G. Kilner, c Nicholas, b Nealor	19
Extras	26
Total	308

ST. BART.'S

1st Innings.		2nd Innings.	
H. E. Scoones, b P. S. Darling	38	} did not bat.	
H. E. G. Boyle, c Rev. Williams, b Paine	11		
W. S. Nealor, b J. Gray	8	not out	17
J. C. Sale, b J. Gray	12	} did not bat.	
C. F. Nicholas, b J. Gray	5		
C. H. Turner, b Paine	7	b Adams	26
H. T. Wilson, b Paine	1	} did not bat.	
G. H. Adam, l b w, b Gray	27		
H. B. Hill, b Darling	4		
F. M. Body, not out	40	c Slade, b Mountford	5
H. S. Ward, run out	0	c Williams, b Mountford	0
L. V. Thurston, c Darling, b Gray	0	not out	4
Extras	11	Extras	5
Total	164	Total 3 (wkts.)	64

SWIMMING CLUB.

MATCHES.

The following swam in the Team Race:—L. B. Scott, W. H. G. Thorne, A. H. Bloxsome, and D. M. Stone.

The following represented the Hospital in Water Polo:—C. Dix (goal); L. B. Scott (capt.), M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, and V. J. Duigan (forwards).

Referee.—Mr. V. B. Nesfield (U.H.S.C.).

St. Bart.'s v. *Ealing S.C.*—This match was played on May 23rd at St. George's Baths. Winning the toss, we started from the deep end. Working hard Bart.'s pressed their way to Ealing's goal, and Thorne scored with a hot shot. The passing on both sides was good. From now the game was very fast, Ealing trying their best to get through our defence, but for some time we resisted their efforts, but just before half-time they scored. On resuming Ealing played up well, and from a scrimmage in front of goal Cross scored. Dix saved two or three good shots in goal. Owing to Ealing's men turning up late we were unable to have a Team Race. Result, lost 1—2.

The following represented the Hospital:—C. Dix (goal); L. B. Scott (capt.), M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, and V. J. Duigan (forwards).

Referee.—Mr. E. H. Hunt.

St. Bart.'s v. *Cambridge University.*—This match was played on May 19th at St. George's Baths. Cambridge scored first by Bentinck. Then Thorne placed one to our credit. On resuming Bentinck added another for the Varsity, and at this the score remained. The game proved a fast and very even match. In the Team Race we proved the superiors, winning by over three yards. Result, lost 1—2.

St. Bart.'s v. *London Scottish.*—This match was played on Friday, June 15th, at St. George's Baths. The Hospital won the toss, and started from the deep end. On starting Bart's were first on the ball, and after some hard work a corner throw was awarded to them, which resulted in a goal being scored by Douglas. Even play now ensued, and just before half-time the Scottish scored through Cross. On changing ends the Scottish pressed, but failed to score. Shortly after another corner was given to the Hospital, and Douglas was again enabled to score. Nothing further being scored, the Hospital won a good game by 2 goals to 1.

The Hospital Team was as follows:—C. Dix (goal); L. B. Scott (capt.), M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, and R. I. Douglas (forwards).

LAWN TENNIS CLUB.

Final Round.

ST. BART.'S *v.* ST. GEORGE'S.

Played June 15th.

Singles.—C. I. Nedwill beat A. S. Bradley, 3—6, 6—3, 9—7.
E. H. Hunt lost to P. A. Hayne, 3—6, 6—3, 3—6.
A. O'Neill beat M. O. Hunter, 6—2, 7—5.
H. Whale beat N. J. McCaskie, 7—5, 6—4.
L. E. Hughes beat C. R. S. Bradley, 6—4, 6—2.
J. S. Hamilton beat G. H. Jones, 4—6, 6—4, 6—4.

Doubles.—C. L. Nedwill and H. Whale—
lost to A. S. Bradley and P. A. Hayne, 5—7, 2—6.
beat Bradley and Jones, 6—4, 5—7, 6—1.
E. H. Hunt and A. O'Neill—
beat Hunter and McCaskie, 6—0, 6—1.
beat A. S. Bradley and Hayne, 6—3, 8—6.
J. S. Hamilton and L. E. Hughes—
beat C. R. Bradley and Jones, 6—3, 6—0.
beat Hunter and McCaskie, 6—4, 5—7, 6—3.

Result—St. Bart.'s 10 matches, St. George's 2.

ST BART.'S *v.* R.I.E. COLLEGE.

Played at Cooper's Hill on Saturday, June 16th, and resulted in a win for the Hospital by 6 matches to 3.

Doubles.—E. H. Hunt and C. M. Pennefather—
beat Brancker and Green, 10—8, 4—6, 6—0.
beat Bœvey and Mr. Hicks, 5—7, 6—1, 6—4.
beat Murphy and McCraik, 6—3, 6—4.
J. S. Hamilton and L. E. Hughes—
beat Brancker and Green, 6—4, 6—3.
beat Bœvey and Mr. Hicks, 3—6, 6—2, 6—4.
beat Murphy and McCraik, 6—4, 6—1.
V. Bell and H. Walker—
lost to Brancker and Green, 4—6, 2—6.
lost to Bœvey and Mr. Hicks, 3—6, 2—6.
lost to Murphy and McCraik, 3—6, 6—4, 4—6.

CUP TIES.

2nd Team.

St. Bartholomew's II	a bye	Middlesex.
Guy's II	Middlesex	
Middlesex I		
St Mary's II	St. George's	St. George's.
St. George's II		
St. Thomas's II	St. Thomas's	
London II		

ST. BART.'S *v.* MIDDLESEX I.

Singles.—L. Furber beat E. T. Harris, 6—1, 6—0.
F. E. Wood lost to H. H. Boys, 0—2 sets.
L. R. Tosswill beat G. Hughes, 6—4, 5—7, 6—2.
H. J. Wraughton lost to W. Bain, 0—6, 2—6.
H. H. Butcher lost to F. L. Henderson, 3—6, 2—6.
V. G. Ward beat H. H. Rees, 6—0, 6—1.

Doubles.—L. R. Tosswill and L. Furber—
beat E. T. Harris and W. Bain, 7—5, 6—4.
lost to Boys and Hughes, 1—6, 6—4, 4—6.
F. E. Wood and V. G. Ward—
lost to Harris and Bain, 0—2, sets.
lost to Boys and Hughes, 0—2.
beat Henderson and Rees, 2—0.
H. J. Wraughton and H. H. Butcher—
lost to Harris and Bain, 0—2.
lost to Boys and Hughes, 0—2.
lost to Henderson and Rees.

ATHLETICS.

UNITED HOSPITALS *v.* DUBLIN UNIVERSITY.

The Dublin University Athletic Team came across to meet the United Hospitals on Monday, July 9th. In spite of the fine weather there was, unfortunately, but a scarce attendance. Mr. Rose kindly gave away the medals afterwards. The best race of the afternoon was the mile, when B. N. Ash (St. Bart.'s) beat the Dublin runner, W. H. Fry. Fry was second in the Irish championship mile. Meredith, who has previously won the English Quarter-mile Championship, won both the Quarter-mile and 100 Yards for Dublin. Horan also ran a good three miles. Appended are the results:

100 Yards.—Meredith (D.U.A.C.), 1; Wadson (Guy's), 2. Time, 10⅖ secs.
Quarter-mile.—Meredith, 1; Wadson, 2. Time, 52 secs.
Half-mile.—H. E. Graham (Bart.'s). Time, 2 min. 1 sec.
Mile.—B. N. Ash (Bart.'s), 1; W. H. Fry (D.U.A.C.), 2. Time, 4 min. 21 secs.
Hurdles.—Gibson (D.U.A.C.), 1; Watson (D.U.A.C.).
High Jump.—H. E. Lascelles. 5 ft. 9¾ in.
Long Jump.—H. E. Lascelles. 20 ft. 9 in.
Weight.—Bennett (St. Bart.'s).
Three Miles.—Horan (D.U.A.C.). Time, 16 min.

INTER-HOSPITAL SPORTS.

President.—W. Rose, Esq., F.R.C.S.
Captain.—C. H. R. Coltart.
Hon. Sec.—G. M. Leviek.
Judges.—H. S. Desprey, Esq., M.D., G. R. Turner, Esq., F.R.C.S., H. R. Drysdale, Esq., M.D., H. A. Munro, Esq., M.D.
Referee. C. Herbert, Esq., A.A.A.
Timekeeper.—P. Furnival, Esq., F.R.C.S.

It is to be regretted that these sports are so little patronised. They form one of the most interesting athletic contests of the year, even from the point of view of the outsider, who enjoys them only on account of the high standard attained by most of the winners, and the really sporting spirit maintained throughout. But when we consider that added to this great attraction there is that of keen competition between the hospitals for the Challenge Shield, we are utterly at a loss to understand why there are not more men to be found who are keen enough sportsmen to come and support their hospital. We can only suppose that the majority of hospital men do not care in the least whether their hospital wins or loses. Our own hospital is, if not quite the worst, certainly one of the worst in this respect. We do not propose to write a detailed description of events in which so little interest is taken, as it would obviously be waste of space.

Two of our representatives, both certain winners, were unable to be present. B. N. Ash deserves our thanks for the way in which he ran and won the mile. We want more of these men who take the trouble to train properly. St. Mary's won the Shield, and thoroughly deserved their success, as they broke two hospital records.

The Medals were presented by Mrs. Langton at the close of the Sports. Both she and Mr. Langton earned our gratitude for the way in which they turned up, both to these and to our own Hospital sports.

At the dinner afterwards at the Trocadero Mr. Rose presided, and when proposing the health of the visiting team promised that next time they came over there should be a larger attendance. For the last two years it has been customary for the visiting team to bring over only five men. It is to be hoped that next year the hospitals will see their way to send over a more representative team.

The League of St. Bartholomew's Hospital Nurses.

ON Saturday, July 7th, a general meeting of the League of St. Bartholomew's Nurses took place in the Great Hall of the Hospital. We are indebted to the columns of our contemporary, *The Nursing Record*, for the following details:

Punctually at 3 o'clock Miss Stewart took the chair, and was supported on the platform by the Hon. Secretary, Mrs. Walter Spencer; the Hon. Treasurer, Mrs. Launcelot Andrews; Miss Smedley, St George's Hospital; Miss Lofts, Lewisham Infirmary; Miss Finch, New Hospital for Women; Miss Barling, Kidderminster Infirmary; Miss Mollett, Royal Southampton Hospital; and Sisters Ophthalmic, Mark, and Surgery, members of the Executive Committee.

Miss Stewart, who on rising to speak was warmly applauded, said that the day was one of the happiest in her life. She could not help wondering if Henry VIII was very delighted also. She reminded the members of the League of their responsibility as the first society of certificated nurses formed in connection with a training school in this country. It was not the first society of the sort, because the Americans had had their Alumnæ Associations before it, but it was the first in this country. At the last meeting the constitution had been adopted, and since then the Executive Committee had been at work, and to-day the bye-laws were before the meeting. The consideration of the benevolent scheme was also a most important matter.

The President then expressed the pleasure she felt in welcoming so many former nurses of the hospital back to their old training school. The fact of renewing old friendships enhanced the pleasure of the meeting to many, but she could sincerely say that no one felt half as much pleasure in being present as she had in seeing them there.

The minutes of the previous meeting were then read and confirmed.

The Hon. Treasurer then presented her report, and remarked that, as the financial report was always a matter of some anxiety, she would at once allay this by announcing that there was a balance in hand of £14 19s. 7d.

The Hon. Secretary's report was as follows:

"I have to report that seventy new members have been enrolled since the last meeting on December 4th. The League now numbers 313 members—a gratifying result when we take into consideration the fact that it was only started nine months ago.

"At the meeting on December 4th the desire for a suitable badge was unanimous. Two hundred badges were ordered, and up to the present time about 100 have been sold. The initial expense was heavy, owing to the cost of the die and the large number ordered. We hope that members will apply for badges as soon as convenient, and thus relieve the Executive Committee of the responsibility of having too large a stock in hand.

"An event of interest occurred in May, viz. the issue of the first number of *League News*. The editorial, written by the President, showed a keen and sympathetic insight into and understanding of the needs and wishes of her nurses. It must have appealed strongly to the hearts and minds of all who read it. The bye-laws have been printed and circulated. To-day they will be brought before you for consideration. A Benevolent Fund scheme will also be submitted to you. Both of these are important subjects, and deserve a free and frank discussion."

Both reports were adopted.

The bye-laws were then considered and keenly discussed. Amongst those who took part in the discussion were Mrs. Bedford Fenwick, Mrs. Howard Marsh, Miss Barling, Miss Mollett, Mrs. Spencer, Miss Smedley, Miss Armitage, Miss Rodgers, Miss Saw, Miss Webb, Miss Todd, Miss M. Breay, Miss Kingsford, Miss Pearce, Sister Mark, Miss Lofts, Miss Harrison, and Miss MacVitie.

The bye-laws were ultimately adopted as follows:

I. The Honorary Officers shall be—President, Acting Vice-president, Treasurer, and Secretary. The Acting Vice-president, Treasurer, and Secretary shall be elected by the members in general meeting, assembled upon the nomination of the Executive Committee. They must be elected by a majority of at least two thirds of the members present at such meeting.

II. The League shall have power to appoint members as Vice-presidents.

III. Applications for membership shall be made upon a form provided for that purpose. The subscription must always accompany the form.

IV. The annual subscription of 2s. 6d. shall be due on November 1st.

V. The Summer General Meeting for the transaction of business, followed by a social gathering, shall take place at such time and place as the Executive shall determine.

VI. The Winter Social Gathering shall take place early in December.

VII. The President and Honorary Officers shall have power to summon a Special General Meeting, of which fourteen days' notice must be given to the members. Forty shall form a quorum.

VIII. The Secretary shall call a Special General Meeting on the requisition of twenty members, of which fourteen days' notice must be given to the members. Forty shall form a quorum.

IX. There shall be a Standing Sub-committee to deal with the Benevolent Fund.

X. There shall be a Standing *Journal* Sub-committee. The *Journal* shall be published in May and November.

XI. No bye-laws shall be altered or rescinded without due notice of such alteration or omission having been sent to the Secretary at least fourteen days before the date of the Executive Meeting, and such alteration shall not come into force until it has received the sanction of the next General Meeting.

XII. The members of the League shall have power to expel any member who shall, after full inquiry, be found guilty of moral delinquency or professional misconduct.

XIII. No nurse's name shall be removed from the roll of membership until she has been informed of the charges brought against her by registered letter, and also not until she has been given an opportunity of being heard by the members in general meeting assembled. At such meeting there shall be at least 100 members present, and not less than three fourths of those present must vote for such removal.

XIV. The Executive Committee shall meet once a month (from October to June inclusive), at such times and places as may be decided upon, to receive applications for membership, and do such other business as may be necessary. Four members shall form a quorum.

Miss Stewart then proposed a Sub-committee to deal with the formation of the Benevolent Scheme, and her suggestion was adopted.

The President said that before the meeting resolved itself into a social gathering she would like to remind the members of the responsibility and power which, by forming themselves into the League, they had taken into their hands. She believed that the power was in good hands, and that the League would grow both in numbers and in unity. The opinion of the League would necessarily be of weight in matters affecting the nursing profession, and she asked the members to form an opinion on matters which affected them. There was, for instance, the question of the legal registration of nurses. She asked the members to inform their minds on that question; and if they came to the conclusion that it was desirable, then they should be prepared to work for it. For herself, she believed more strongly every day that it was necessary.

The business meeting then concluded, and the members moved to the other part of the hall, where the tea tables were most invitingly laid out. The decorations in pink and mauve were charming, and the good things provided were not only pleasant to the eye, but excellent to taste. Iced coffee, dainty sandwiches, strawberries and cream, and many other delicacies, disappeared, and days of "auld lang syne," as well as to-day and to-morrow, were discussed. But the pleasantest meetings must come to an end in time, and lingeringly, lovingly the members took their leave at last of "dear old Bart.'s," looking forward to their "next merry meeting," and feeling happy in the certainty that a welcome would then await them.

The Annual Concert.

THE Annual Concert given by the Junior Staff and Musical Society took place on July 17th, under most favourable conditions of wind and weather. Suffice it to say that it was a perfect summer evening. Following the precedent set last year, the square was tastefully illuminated by a pleasing display of coloured fairy lamps and Japanese lanterns, hung round each shelter, and in festoons from tree to tree.

A charming effect was produced by the arrangement of lights round the base of the playing fountain. Welcome refreshment was provided on tables placed between the shelters during the interval in the programme of music.

The seductive influence of the summer night, the soft glow of coloured light, and the refreshing sound of falling water, assisted in carrying the interval beyond its full extent, and the result was that many of the audience preferred listening to the second part of the programme from under the cool of the trees.

Possibly owing to the excessive heat of the day the attendance was not as large as usual. The programme was opened by the first movement of Brahms' only quintette. Its full merit was most ably sustained by the performers in spite of its many difficulties. The movement was listened to with much appreciation by the audience.

Sister Luke then sang one of Hatton's most charming songs, "The lark now leaves his wat'ry nest," so well that we much regretted that the call for an encore was not responded to.

The quartette "Moonlight" was the first attempted for many years, and proved a distinct success, the voices being well balanced.

Other items calling for particular mention were Bach's famous Concerto for Two Violins, by Messrs. Prentice and Lawrence, and Dr. Womack's capital performance on the violoncello of Poppa's Gavotte and Tschaikowsky's songs without words. Dr. West once more delighted an appreciative audience by singing with charming expression "Tell me, Mary, how to woo thee," and as an encore, "Come into the garden, Maud."

Mr. Nixon's song, "Blow, blow, thou winter wind," was sung with great spirit, and enthusiastically received. As an encore "The Yeoman's Wedding" proved equally successful. The chorus has on eminent authority never been better. In particular Charles Wood's part song, "Full fathom five thy father lies," was much appreciated. The attack in each instance was decided, the tone throughout full, and the pianos well observed, a finish so difficult to obtain in choral music. The Junior Staff song, "The March of the Cameron Men," was loudly applauded, and brought a very successful programme to a fitting conclusion.

After the National Anthem had been sung the audience dispersed.

PROGRAMME.

PART I.

1. Pianoforte Quintette — *Brahms.*
   Mr. Pollard, Mr. Prentice, Mr. Lawrence, Mr. Jordan, Dr. Womack.
2. Song — "The lark now leaves his wat'ry nest" — *J. L. Hatton.*
   Sister Luke.
3. Vocal Quartette — "Moonlight" — *Eaton Faning.*
   Nurse Marsden, Nurse Buckingham, Mr. Smith, Mr. Nixon.
4. Concerto for Two Violins — *Bach.*
   Mr. Prentice, Mr. Lawrence.
5. Song — "Blow, blow, thou winter wind" — *Sarjeant.*
   Mr. Nixon.
6. Part Songs — a. "Love's influence" — *Filby.*; b. "Full fathom five" — *Charles Wood.*

PART II.

7. Pianoforte Quintette
   Mr. Pollard, Mr. Prentice, Mr. Lawrence, Mr. Jordan, Dr. Womack.
8. Song — "Tell me, Mary, how to woo thee" — *Hodson.*
   Dr. West.
9. Solo Violoncello — a. Gavotte — *Poppa.*; b. "Songs without words" — *Tschaikowsky.*
   Dr. Womack.
10. Part Songs — a. Sclavonic "Cradle Song" — *Dvořák.*; b. "You gentle nymphs" — *Parry.*
11. Chorus — "March of the Cameron men"
    The Junior Staff.

"GOD SAVE THE QUEEN."

Reviews.

DISEASES OF THE TONGUE. By HENRY T. BUTLIN, F.R.C.S., D.C.L., and WALTER G. SPENCER, M.S., M.B.(Lond.), F.R.C.S. Illustrated by eight chromo-lithographs and thirty-six engravings. Second edition. Pp. 475. Price 21s. (London: Cassell and Company, Limited.)

This book, on the title-page of which Mr. Spencer's name now appears, contains so much new matter and so many alterations that it is practically a new work. In the preface the authors trust that the book "may be useful to those who need help in the diagnosis and treatment of the more common diseases of the tongue, or who happen to meet for the first time with one of the rarer affections, and would know where and under what circumstances similar cases have been seen before." We may say at once that this hope is fulfilled. All the commoner diseases are described in detail, their diagnoses discussed, and the appropriate treatment given. The rarer diseases and affections are dealt with more briefly; and in the bibliography at the end of the book references are given, where fuller information may be found.

The first chapter is devoted to the anatomy of the tongue and accessory glands. A full description of the thyreoglossal tract—not "duct," as there is no evidence of a duct in any living animal either during embryonic or later life—is given, and the relation of this tract to cysts and accessory thyroids is pointed out, a fuller description of these tumours being given in another chapter. The lymphatic system is carefully described, especially the upper and lower deep cervical glands lying along the internal jugular vein. The former receive all the lymphatics from the mouth, tongue, palate, and pharynx; and attention is called to their relation to carcinomata of the tongue, as they are the "end lymphatics," and are thus liable to be affected in the disease, although not appreciably enlarged in the early stages.

In the chapter on congenital defects the rarity of tongue-tie necessitating operation is pointed out, and the dangers attending the operation, if carelessly done, are illustrated by several cases. So many infants are supposed by midwives and others to be tongue-tied, and to require operation, that the rarity of cases in which it is necessary to operate should be insisted upon.

In the next chapter accidents and injuries of the tongue are dealt with, and special attention is drawn to the serious nature and dangers arising from foreign bodies.

Then follow chapters devoted to the appearances of the tongue in health and disease, acute inflammatory conditions, and parasitic diseases.

A full description of chronic superficial glossitis in its many forms is given; and this chapter is one of the best in the book. The description is based on actual cases, a

coloured plate of each being given to illustrate the various forms. The relation of the disease to carcinoma, and the various ways in which the graver disease begins as a lump, wart, or sore, are described. The necessity for prompt and free removal of the portion of the tongue thus affected is insisted upon when one of these events occurs. In the treatment of leucoma many valuable suggestions and hints are given—*e. g.* the use of ointments rather than solutions, on account of their more lasting effects, some simple basis being employed and the required drug added. In no case of leucoma should caustics be used; they do not cure or beneficially affect the disease, and, as they irritate the affected part, they certainly increase the liability to cancer. The various syphilitic affections of the tongue are well described, and the value of chromic acid (grs. x ad ℥j) applied locally to mucous tubercles is pointed out, the patches rapidly disappearing under the influence of the drug after resisting all other treatment, local or constitutional.

In the chapter dealing with tumours of the salivary glands it is pointed out that many of them are endotheliomata—*i. e.* they grow from the endothelium of the lymph spaces and blood-vessels. Tumours of a similar nature occur in the parotid, and the composite character of these growths is explained by their origin. Endothelium having the same origin as connective tissue, its pathological change into fibrous tissue or its myxomatous degeneration is thus explained. What was formerly called hyaline cartilage in these growths is not true cartilage, but a gelatinous substance, due either to a secretion of the cells or degeneration of them. The cysts which occur are new formations. Clinically these growths are benign tumours in most cases, sarcomas and carcinomas being much rarer tumours.

The term "ranula" is used to signify any obstruction cyst of the mucous or salivary glands under the tongue, and thus we have ranulas corresponding to the different glands.

In that part of the book which deals with epithelioma of the tongue a full account of the causes, early signs, and clinical manifestation is given, as well as the microscopic appearances of the disease. The value of an early examination of sections is insisted upon in all doubtful cases rather than treatment by local and constitutional means, the examination being repeated from time to time. The importance attaching to "cell-nests" in the diagnosis of epithelioma from sections is discussed. It is pointed out that they frequently occur in the large columns of down-growing epithelium. On the other hand, they are often absent in rapidly-growing vascular epitheliomata, and may be present in some sections, whilst absent in others from the same growth. They may be found in the stratified layers of normal epithelium. Difficulties are more likely to arise in the diagnosis when there is extensive small-celled infiltration around the growth, covering or obscuring the ingrowing epithelium.

The early infection of the lymphatic glands in cancer of the tongue is emphasised, and the importance of removing them in all cases, whether they can be felt to be enlarged or not. A full account of the operation for the removal of the tongue and glands is given, division of the operation into two stages being strongly recommended, the affected portion of the tongue being first removed. Whitehead's operation is preferred whenever possible, and some three or four weeks later the glands are removed, the whole of the glands in the anterior triangle of the neck, as well as the submaxillary salivary glands, being taken away. With regard to this portion of the operation, it is pointed out that the glands over the carotid sheath and jugular vein should be peeled off with the sheath, though in some cases they are so adherent to the sheath that it is not possible to do so. (No mention is made of the removal of part of the jugular vein in such cases, which has been successfully done.) On the other hand, if the glands are adherent to the carotid artery, complete removal of the disease is not to be hoped for.

Another question also arises: whether in some cases it would not be better to remove the glands first and the tongue at the second operation—*e. g.* when there is extensive glandular involvement, and only a comparatively small amount of disease in the mouth. An obvious objection is that the primary disease is still left behind, and may infect the wound in the neck through the lymphatic vessels. But the authors point out that there are reasons for believing they are not infected or full of the cancer, as is the case in the lymphatics passing between the breast and axilla.

Again, if the wound in the mouth is very large it may become very septic; the lymphatics would absorb the septic matter, and the glands would become inflamed. Rapid increase and matting may then take place, and the difficulty of completely removing the disease is much increased. We should have thought that three or four weeks was too long a time to wait before doing the second operation. In many cases the wound in the mouth is quite healed before that length of time has elapsed, especially if the mucous membrane is sewn up in the manner described, and usually the patient has already quite recovered from the effects of the first operation. Three or four weeks is a considerable time to leave a mass of malignant glands in a patient's neck. The growth in the glands is sometimes exceedingly rapid, and in that time they may become inoperable. Many surgeons do not perform such extensive operations on the glands as are here advocated, contenting themselves with removing the lymphatics of the submaxillary region and those obviously affected. There is very little doubt that it is better to remove the glands freely and widely in the first instance, as recurrence so often takes place in them, and operation is then almost useless.

Discussing the question of removal of the whole tongue for disease limited to one side, the authors do not advise such an operation, pointing out that recurrence takes place in the stump at the site of the original disease or on the floor of mouth of the same side.

As regards a preliminary tracheotomy, a decided opinion is given against doing this operation except in rare cases. Laryngotomy is spoken of more favourably, and we ourselves have recently seen two cases in which this was done, with no ill effects immediate or remote. This part of the book will repay careful study by all surgeons, and the views here enunciated, coming from such excellent authorities as the authors, merit special consideration.

As regards the book itself, attention must be called to the illustrations, the coloured plates being specially good reproductions of the diseases they illustrate. Some of the photographic reproductions, however, are indistinct. The diagrams are good and useful, but the lettering is somewhat unusual, and in reference to this we would point out that the arrangement of the descriptions would be much better if it were done alphabetically. In reading through the book we notice a few misprints. Thus, on p. 136, "lighter" should be "slighter;" on p. 137, "cebaceum" should be "cetaceum;" on p. 396, "p. 294" should be "p. 394."

A historical survey of the various operations of the tongue is added to the chapter dealing with that part of the subject, and a very useful bibliography is given at the end of the book.

There cannot be two opinions as to the great value of the work, and it has the special virtue of embodying the personal experiences of the authors.

ON GRANULAR KIDNEY AND PHYSIOLOGICAL ALBUMINURIA. By Samuel West, M.D. (Oxon.), F.R.C.P. (Henry Glaisher, London, 1900; pp. 200, price 7s. 6d.).

This book embodies the Lettsomian Lectures delivered before the Medical Society of London last year, and deals with a subject to which Dr. West has paid long and painstaking attention.

Though, as he says in his epilogue, the author hardly expects his views will commend themselves to all, there is no doubt as to the "defined opinions" and, therefore, no doubt as to the value of the book. Moreover, apart from opinions of all kinds, there is a mass of such useful information, tersely and clearly put, that the work forms a needed addition to the literature of the subject. Specially instructive in this respect are the sections dealing with Albuminuric Retinitis, Acute and Chronic Renal Toxæmia, and the so-called Physiological Albuminuria. We unhesitatingly add to these the chapter on Affections of the Skin in Renal Disease, if only for the reason that we have not seen any full and systematic account of uræmic skin eruptions elsewhere. The statistical tables dealing with the age-incidence of granular kidney, its frequency as a cause of sudden death, and the future history of cases of "Physiological" Albuminuria, are of great service, and the author is to be congratulated upon giving them a permanent place in medical literature.

It is difficult in a monograph such as this for the author to avoid giving his readers the impression that he is over-stating the importance of his subject. But here, surely, Dr. West may be allowed full weight to his aphoristic introduction: "Granular Kidney is a disease of great importance on account of its great frequency, a frequency which is by no means adequately recognised. It is often in itself the cause of death, even of sudden death. It often explains why death has happened in other diseases which otherwise might not have proved fatal. During life it is often discovered unexpectedly if looked for; it is often overlooked if not suspected; and it often explains a case which has been a puzzle until Granular Kidney gave the key to its solution." With this emphasis of the importance of the condition, therefore, we quite agree. With its too rigid isolation as a pathological condition from allied morbid renal and cardio-vascular conditions, however, we hesitate to concur. And this would seem to be the *motif* of Dr. West's carefully argued thesis. Thus, the statement that "all forms of Chronic Interstitial Nephritis are not necessarily Granular Kidney" seems to us rather too broadly illustrated when the author not only excludes cases in which the lesion is unilateral, and cases of patchy fibrosis (from infarcts or gummata), but *also* adds that "even when the lesions are bilateral, I should still exclude from the category of Granular Kidney certain forms of Chronic Interstitial Nephritis . . . . met with in connection with atheromatous disease, or with the chronic gout of elderly persons; in fact, the kidneys which used to be commonly called senile or gouty." For if "Granular Kidney," as a term, means anything at all, it must mean a clinical condition, and this Dr. West, of course, himself emphasises. Now unilateral or patchy fibrosis does not, as a rule, produce this condition, therefore there is no temptation to apply the term "Granular Kidney" to the disease. On the other hand, the author's own contentions lend the fullest sanction to the use of the term for a given clinical picture *whatever* the particular state of the kidney may be, and with this view of the matter before us we fail to see any room for distinction between the two terms "Granular Kidney" and "Chronic Interstitial Nephritis," for the latter term, just as much as the former, depends for its application to any particular case upon the general clinical condition met with. And this clinical condition is the same in all points as that to which we apply the (to us) synonym of "Granular Kidney." If we are correct in thinking that Dr. West regards "Granular Kidney" as a disease *sui generis*, we are unable to accept that view after a careful consideration of all the facts. We should prefer to regard it as a condition which may result from several causes, and which

may, not unnaturally, vary considerably as regards the actual extent of morbid lesion found. Dr. West refers to the analogy with cirrhosis of the liver, but does not take the analogy as far as we should deem it might rightly go. Thus, *post mortem*, a liver which during life has given many symptoms justifying the diagnosis of cirrhosis, may be found smaller than normal and granular (hob-nailed), or larger than normal and with a smooth surface. But microscopically it will show a multilobular fibrosis in each case. Shall we therefore separate off the hob-nailed variety as a separate entity? The question is answered by reflecting that this was the attitude of pathologists of twenty years ago, and it is by abandoning this view that some order has come into the chaos of the older classification of cirrhotic livers.

There are a few points lying away from the main purpose of the book upon which we should like to remark:—(1) Is the prognosis in cases accompanied by erythemata so bad as the author states? ("Rashes of these kinds in Granular Kidney seem almost invariably to end fatally.") We should like opinions upon this point. And we are rather surprised to find the association of skin eruptions with albuminuria dismissed as cursorily as this:—"It is, of course, true that acute eruptions of the skin of an erythematous character are not unfrequently associated with a little albumin in the urine, especially if the temperature be raised." Surely the question of kidney disease as a *sequel* to skin diseases might have been considered as well as the two conditions occurring in the reverse order?

(2) Uræmic hemiplegia is only mentioned incidentally in the account of a case.

(3) Ascites, associated with fibrosis of the peritoneum and capsules of abdominal organs (perihepatitis, etc.)—not an uncommon condition in "Granular Kidney"—receives no mention. The cases are very important and the diagnosis from simple cirrhosis of the liver often difficult. The prognosis as regards the ascites, however, is much better in the cases of chronic Bright's disease than where it is due to cirrhosis of the liver.

We have freely availed ourselves of the author's concluding remark that "defined opinions challenge criticism, and criticism tends to advance knowledge." As we remarked before, there is no doubt about the excellent manner in which Dr. West has performed his share of this scheme.

Staff Appointments.

THE following nominations have been made for Resident Staff appointments:

HOUSE PHYSICIANS.—October, 1900.

Dr. Church.	T. Gillespie.
Dr. Gee.	W. P. S. Branson.
Sir Dyce Duckworth.	W. S. Darby.
Dr. Hensley.	J. A. Nixon.
Sir Lauder Brunton.	C. W. von Bergen.

HOUSE SURGEONS.—October, 1900, and April, 1901.

Mr. Willett	October	H. B. Gibbins.
	April	C. E. West.
Mr. Langton	October	C. A. S. Ridout.
	April	F. E. Brunner.
Mr. Marsh	October	J. G. Cooke.
	April	W. S. Danks.
Mr. Butlin	October	F. A. Rose.
	April	H. G. Pinker.
Mr. Walsham	October	C. S. Hawes.
	April	A. W. Izard.
Intern.	October, 1900	F. C. Borrow.
Extern	October, 1900	T. A. Mayo.
"	January, 1901	A. W. Dickson.

Appointments.

DOUGLAS, A. R. J., F.R.C.S., appointed Surgeon to the Imperial Yeomanry Branch Hospital.

* * *

HAYES, A. H., M.R.C.S., L.R.C.P.; PROVIS, F. L., M.R.C.S., L.R.C.P.; and F. BRICKWELL, M.R.C.S., L.R.C.P., appointed Assistant Physicians to the Imperial Yeomanry Branch Hospital.

* * *

HUTCHENS, H. J., M.R.C.S., L.R.C.P., appointed Medical Superintendent of the Plague Hospital, Brisbane, Queensland.

* * *

PRANCE, C. H. G., M.R.C.S., L.R.C.P., appointed Medical Officer to the Workhouse and No. 1 District, and Public Vaccinator, Plympton.

* * *

VAUGHAN, A. LL., appointed House Physician to the Norfolk and Norwich Hospital.

Examinations.

UNIVERSITY OF CAMBRIDGE.

Human Anatomy and Physiology. W. Hyde Hills, W. E. Lee, J. G. Slade.

CONJOINT BOARD.

Diploma in Public Health.—A. E. Carruthers, M.B., B.C.(Cantab.).

Anatomy and Physiology.—G. H. Adam, W. B. Ainger, D. A. Aldred, T. W. Chaff, J. W. Cleveland, F. S. Lister, H. T. Wilson, R. M. im Thurn, A. Hallowes, B. B. Riviere, L. L. Winterbotham, A. H. Pinder, K. D. Bell, F. H. Wood.

Physiology only (old regulations).—J. Wilding.

Birth.

LOWE.—On June 7th, at St. Catherine's, Lincoln, the wife of Godfrey Lowe, M.R.C.S., L.R.C.P., L.S.A., of a daughter.

Marriage.

HOWARD—WILSON.—On July 12th, at St. Matthias's Church, Earl's Court, by the Rev. W. Carter, Vincent Howard, M.R.C.S.Eng., L.R.C.P.Lond., second son of the late John William Howard, M.R.C.S.Eng., L.S.A., of Sandgate, Kent, to Louisa Jane, only surviving daughter of the late Robert Hill Wilson, of Broach, India.

ACKNOWLEDGMENTS.—*London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review, The Practitioner, University College Magazine, The Student, The Hospital, Transactions of the Students' Society of Dental Hospital.*

St. Bartholomew's Hospital Journal.

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NOTICE.

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St. Bartholomew's Hospital Journal,

AUGUST, 1900.

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

"Things Seen."

THE first volume of the memorial edition of the works of George W. Steevens* contains some of the best examples of this brilliant young writer's efforts in literature. How many of the included chapters the author would himself have chosen for permanent publication, had the opportunity of choosing been granted him in later years, we cannot say. The question is one which an untimely death for ever left unanswered, and Steevens' future claim to literary excellence must necessarily rest, in this respect, with the discretion and judgment of those friends who will in this and other volumes doubtless act the part of posthumous editors in as honest and kindly a spirit as possible. The issue at stake is by no means a small one, for in the brief lifetime that lasted from 1869 to 1900 were crowded many opinions and generalisations which found facile expression during its last few years, at a time when as yet the great majority of even the most gifted minds find growth incompatible with copious literary production of permanent worth.

The chapters before us show the great versatility of the writer; they deal with all sorts of subjects,—with the old-time question of the significance of physical pain and its place in the evolution of the human race, with an analysis of Tennyson's immortal elegy, with a critical estimate of the conditions underlying the Dreyfus case, with a description of the Jubilee procession, with the detailed steps in a major surgical operation as witnessed by a layman. But versatility is not a gift for which to thank the gods without an added supplication for guidance in its use. Few of us have any doubt as to Steevens' great descriptive power; he was a painter in words of quite the first order; but no man needed to have his subject more carefully chosen. A battle, a march, a trial scene, a gorgeous spectacular display, the asylum playground, the prison cell—these he could portray with a vivid and realistic colouring rarely, if ever, quite excelled. And the quicker the scene might change, or the more rapidly varied the actors and their parts upon the stage, the more lifelike did his description become. All objective realities his eye could rest upon were instantly transmuted into easy and fitting words, so that he possessed the chief desideratum of the correspondent, whether of war or other event, in a marked degree.

And if in this realm he reigned a king, outside it he lacked as many necessary qualifications for success as need be, and how many these were, one or two of the articles in the present volume amply testify. "The New Tennyson," for instance, which was contributed to the *National Observer* in 1893, is full of rash and ill-digested statements, which only

* *Things Seen:* impressions of men, cities, and books, by G. W. Steevens. Selected and edited by G. S. Street, with a memoir by W. E. Henley. (Wm. Blackwood and Sons, 1900. Pp. 316, price 6s.)

serve to demonstrate the author's incapacity for appreciating certain forms of poetic expression, and his inability to deal fittingly with matters essentially subjective and psychological. It is a criticism of *In Memoriam*, and resolves itself into a drastic charge of self-conscious dissimulation on the part of the poet.

"Poetry, we please ourselves to think, is the resultant of emotions too importunate not to chafe at the commonness of the common expression, and burst through them into a form where words can pulse with the rhythmical throb of grief and joy. By the grave, if anywhere, poetry claims the right. Then, if ever, our ears are open to the poet. But what shall we say if he catches at the occasion of his bereavement to spin cobwebs of disquisition about himself and nothing else? Are we not right to complain that he abuses the right of his order? Surely. And we take *In Memoriam* to be such an abuse. . . . He has, like other men, a right to talk about himself, to strip his soul naked in the eyes of mankind. But he has not a right to do so under the pretence of an elegy. The penalty for his transgression is that his elegy rings hollow. We look first in such work for the energy of sorrow; instead of it we find this poet on the threshold obscurely quoting some classic, we know not whom, and wondering to himself how long his sorrow will endure, and what will be its nett effect on his character. . . . Look at this dandy heartbreak of *In Memoriam*, patting its lines into shape, and testing the flavour of its epithets—evermore picking, picking, picking at the scar that never bleeds. . . . It may be great philosophy, it may be wonderful poetry, but it is most frigid elegy. Read Shelley, who was all things sooner than full-blooded, and you will see the difference between straight and crooked, deep and shallow. . . . Nothing could have kept him (Tennyson) through all these years, drying his tears, then blubbering out afresh, moaning out his timid doubts and fears and hopes, now an Atheist, now a Christian, now a Pantheist,—always anything for poetical copy, and at bottom always nothing at all."

And so on. With the author's definition of poetry we have no quarrel; it will do as well as most other definitions of a thing that is indefinable. But with his limited conception of the privileges of the poet in his record of the undermining power of a great personal grief we entirely disagree. The loss of a man's dearest friend is as likely to prove the stone thrown in his "life's mid current" as any other thing that comes to change its even flow—probably more so. And the psychological effect will be deep and wide-spread according to the mourner's temperament. To the poet it is not surprising that it should include a revision of all the hitherto accepted bases of belief—

". . . . Obstinate questionings
Of sense and outward things,
Fallings from us, vanishings,
Blank misgivings of a creature
Moving about in worlds not realised."

To Tennyson himself this temporary wavering of fixed points in the spiritual life seemed a strangely inappropriate product of a purely personal grief:

"What words are these have fall'n from me?
Can calm despair and wild unrest
Be tenants of a single breast,
Or sorrow such a changeling be?"

Yet the very depth and sincerity of the poet's sorrow are better evidenced by the signs of mental shock and unhinged opinion than by any mere "instinctive animal cry of pain," which his critic regards as the truest response in the face of death.

Shelley is instanced as a better type of mourner in *Adonais*, but it was the same with Shelley as with Tennyson:

"Whence are we, and why are we? of what scene
The actors or spectators?"

he cries in the midst of his lamentation. Moreover, as an expression of personal sorrow for the loss of a friend, *Adonais* is quite unconvincing. It was never intended to depict the poet's grief, for Shelley himself said that personally he knew but little of Keats. The elegy was written as an expression of indignation against the treatment Keats had received at the hands of his critics.

Milton's fine elegy should, on the author's principle, get even more unsympathetic treatment than Tennyson's, for in the midst of his sorrow for *Lycidas* the poet digresses into a scathing rebuke of the bishops of the Church of his day—a subject far more remote from personal grief than any touched upon in *In Memoriam*.

The author's paraded ignorance of the "classic"

"Who sings
To one clear harp in divers tones,"

only tends to confirm our impression that he never attempted to interfere with a natural incapacity to understand poetry by any study of this branch of literature. But the views expressed in "The New Tennyson" can only be explained by the additional assumption that he understood the psychology of sorrow just as little as he understood poetry.

We have taken an example of the things which were ill chosen as material for Steevens' exceptional gift of facile writing. For one such there are a dozen in this book alone where he shines, beyond any question, as a master in the art of description. We choose one which shows him at his best, and one which is specially appropriate for the columns of the JOURNAL, however inappropriate, by the way, it may have been for the columns of a daily paper, where it first appeared. It is the description of a surgical operation performed at a London hospital. Remembering that the artist is a layman, the accuracy of the picture is remarkable, and is a fine example of Steevens' incomparable power in word-painting:

"The theatre was full of the piercing smell of iodoform. About its lowest tiers lounged a dozen students.

On the floor stood a doctor, grey-bearded, motionless, hands thrust into his overcoat pockets. Everybody else on the floor was all strained attention and swift movement—the two elder students behind the tables with bright steel instruments in small tanks of water-made antiseptics; the nurse at the table with the sponges and basins of water—some clear, some pink, some scarlet; the probationer at the sink and tap; the nursing sisters handing things to the surgeons; the two surgeons themselves, shirt-sleeved, arms bare to the elbow, covered up in big white aprons.

Between their swift movements you could see lying on the slab in the centre a human body. Man or woman you could not say, for over the whole face was a large leather cap, and growing out of it a brown bladder like an empty football; the chloroformist held it tight over mouth and nose. Suddenly the bald-headed surgeon, stepping aside, lets in a glimpse of an amputated arm.

There hung from it a bunch of what looked like little steel skewers. These were the clips with which they catch up and close the ends of the severed vessels. The arm was off above the elbow, and the second half of the operation was in rapid, almost stealthy progress.

You could hardly follow the surgeon's hand as he took a bit of salmon-gut from the watching attendant; before you saw it was whipped round an artery and had tied it up. The clip was off and passed back to the hand waiting to receive it. One after another the clips came back into their tank. Then the surgeon's brisk word of command broke the dead silence. "Hot lotion," he said, without looking up. It was there, ready, in the slight sister's hand; in a second, as by jugglery, it was in the surgeon's, and being passed over the wound. Then the flaps of skin were drawn.

"Iodoform"—and by another hardly perceptible piece of legerdemain a pepper-caster was shaking yellow powder on the wound.

"Bandages"—and they had sprung up in the sister's hand, and in a second the light-coloured antiseptic dressings were being strapped on hastily, firmly, with exact precision. Now you saw the leather cap was off the face: it was a young beardless man, very pale, rolling his head over on the pillow, with a twitter of returning life, very ill from the ether.

But before he had time to realise what had happened the maimed arm was strapped to his side; a door had opened noiselessly, and a bed had trundled in; the bundle of blankets was lifted swiftly but gently—by two attendants catching him up on the same side, so as not to jar the shattered body—back on to its bed. In an instant the bed was away and the door was shut. And, looking round, you saw that all the paraphernalia, the tables and instruments, sponges and basins, had disappeared too. . . . .

Almost before you have had time to wonder, another bed has come in by another door. The patient on it is a woman, white-haired, seventy years old. But her face is placid and quite unafraid as she is lifted on to the operating-table; indeed, there is nothing visible to frighten. But as she is laid down the noiseless miracle begins again. Suddenly the instruments and attendants are all in their places again. The patient is breathing in anodyne insensibility from the cup and bladder. The surgeon, tall, grey, bushy-browed, his long hands a model of delicacy linked with strength, is explaining the case to the students: it is cancer, and he has authority to cut it away. It is part of the miracle—only by now you have ceased to be surprised—that he has finished his explanation exactly at the moment the patient is ready for him. He steps up to the body, gives a keen glance at the stain on the arm, touches it. "Scalpel," he says, without looking up, and the keen blade is instantly in his hand.

His hand is travelling over the arm—but surely not cutting? The flesh seems to divide before it, so exquisitely edged is the knife, so firm and true the fingers and wrist. Little streams suddenly well up and trickle down the arm. "Sponge," and a sponge has appeared and swept them away. "Clip," and a clip has glided from its tank, and has stopped the cut vein. Gradually—it is only seconds, but they are packed with the interest of hours—there grows a deep red gash behind the ever-moving scalpel. It moves a shade more slowly now; it is picking its way among arteries, and a hair's-breadth to left or right may mean death. No sound but the sharp orders and the perpetual gush of water from the tap where the probationer is emptying the reddened water and refilling the bowl for clean sponges. There remains the crimson chasm fringed with clips. Now comes what we have seen before: the clips come off one by one as the blood-vessels are tied up; the lotion washes all clean; the gash, which looked as if half the arm had been cut out, closes up to a natural form and size. And as that dimly waking woman is whisked away, the surgeon, calling for a basin, and passing it round, resumes his remarks on cancer.

The next case is cancer too, only it is cancer in the mouth and jaw. Cheek and jaw are to be cut away: to keep the man alive yet insensible the while, he must have chloroformed air pumped into his lungs. The chloroformist has got a long tube with a bladder at the end. The sponges in this case are small, and held on long clips. He is an obscene-looking old man, his face dyed with drink, and two front teeth gone. As he is strapped down, the sweet sickly smell of chloroform begins to conquer the iodoform: it is being sprinkled on to the cloth over his face. As it gets hold of him he starts muttering in a thick drunken tone, then struggles and tries to sit up, while the mutter swells into a half-articulate curse. But now he is ready, and "Scalpel," calls the surgeon. He bends over, and you see the blade gleam. Again it is not like cutting. The man is sobbing and moaning now, his cries rising and falling as if with the violence of the pain, though he cannot really feel anything.

As the moan rises louder to a muffled yell, the surgeon pauses to let the chloroformed cloth lie over the mouth for a moment; then comes the time to cut the bone. The long keen saw is so fine that but for the grinding of the bone you might have thought it a simple steel rod.

Everybody is working now for the man's life; the lithe swiftness of movement is almost dazzling. Left hands and right hands seem each to be thinking for themselves; the sponges are handed with breathless haste; the sister slips them in, now over a shoulder, now under an arm, to the ready hand that must not wait half a second; surgeon, assistant, and chloroformist, whoever has a hand to spare, nips up the sponge and plunges it down the subject's throat. Then the shining shears plunge in too and grip the bone; the veins stand out on the surgeon's hands as he forces the sharp blades together with every ounce of his strength. Crack from somewhere inside.

Then another grip, another wrench, another crack; "Basin"—and the lump of bone comes away. It is over now; the clips sticking up out of the throat disappear one by one. Then the deft healing hand closes the wound, and the face is a face again."

No; distinctly *not* appropriate in the columns of a morning newspaper. But "things seen" indeed these are—seen by an eagle eye and with a truthfulness of vision seldom found. Set down, too, in words that are no mean exponents of our English tongue, by a hand that is missed and mourned wherever that tongue is spoken.

Notes by a Country G.P.

II (*continued*).

MY little article, which appeared in last month's JOURNAL, ended with what, I hope on a future occasion to show, is a sufficient, *i. e.* an inclusive, classification of the causes of mistakes made in the practice of our art, at once retrospective and prophylactic. But, alas! there was much in this little effort of mine that fills me with gloomy foreboding of the criticisms which I myself did invoke! My idea, as written therein, of chance was sadly chaotic. But having put my ship to sea it ill becomes me now to turn back. I may only wish I had been more careful in revising my "proof." May you, gentle reader, forgive me for confusing "form" and "matter," if you forgive me at all for writing, and give me credit for meaning logic *has* to do with matter and actuality, *not* with form and potentiality. Moreover I see I was wrong in saying in chance there was *no* element of logic or reason. For there *is*, and I think I can make no better definition of chance than that given by A. H. Killick, M.A., in his *Student's Handbook of Mill's System of Logic*, pp. 157, 158 (the italics are mine):—"Chance only applies to *conjunctions* (sequences or co-existences) of phenomena; and conjunctions of phenomena are said to happen casually or by chance when these phenomena are in no way related through causation." And again, "No phenome*non* or *event* can properly be said to be produced by chance, *i. e.* immediately produced. . . . When an event is said to be produced by chance, what is really meant is that the *conjunction* of antece*dents* or conditions upon which that phenomenon followed happened without any causal connection between them." Obviously, from this definition, causation (reason

or logic) *has* its place in each *immediately* preceding event, but *not in all the preceding events taken together.*

Assuredly the stumbling against the unwary bootblack can be reduced to physical causes, but chance had most to do with the journalist's unpunctuality, the bootblack's character, and the game of marbles and its surrounding conditions. Chance causes "Tommy" to be hit by a spent shot in his abdomen, when he was in a certain position in the firing line, at a given moment, in a given war, but working back, each immediate preceding event is due to stern reason.

Again, my classification and a term employed therein require a little more explanation in order to fit them for their hoped-for function:—a big I should have been put before 1 and 2, thus—I 1 and I 2; for of course (*e.g.* in 2) premises being right do not result from the causes bracketed opposite, but the whole of I 2 results therefrom. As regards the term conclusion, I have used this word to mean the result, whether mistake or no mistake from the patient's point of view, and not in the sense of a formal logical conclusion. An example will make this clearer:—

III. *The conclusion is right but the premises are wrong.*—Now, from the point of view of formal logic, quite a right conclusion can be drawn from wrong premises, but from the patient's point of view a mistake would result. I can argue that most ulcers with hard, raised, everted edges, whose section under the microscope shows cell nests, and which are associated with fixed nearest lymphatic glands, are probably malignant;—this patient has an ulcer of this kind; therefore this patient has a malignant ulcer,—with logical accuracy. But if I neglect to ask him the history of his past, overlook other hypotheses, do not see that similar ulcers exist elsewhere; and if my sense of touch is wrong, my experience deficient, and I mistake inflammatory collections of cells for cell nests, then my premises are wrong, and a mistake results, although I reason quite correctly to the conclusion. A correct result for the patient would occur merely by good luck (chance).

I must also say something on an all-pervading influence which I scarcely realised when I attempted my classification, an influence which seems to me unclassifiable. It is an undercurrent defying logic. This is that psycho-physical condition that induces negligence and carelessness, warps and obscures judgment. It explains a vast number of our mistakes, and makes a cut and dried prophylactic classification so hard. The liver pill, some bromide, or strychnine and fresh air are the kinds of prophylactic measures suited for such mistakes; no classification standing by itself can present them. I need give no examples, they will arise to us all too quickly. This "personal factor" insists on cropping up, perhaps like a precious mineral in a dull seam, and defies legislation and science. It does much to make life less tedious. Just so, also, it is with our patients, often so truly dear and interesting to us as naturalists and men of the world, not mere scientists (which can we ever be in medicine?). No, they are not mere lifeless mechanisms, cases, but even as we ourselves,—masses of living, nervous, pulsating, protoplasmic humanity. The factor finds its place in the classification on page 151 in (i) and (iv). The question of excusability of mistakes due to this cause opens up the larger subject of free will and necessity. Into such a wide arena have my reflections led me that I must plead forgiveness, and having cleared the way, I can, if permitted, continue the narration of my mistakes in your next number.

A Letter from South Africa.

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

KROONSTAD FIELD FORCE, SOUTH AFRICA;
July 1st, 1900.

DEAR SIR,—I am a trifle late, but I trust you will give me a hearing.

Eight solid months have passed since I last set foot in Bart.'s, and I feel I must have commune, if only with the pen; hence these lines.

Though 7000 miles divide us, little that goes on at Bart.'s escapes us—Mark Twain on "Bluff King Hal," the latest Exam. List, the last engagement. I say "us," for we are a large Bart.'s colony. A few days ago P. Wood, Littler Jones, Jameson, and myself were here in Kroonstad together, and no less than seven Bart.'s nurses.

Wood and Jones have gone on to Pretoria, also Sister Abernethy. They belong to No. 2 General Hospital, which has just moved on from Wynberg.

Jameson and I were together at Wynberg till the middle of April, when Jameson went to Bloemfontein, joined the Field Hospital of the 3rd Cavalry Brigade, and escorted Lord Roberts up to Kroonstad with great *éclat*, only to fall a victim here to a very severe attack of enteric; I arrived just after he had fallen sick. Thanks to the devoted attention of a Bart.'s nurse, who stuck to him day and night, he is now convalescent, and I hope he will soon report progress in person at Bart.'s.

While at Wynberg I had the good fortune to have Sister Charity in one of my officers' wards, and for a time Sister Rahere as night sister before she left for Natal. It is needless to say how much they were appreciated. Sister Charity was recently in charge of the hospital at the "Residency," Bloemfontein, and high in the esteem of Lady Roberts, and I recently met her *en route* for Pretoria with Lady Roberts, and escorted by an armoured train.

Granville and Parker, R. D., have both been victims of enteric at Wynberg and Naauwport respectively. I heard recently from Granville from Springfontein, where he is convalescing. Unfortunately he is tied to his bed with thrombosis in the leg, a very common sequel out here, especially when patients are moved early in convalescence. Parker I have not heard of, but "no news" doubtless is "good news."

Mr. Bowlby keeps you well informed of the doings of the Portland. We frequently met before they left Rondebosch, and I had the pleasure of dining with them at Bloemfontein on my way here, and also of looking round the many hospitals there.

ENTERIC FEVER.

This brings me to a few remarks on the great epidemic of enteric fever; everywhere a seething mass of typhoid. Surgery had collapsed before the arch-fiend enteric. Every hospital was crammed to overflowing; everybody overworked and struggling against a never-ending stream of cases. The cause was not far to seek; Paardeberg started the ball rolling. The water there had to be drunk, and how foul it was is known to all. Cronje, though he compassed his own destruction, never did us a worse turn than when he sat down in that laager at Paardeberg. Then came the rapid march to Bloemfontein, and a heavy sick bill. They, the Boers, cut off the water-supply, leaving only infected water. Cases multiplied

Then came the advance from Bloemfontein, and the field hospitals, which were crowded, had to be emptied into the general hospitals, already full. Then for a time came chaos, . . . and here I must draw a veil on a pitiable picture, far too pitiful to paint. The horrors of war were writ large on Bloemfontein, but there were bright spots, and the Portland was one; having a fixed staff and a limited number of beds, the balance of work and workers was nicely adjusted. Never was the medical department more severely tested.

I shook off the dust of Bloemfontein, a sadder if not a wiser man. I hear that despite the many disadvantages the death-rate from enteric at Bloemfontein has been only 14 per cent.; if this be correct, then for war results they cannot be considered bad, especially as there are 5000 cases of simple continued fever returned with only one death at Bloemfontein, and who can say how many of these 5000 were not mild enteric cases, thus reducing the percentage?

On arriving at Kroonstad we found that the army had just advanced, leaving behind a nice little legacy of about 500 enterics, accommodated as follows:—about 200 in the Dutch Reformed Church, mainly on the floor, and a few in beds; in the churchyard there were about seventy in bell tents, with mackintosh sheets to lie on, and a blanket to cover them—very cold quarters at night. The Kroonstad Hotel held about 100 and thirty officers, the Grand Hotel a few officers and men, and the Russian Dutch Hospital the remainder. The men in the hotels were accommodated on the floors of the dining-rooms and billiard-rooms, etc.; there were not many beds obtainable.

There was the staff of the Russian Dutch Hospital, three officers of the R.A.M.C., one civil surgeon, and one local practitioner, but no nurses, etc., at the Dutch Hospital.

The patients were of necessity nursed in their clothes, and there was a scarcity of supplies and medical comforts. I came up with the staff of the Scottish National Hospital and some nurses belonging to No. 3 General Hospital. Shortly after the staff and equipment of No. 3 arrived, and later the nurses and equipment of the Scottish.* By degrees things settled down, and the patients were moved down country as fast as the hospital trains could take them, but the death-rate was very high at first. As at Bloemfontein, as soon as the railway permitted, and equipment and supplies were obtainable, the cases were got well in hand.

With only a single line of railway the whole question of transport has been extremely difficult. The army has to be fed, clothed, horsed, and supplied with ammunition. How it has been done with a single line, and a huge army so far from the base, is a marvel to every one, and reflects enormous credit on the Army Service Corps and Royal Engineers. Food and ammunition come before hospital equipment and medical stores.

During the march from Modder to Bloemfontein the hospital transport was cut down by the chief of staff to such an extent that the field hospitals were reduced from ten ambulance waggons to two each, and the result was untold suffering to the sick and wounded.

The sufferings of the Paardeberg wounded are now well known; the question was purely one of transport. Hospital equipment, medical stores, etc., arrived at Kroonstad within a fortnight of its occupation, and within five days of the army advancing. Considering that the line had to be repaired, and then enough supplies brought up to support the army on its march to Pretoria, this was fairly quick work.

The prevailing type of this very severe epidemic is acutely toxic, whether this is due to a specially virulent growth of Eberth's bacillus or to a mixed infection; only the Modder knows the *fons et origo* of this great epidemic. Those who have a personal acquaintance with this water will believe it capable of growing anything.

The treatment for the most part resolves itself into warding off heart failure with strychnine and digitalis; some have used anti-streptococcic serum for the toxæmia, but with no marked success.

If only the patients could be nursed as they should be, fed at regular intervals, kept from jumping out of bed, and their backs attended to, statistics might be better. Wherever the nurses get a chance they are splendid, but the stress of work is too heavy, the conveniences too few.

At the base the work is done admirably, and the results are good.

As far as I have been able to judge, inoculation minimises the severity of the attack, though it does not render immunity. I have seen inoculated cases die, but they would not have died in hospital at home, at least not in Bart.'s. Opinions vary, and we must wait for figures, but for my own part I am convinced that the inoculated come off the best. I have not been inoculated; having written this I must take the next opportunity.

As might be expected in so virulent an epidemic, complications are very common, and no complication is so rare that it has not been met with.

Relapses have been very frequent—far too frequent; the reasons are not far to seek. It has been necesary to continually clear in part or wholesale hospitals at the front, and move the patients down to the base, and it has been no uncommon occurrence for collapse to commence on the downward journey. This is perhaps a necessary evil, but I think the desire "to shove 'em along down" sometimes oversteps the bounds of discretion.

Tommy, too, has no great notion of "slops," and when his stomach cries aloud for food, food he will often get; where there's a will there's a way, and there are many ways in the army. There is another very potent factor; the bulk of the nursing (so called) is carried on by orderlies. The supply has not been equal to the demand; their ranks have been enormously thinned by sickness and death, and a large number of combatant privates have had to be requisitioned to do the work of nurses.

> "The trivial round, the common task
> Will *scarcely* furnish *all* we need to ask."

The Boers have a peculiar form of treatment of their own; it consists in wrapping the patient in a sheet soaked in new milk. A colleague of mine at Wynberg, having had some mortality among the Boer prisoners, was waited on by a deputation of Boers who respectfully suggested this line of treatment as "never known to fail."

I have heard that "aqua pura" has been recommended as the only treatment by one in authority out here, but I am told that the experiment, like the patient, was short-lived. A doctor who was with the Boers round Ladysmith tells me that they suffered very heavily from enteric, they certainly succumbed very readily at Simonstown; their vaunted immunity is purely fictional.

DYSENTERY.

During the early part of the campaign this disease was very rife, but has now almost entirely subsided. For the most part the attacks were mild, and easily cut short by drachm doses of Mag. Sulph. repeated two-hourly, till all blood and mucus had disappeared; it rarely fails with this form of dysentery, and is the common treatment out here; ipecacuanha appears to be valueless except in those cases who have had previous attacks in India and elsewhere; then it is strongly indicated. The fatal cases, I believe, are mostly due to want of good treatment, getting out of bed to use the stool, improper diet, and cold.

Post mortem one finds very minute ulceration very general throughout the colon, sometimes almost complete loss of epithelium, with great thickening of the other coats—a condition much resembling, if I remember rightly, specimens labelled "ulcerative colitis" in the museum.

Large sloughing ulcers, I believe, are rare: in two cases in which I saw them both patients had had previous attacks in India; in one of these the liver was riddled with abscesses. Abscess of the liver is rare following South African dysentery, and I have not seen it.

Antiseptic irrigation of the large intestine suggests itself as a very rational treatment in obstinate cases, but there are difficulties in carrying it out. This is a duty which falls to the lot of the orderly, and he, with the best intentions, is wont to irrigate the bed more than the patient, a condition of affairs unsatisfactory to all concerned. Even when well carried out it is doubtful if the ascending colon and cæcum, often the most severely affected, get sufficient attention. Looking at these cases post mortem, I have sometimes wondered whether in obstinate cases one would not be justified in doing a right-sided colotomy, and washing the colon through from the cæcum, keeping the colotomy wound open so as to allow the colon complete rest from fæcal irritation, on the same principle as cæcotomy for malignant disease. I refer only to those cases of acute dysentery in which drugs fail to check the onward course, and a fatal issue seems not unlikely. The operation, of course, would be a severe one in a patient acutely ill, and the possible prospect of a permanent right-sided fistula not cheering. Dysentery sometimes occurs concurrently with, or as a sequel to, enteric; at least, the symptoms are combined, and post mortem we find the double lesion. Whatever the true pathology, they are a very troublesome class of cases to treat, and are not uncommonly fatal. Typho-dysentery we called it at Wynberg.

* Lord Roberts occupied Kroonstad on May 12th; the Scottish hospital and nurses arrived May 25th, No. 3 General on May 27th, and could have arrived before had trains been available, as they were kept waiting at Bloemfontein.

During the long wait at Modder River enteritis was very common, and went by the euphonious name of "Modders," and the milder attacks by the name of "Riets," a smaller tributary. In some cases this became very chronic, and necessitated the patients going home; but in most it yielded to the time-honoured oil and opium, followed by bismuth. It was due to the sand which was an essential and absolutely unavoidable ingredient of all food and drink.

In November, when I first came out, rheumatism and pulmonary complaints were common; during the hot weather they almost completely subsided; now, I think, they are beginning to make themselves felt again.

Of rarities, two cases of Malta fever came under my notice; in both, I believe, the diagnosis was afterwards verified at home. I am told that the patient's serum gives Widal's reaction with cultures of the particular organism, the *Micrococcus melitensis*. A case of cerebro-spinal meningitis which developed on board ship, this I verified post mortem: I afterwards heard that there were other cases, but whether it was the true epidemic variety I do not know.

One word on "simple continued fever:" it does exist distinct from enteric; it tends to relapse, is seldom serious, and does not yield to quinine; the rest I leave to pathologists. Catarrhal jaundice has been no uncommon complaint, and, as usual, obstinate to treatment. Of malaria in its many forms we saw very little, much to my surprise. The vast stores of quinine brought out here have been but little used.

But I must quit the field of medicine, as I fear the house physician will be on my track, and I have no book of reference.

SURGERY.

We were fortunate at Wynberg Hospital in getting a good deal of surgery during the first few months of the war. During Lord Methuen's advance all the wounded were moved down there with great rapidity, and, sad to say, in great numbers. Throughout the campaign No. 1 General was the principal hospital for officers, and it was my good fortune for six months to have charge of some thirty to forty surgical beds for officers, and 250 wounded officers passed through my hands.

ABDOMINAL WOUNDS.

A great deal has been written on the subject of modern gun-shot wounds, and I will not trespass on your space by vain repetition. Considerable interest has attached itself to abdominal wounds; abdominal surgery was conspicuous by its absence at Wynberg, though abdominal wounds were plentiful: when statistics are at hand, I think it will be found that the great majority of penetrating wounds that survived the first twenty-four to forty-eight hours lived to get well without operation. The subject is too large a one for me to say much, but I have notes of twenty-one penetrating abdominal wounds which I have seen, of which only three received surgical interference, and all but one recovered. One was a wound of the small intestine in which resection was performed, and Murphy's button inserted within twelve hours of the patient being wounded; this occurred recently here at Kroonstad. All conditions were favourable; the patient was brought only a short distance and taken to the Scottish National Hospital, where every appliance was at hand; the circumstances and the result were exceptional. The patient has made a good recovery. Laparotomy was performed because of commencing peritonitis; resection, I believe, because the wound involved the mesenteric edge of the gut, and hæmorrhage was troublesome. There was only one wound of the gut; the wound was antero-posterior, and below the level of the umbilicus. Circumstances seldom make such operations favourable or even justifiable on the field. Of the other two operated on, one was a wound of the cæcum, resulting in pericæcal abscess, which was located successfully; the other, a penetrating wound through the left lung, spleen, kidney, and spine. The patient did very well for a fortnight, and then had a sudden attack of pain followed by rapid septic peritonitis. Laparotomy was at once performed, the distended intestines relieved, and the abdomen washed out and drained; there was no rupture of localised abscess or sudden perforation of injured gut as was expected, nor was there any evidence of pus. A subsequent post-mortem threw no light on the cause of this sudden fatal issue; hæmorrhage had occured along the track of the bullet, but adhesions were plentiful, and no blood-clot had broken down. I have not had an opportunity of seeing recent abdominal wounds on the field; several have been operated on, and, I believe, only one successfully besides the case I have mentioned. To overcome the difficulties of abdominal surgery on the field, which are obviously manifold, and be successful, it requires not only exceptional skill and selected cases, but plenty of time and careful after treatment. After an engagement of any magnitude the field hospitals are flooded, and a great number of cases require immediate treatment, and for these much good can be done; time then cannot be spared for lengthy operations, the known mortality of which is over 99 per cent., at the expense of other patients, the after-treatment may be the sudden evacuation of the hospital and a long journey for the patient. Given a skilled operator and appliances, water which even unboiled is not always to hand, a selected case, and plenty of time, all may be thrown away by unavoidable want of after-treatment. We know that something like 50 per cent. of abdominal wounds get well without operation; if operated on, most of them will die; of the other fifty, forty will die whatever you do; the remaining ten may get well after operation, only under the most favourable conditions. In the case of resection with recovery that I have mentioned all the most favourable conditions were present,—seen within six hours of being wounded, wounded in the narrowest diameter of the abdomen *i.e.* antero-posteriorly, a skilled surgeon, every possible appliance, a stationary hospital, and good nursing.

WOUNDS OF LUNG.

There is a special interest attaching to wounds of the lung. Apart from cases that die on the field, or soon after, from hæmorrhage, we have had a remarkable series of cases associated with hæmothorax, with recovery without operation. I have been exceptionally fortunate in having a great number of these cases under my care, and I hope later to record them in detail.

In no case have I seen empyema occur except after surgical interference. In a few cases simple serous effusion has occurred without hæmothorax. Aspiration has been unavoidable in a few cases of hæmothorax, where displacement of the heart was considerable and respiration embarrassed, but this is the exception. I may here add that aspiration has not been successful in removing the fluid, and incision and drainage has been resorted to as the more satisfactory when interference has been called for. The hæmothorax is often associated with a daily increasing rise of temperature for the first ten to twenty days, followed by a gradual descent; twice I was tempted to explore when the temperature had reached the level of 103°, but taking other points into consideration waited, and then the tide turned: the charts I have, but I am afraid I am not at liberty to publish them. Once I resected because of the presence of a shrapnel bullet in the pleural cavity, localised by the X rays, which caused pain, and was also a source of great mental worry to the patient; this I removed, evacuating the blood-stained fluid at the same time, closing the incision without drainage. Recovery was complete; the patient was up in a fortnight, and returned to the front in a month.

Twice I have seen empyema follow operation, once when a bullet which had penetrated the lung and lodged under the skin close to the sternum was removed at the front, this case very nearly proved fatal from suppuration,—and again when a hæmothorax had been drained also at the front. Some cases give rise to no symptoms, either pulmonary or pleural. In others it seems almost certain that the heart must have been perforated, and no harm done.

ANEURISMS.

Traumatic aneurisms have been practically a new experience to me; we had all sorts and conditions at Wynberg—carotid, subclavian, axillary, brachial, femoral, popliteal, and posterior tibial. Thrice the common carotid was tied, once the axillary, twice the brachial, once the femoral, thrice the popliteal, once the post-tibial; there may have been others, but these I was present at. All these operations I have mentioned, as far as we know, were successful except the femoral (tied in Hunter's canal), which was followed by gangrene and amputation of the thigh (middle third), but recovered. Proximal ligature in each case was adopted except in one brachial case, where the sac was opened and the vessel tied *in situ* above and below. This course, I think, would have been adopted in other cases, only the dangers and difficulties were rather great.

Several arterio-venous aneurisms were seen which were not treated surgically; the purring thrill in these is very striking. I think I am right in saying that the greater proportion of cases have been arterio-venous. A point worth noting about these aneurisms is that very often they do not make themselves known till some weeks after the injury, when the wound may be healed, and the patient considered fit to walk about; several have been discovered accidentally in convalescent patients; twice aneurisms have ruptured with fatal results aboard ship going home. It will be instructive to hear how some of the cases which have been left, in order that rest may be tried, have got on. I do not know whether any pulsating cases have completely subsided without operation. I fancy rest might have been tried more often, especially as the operations were often very severe and very difficult.

It is a striking fact that large arteries can be injured, and even perforated, without death from hæmorrhage on the field. This holds good for the carotid. As for smaller arteries, one case which I saw, with apparently a large thoracic aneurism, afterwards died of hæmorrhage, and post mortem we found that a portion of the lumen of the left subclavian had been clean cut out by the bullet, and yet a temporary clot and ultimately a sac had formed.

Two officers in the same regiment were wounded in the same engagement, one in the right side of the neck, the other in the left; they were laid side by side in the same waggon, and they both complained that they were possessed of a devil in the shape of a purring cat. They ultimately both found their way to Wynberg; they both had large arterio-venous aneurisms of the carotid; they both had their common carotids tied by Mr. Makins, and both made good recoveries up to date.

One patient came to Wynberg from Natal; he was on his way home, but owing to some hæmorrhage from his wound was disembarked. The bullet had entered close to the outer margin of the orbit, and emerged about an inch behind the angle of the jaw. The orbital wound never quite healed, and subsequently broke down and gave rise to attacks of spontaneous hæmorrhage; concurrently with this a hard swelling like a hæmatoma situated in the region of the other wound gradually increased in size, but did not pulsate. As frequent attacks of hæmorrhage occurred from the upper wound, and there appeared to be a connection between the two, *i.e.* by squeezing the swelling blood oozed from the orbital wound, Jameson, whose case it was, decided to explore, and if necessary tie the carotid. Having ascertained that there was no bleeding point at the orbital wound he cut down directly on the swelling behind the jaw, and was promptly greeted with a fountain of blood in his face. The wound was quickly plugged, but the hæmorrhage with difficulty checked, and the common carotid quickly cut down upon and tied. The patient made a good recovery.

In another case a large pulsating swelling developed in the middle of the calf beneath the muscles; the posterior tibial was exposed in the upper third of the leg, and found not to control the pulsation; the popliteal was then exposed, and the vein was accidentally wounded, artery and vein were both tied. The contents of the sac, however, broke down and suppurated; the sac had to be opened up and drained. Several mild attacks of hæmorrhage occurred, but eventually everything healed; though both popliteal artery and vein were tied, the circulation of the leg was never dangerously embarrassed.

HEAD INJURIES.

Of all wounds in this war none have been more striking than those of the head. The Mauser bullet has shown itself capable of penetrating the brain substance in almost any direction without reducing it to a pulp and without destroying life. It is mainly in the front half of the brain that this holds good. Wounds in the occipital region are nearly always fatal. At short range probably the damage to the brain is very much greater than at long range, just as the long bones are much more *liable* to be splintered at short range and perforated at long range, though this, I believe, is disputed.*

One has met with numbers of cases where the brain has been penetrated without any permanent mental or paralytic symptoms, though it is possible that later on, after healing and contraction of scar tissue, some symptoms may arise.

Whenever the skull is penetrated some splinters of bone are pretty sure to be driven into the meninges or brain substance, so that the great majority of cases require some surgical interference, and the sooner the better rather than wait for symptoms. There are cases in which the skull is struck obliquely, and the cranial cavity not exposed; experience shows that in all these cases the inner table is generally splintered, and trephining indicated. A great number of trephinings have been done, and have been, as far as I have heard, singularly successful. We had a few at Wynberg after the earlier fights, and they all, I think, did well; of course a large percentage of the killed are head cases, and of those that die on the field or shortly after, many of the latter, I take it, die from hæmorrhage. I only deal with cases treated at the base or thereabouts.

* The whole question of range is a very difficult one. Tommy seldom knows, and even if he thinks he does he generally understates it. Apparently it is much more gallant to be shot at 200 yards than at 1000.

NERVE INJURIES.

It is found that the great majority of wounds of the extremities are associated with some nerve symptoms; it may be a little local numbness, tingling anæsthesia or hyperæsthesia, or acute neuritis with excruciating pain or temporary paresis. Time soon rights these; but there is a very large class of cases in which the nerves are either divided, crushed, or involved in scar or callus. The most popular nerve is the musculo-spiral. It is no easy matter at first to decide whether there is division or not, but time and the battery generally clear up the doubt. A good many sutures have been done, but time has not allowed results to be known. In one case which I cut down on, the nerve (musculo-spiral) was partially divided and tightly bound down in scar tissue, though paralysis was complete at the time. Some return was manifest after three weeks, and in another case R.D. was well marked after a month. On cutting down division was complete, the upper end was bulbous and degenerated for three quarters of an inch, and the lower end thinned and frayed out, the bullet had at the same time produced a severe comminuted fracture of the lower end of the humerus, involving the elbow-joint. The nerve was not explored till after union was complete. This was two months after the injury, as the wound was a septic one. The divided ends were sutured, and the wound healed in four days.

ANÆSTHETICS.

A word on anæsthetics might prove of interest to some. From the beginning of November till the end of February about 400 anæsthetics were given, *i.e.* an average of 100 a month, at No. 1 General Hospital at Wynberg. In all these cases chloroform was used. In the next three months there were not so many cases, but during the whole time no deaths occurred. Jameson was in great demand, especially in serious cases, and if possible added to the reputation he gained at Bart.'s as an anæsthetist. Ether was not used at first, partly because there was no gas, and partly because it was said to be too hot. During the latter part of the time ether was occasionally used, at first alone, and then with gas, of which we secured a few cylinders; nor did we find it evaporate inconveniently quickly with Clover's inhaler. It was interesting to see the different methods of administration of the different schools. I must say I was more than ever impressed with the superiority of the Bart.'s method. Jameson and I were always in a fever of excitement when watching the Scotch method. Tommy is a good subject for anæsthetics, but he has an unpleasant habit of expectorating rather freely during the early stages, which is sometimes a little disconcerting to the novice.

SEPSIS.

There is one other matter upon which a great deal has been said—the remarkable way in which wounds heal, and the high standard of asepsis. Doubtless to those who have dealt with wounds in campaigns previous to the introduction of small-bore rifles and the universal use of first field dressings these are very real and striking facts, but I would point out that they are also very relative facts.

Tetanus, hospital gangrene, and the like are unheard of, septicæmia and pyæmia very rare; erysipelas has occurred in isolated cases. Secondary hæmorrhage from suppuration has been unpleasantly frequent; many cases of severe fracture of the femur have succumbed to this or to septic absorption. When it is remembered how many hands a patient passes through before he reaches his final resting-place, one cannot wonder if a link in the aseptic chain is sometimes wanting. With a healthy patient and a healthy atmosphere great precautions are neither expected nor required, nor are they to any extent possible. The use and supply of antiseptic dressings has been most liberal, but a little economy here and a little more liberality in the use and supply of soap and nail brushes would have provided a link in the chain that was often wanting.

An important link is formed by the hospital orderly. The task of the hospital orderly is no light one. He has to be efficient in the drill of a bearer company,—no light task, as I can certify from personal experience,—in company and battalion drill, in first aid to the wounded, and in the practical nursing and tending of the sick.

A large proportion of his time is occupied in mastering the intricacies of stretcher and waggon drill, a necessary discipline and very effective on the plains of Aldershot, but on the field of battle for practical purposes it does not exist.

Can it be wondered at, then, that his efficiency in hospital training is not all it should be?

He is expected to be soldier and stretcher bearer, nurse, dresser, and wardmaid; he is seldom the complete article, but nevertheless a very good fellow, and generally works like a slave.

BULLETS

Before this war the question of the stopping power of the modern small-bore missile was much debated, but I think it is now settled. Nine out of ten wounded men will tell you that they felt as if they had been hit with a sledge-hammer, so great is the force of impact, and the majority are put out of action for the time being, and that is all that is required. There has been a lot of talk about explosive bullets; they are seldom used now, I believe, even in the sporting world, and there is not a particle of evidence that they have ever been used in this war.

Expanding bullets, *i. e.* soft-nosed bullets, or bullets with nickel casing split at the point, have undoubtedly been used, and produce explosive effects, but not to any great extent judging from the wounds. The damage that a soft-nosed bullet does is due to the fact that the exposed leaden point on impact with bone "sets up," *i.e.* bends and becomes split up, after tearing up the nickel sheath behind it; this is apt to cause great comminution of the bone and laceration of the tissues. The old leaden bullet has very much the same effect as Martini, Remingtons, Guides, etc. The most severe and the most septic wounds that I have seen have been produced by Martinis. I recently met an old Boer coming in to give up his arms; he had on a bandolier which was full of soft-nosed Mauser bullets; he seemed a little surprised when I took a few as a sample. I expect you are familiar with the size, shape, and appearances of the different bullets, and there is no need for me to describe them.

The Boers have been accused of dipping their bullets in green sticky fluid, which is said to be poisonous, and I have been shown a clip of bullets taken from the Boers in this condition. I may mention that I recently saw an officer open a packet of Mauser pistol ammunition which he had brought out from home, and these bullets had exactly the same appearance. It may be a coincidence, but it points very strongly to the fact that the bullets had been oiled or greased to prevent fouling, and that some form of verdigris had resulted.

Supposing the bullets to have been intentionally dipped in poison, how much would remain by the time the bullet left the rifle? Supposing that they do dip them in something, the most probable explanation is that they do it to prevent fouling of the rifle.*

I cannot complete this without a word of praise for the Red Cross Societies. What Tommy would have done without them Heaven and the War Office only know.

How the nurses have worked, and what magnificent work they have done, no one will ever know but Tommy; he knows, and he remembers.

To appreciate at its full value the magnificent work that has been done by everybody concerned in the treatment of the sick and wounded, it is necessary first to appreciate the difficulties encountered. Those who have an intimate knowledge of the latter can and do appreciate the former, and history shall put it on record, whatever the stay-journalist may say, at its true value.

I have trespassed somewhat severely, Mr. Editor, on your space: as an old member of the Publication Committee I recall that in the long vacation the supply of copy is not always equal to the demand; let this be my excuse. My remarks have been sketchy, I humbly confess, for I have endeavoured to cover a large field in a small space at the expense of detail. I have but dealt with cases as I have seen them in one little spot in a vast field of operations. As such only must they be considered.

Those who have had a wider experience and have travelled further afield may have a different tale to tell. 'Tis a small thing, but my own.

C. GORDON WATSON.

* Since writing this I have been told that it has been stated at home that analysis shows this stuff to be oxide of nickel, which supports what I have said.

Scene—THE OUT-PATIENT ROOM.

Patient's Husband: "Do you think it is consumption, doctor?"

Physician: "I'm afraid there's no doubt about it." (Pause.)

Patient's Husband: "Would you advise me to get a consultant's opinion, doctor?" ——!——

The Law of Defamation in Relation to the Medical Man.

A Paper read before the Abernethian Society, November 23rd, 1899.

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No apology is tendered this evening for the non-clinical, but wholly forensic *matter* of this paper; our Committee deeming apparently that whereas the subject was not of the nature of medical science, it was at least related to medical practice, and was therefore admissible by our rules for consideration and subsequent discussion. As to the *manner* of dealing with the question, I have presumed, not, I think, unfairly, a certain lack of definite knowledge among my hearers with regard to the purely legal aspect of the question—"that lawless science of our law, that wilderness of single instances;" and I have ventured to briefly recapitulate the main features of this branch of the law before plunging into the midst of the titular subject.

In England there is no actual Act of Parliament which confers upon the citizens of this country the right of freedom of discussion and expression of opinion, for this right is a corollary from the general law of the land. "*Our present law permits anyone to say, write, and publish what he pleases; but if he make a bad use of this liberty he must be punished. If he unjustly attack an individual the person defamed may sue for damages, if, on the other hand, the words be written or printed, or if treason or immorality be thereby inculcated, the offender can be tried for the misdemeanour either by information or indictment.*" This is a comprehensive statement of the law of defamation by its classical exponent, Dr. Blake Odgers. In a State trial it was said, "*The truth of the matter is very simple when stripped of all ornaments of speech, and a man of plain common sense may easily understand it. It is neither more nor less than this, that a man may publish anything which twelve of his countrymen think is not blamable, but that he ought to be punished if he publishes that which is blamable*, i. e. *that which twelve of his countrymen think is blamable.*" So that if a dozen of your fellow-citizens empanelled in a jury consider, after hearkening unto the evidence, that you have publicly and maliciously defamed some one's character, you will have to pay a penalty for the defamation you have published; if from another you publicly filch his good name, it may enrich him and leave you poor indeed; and remember, technically publication means making public, it may be to the whole world, or it may be merely to one stranger. If the defamation was *vivâ voce* it is *slander*, but "a false and unprivileged publication in writing, printing, picture, or effigy, or other fixed representation to the eye which exposes any person to hatred, contempt, or ridicule, or which causes him to be shunned or avoided, or which has a tendency to injure him in his occupation," is a *libel*, and is properly considered as a more serious offence than slander.

The varieties of defamation may be instanced thus:—A person may shout or tell his friends "Dr. X. is a quack," or he may write that legend on Dr. X.'s gate, or send him a post-card to that effect, or even draw around the streets a guy purporting to represent Dr. X, so making him ridiculous: each act is defamatory.

The legal attributes of the two possible forms of defamation differ. Slander is considered as less culpable than libel, for *verba dicta pereunt, but literæ scriptæ manent.* Words are often spoken thoughtlessly in a rash moment of anger, but writing seems to imply some cogitation precedent to the publication of the libel; and further, it is sufficient effect for an action of libel if "*a fixed representation to the eye*" brings the person defamed merely into hatred, contempt, or ridicule, whereas some actual pecuniary loss must be substantiated as the direct consequence of the alleged slander unless the imputation is of such a nature that a jury may infer damages as a necessary consequence. Again, generally speaking, an action for slander must be brought within two years of its publication, whilst six years may elapse before an action for libel dies. As gross libels (blasphemous, obscene, seditious, or those in the nature of a challenge) often tend to cause a disturbance of the Queen's peace by those grossly libelled thereby, they may be dealt with as criminal acts. But words obviously and palpably out of proportion to the occasion (*e.g.* election epithets) may fail to be sufficient for an action, the Court regarding them as mere vulgar abuse, and hence unlikely to harm the person to whom they are applied.

The rule that a consequent special pecuniary loss must be proved to successfully uphold an action for slander is probed by several exceptions, which are perhaps especially interesting to members of the medical profession. Thus if you *vivâ voce* impute to a person a crime which, if proved, would involve imprisonment or other corporal penalty, or if you impute to him a present contagious or infectious disease of a definite kind, or to a female unchastity or adultery, or if you make statements alleging bastardy, so tending to the disherison of the plaintiff, an heir apparent, he is not bound to show that he has suffered actual loss as the result. On the other hand, if X publishes statements directed against your fitness and competence in your professional calling, you need not prove a subsequent actual monetary loss in support of your action for slander against him. You may, of course, defame another by, so to speak, *oratio recta*, in which you express your own personal opinion, or by *oratio obliqua*, in which you relate what somebody else said of him, for in each case you are the means of publishing the opinion. Lastly, an *individual* must be defamed. A profession as a whole can no more be defamed than can a nation be indicted, and thus the old *surgeon* was able to say with impunity, "Physicians amuse their patients while Nature effects the cure;" and similarly no action could be founded on the statement of Gil Blas, who being taken ill during his travels puts up at a village inn, and narrates "But there being no doctor in that village I soon got better."

The lines of defence to an action of defamation are threefold.

1. A technical publication may be denied.

2. Publication may be admitted, but the plea of justification may be set up, on the ground that the whole statement was true in substance and in fact. Such a plea is always a sufficient answer to a mere action for damages, but it must also be shown, if the defendant wishes to avoid all penalty, that the occasion warranted that statement, which was not used as a means of exhibiting malice or personal bias. Thus criticisms must not go beyond fair and *bonâ fide* comment on matters of public interest, and your certain knowledge of a fact detrimental to another's reputation does not allow you to take the world into your confidence; for to publish statements which, though perfectly true in themselves, tend to damage an individual without being of any benefit to the public, is punishable criminally. It was in such a case that Lord Mansfield said, "The greater the truth, the greater the libel."

3. Or privilege may be pleaded. It is a matter for the judge to decide whether the occasion when the statement was made is privileged. Cases are referred to later where the privilege is absolute, and where it is merely qualified; in the latter case the plea avails not if it can be shown that malice prompted the defamatory statement.

A medical man is primarily a citizen, and thereby a subject of the general common law of the land; but the State, by indirectly granting him a licence and registration, recognised him as having a special status, a position which carries with it special privileges and special responsibilities. The relations between A. B. C., Esq., and Dr. A. B. C. are often difficult of definition, and have led to great discussion, and it is for the consideration of some of the results of this peculiar relationship—the rights and duties arising therefrom—that this paper has been written. In sum the law of defamation applies to Dr. A. B. C. generally, as to all other citizens, and specially as to a medical man.

In passing it may be hinted that it is always undesirable as a matter of practical policy for any public man to be found occupying a prominent position in a law court, for as a matter of fact there is nearly always a vague if unmerited stigma of reproach attaching to a frequenter of courts of law: this caution, I need hardly observe, does not apply to the learned profession of the law. In petty matters it pays better to abstain from litigation, even if one is not naturally pachydermatous. It is because the ordinary man does not consider that the judges are the most suitable washerwomen to deal with dirty linen, that he is often preferred to settle matter defamatory out of court. And thus it is that whilst every practitioner has in memory some case where a threatened action for defamation was settled by a humble public apology or a high private compensation (or even by both), yet so few actual cases have come under the eye of the law and of the general public; and thus the subject of defamation with relation to medical men is more widely applicable and of greater importance than it would casually appear to be from the mere quotation of recorded cases, leading or otherwise.

Turning now from the osteology, so to speak, of the question, we come to the every-day facts which clothe these dry bones of the law before they appear in public; from the general statement of the law of defamation of character we proceed to its special application to the qualified registered medical man. At once we are confronted by a double aspect; the medical man may either be wronged or be wrong, he may be passively defamed, or he may himself—often, be it said at the outset, unwittingly—be the active defamer. It is this latter aspect which demands as a practical rider a consideration of the great question of the proper limits of professional secrecy and confidence, and the extent of the privilege allowed by the law in cases involving this factor.

Firstly, then, in what cases is a medical man, as such, likely to be defamed? and secondly, into what pitfalls may he project himself in referring to his patients or brother practitioners?

Of the many cases which might be chosen to illustrate the malicious defamation of a medical man as such, I have selected the following as being not without interest, thus:

To advertise falsely that certain quack remedies were prepared by an eminent physician was sufficient to be regarded as a libel against that physician.

Again, when an American M.D. published part of his treatise on an infallible consumption cure in the advertisement (!) columns of the *Times* newspaper, the *Pall Mall Gazette*, criticising his effusions, called him "an impostor and quack," and said he was "like scoundrels who utter base and forged coin," the jury only allowed him one farthing damages, as they considered the remarks little more than fair and *bona fide* comment on a matter of general public interest. The limits to which such comments may extend are stated in the following quotation:—"A critic must confine himself *to criticism*, and not make it a veil for personal censure, nor allow himself to run into reckless and unfair attacks merely from the love of exercising his power of denunciation."

It is libellous to say in print of a medical man that he is "the Harley Street quack, physician extraordinary to several ladies of distinction;" but it is *no* libel to write and publish of a physician, as in the case arising in connection with the death of the Earl of Beaconsfield, that he has met homœopathists in consultation, notwithstanding it be averred in the declaration that so to do is a breach of professional etiquette, for a Medical Act declares "the name of no person may be removed from the register on the ground of his having adopted *any theory of medicine or surgery.*"

In the following cases a *proof of special damage, i.e.* financial loss, was held to be unnecessary to successfully support an action for slander:

When accusations were made against a medical man that a patient died through his ignorance or culpable negligence, and in a similar case that he administered medicine in excess, or wrong medicine ignorantly or unskilfully; for, as Chief Baron Pollock—"the Last of the Barons"—once said, "it would be most fatal to the efficiency of the medical profession if no one could administer medicines without a halter round his neck." Again, where a qualified medical man was defamed as a "quack-salver," as an "empiric mountebank," and where A said to B, referring to B's doctor, "he is a bad character; none of the medical men here will meet him."

To support the action in the following cases it was necessary for the plaintiff to prove as well pecuniary loss, as the names of specific patients who forsook him, thus diverting fees from his pocket:

When one said "he did poison the wound of his patient" the Court hinted that the poison alleged might have been a proposed means of cure. So general accusations of "malpractice," without affirming a specific and consequent death, calling an *un*qualified man a "quack"-or "impostor," and accusing a medical man of adultery in his purely private as distinct from his professional life, must involve special damage to be successfully actionable.

There remain the cases where a medical man is called in to supersede a former alleged unsatisfactory practitioner; he must be careful what he says of his predecessor or his treatment. And, finally, the recently published cases of attempted abortion, criminal or otherwise, suggest a warning to those who have to remedy or report upon the previous professional acts of another person.

The second aspect of the subject is how may a medical man by his statement find himself set down as the defendant in an action of defamation of character?

Mr. George Meredith, describing in one of his novels a solicitor, says of him, "A very worthy old gentleman he was, with a remarkable store of anecdotes of his patrons, very discreetly told, for you *never heard a name* from him." This is the kind of character which every professional man should strive after, be he a medical adviser, a professional man should strive after, be he a medical adviser, a minister of religion, or a lawyer. These professions are largely

based upon purely confidential relations. The fact is that many of the transactions which result from such relations need the fullest disclosure of the patron's secrets; he must reveal his "business and bosom." Think, for instance, what the phrase "family doctor" implies; it can well be appreciated on this ground alone what an excellent if dangerous source of apposite anecdote the professional relations must be, and in fact are.

The medical man, as have other professional men, has formed a standard code of etiquette tacitly binding the members of his profession. One of the oldest items of this code is instanced by the proverbial oath of Hippocrates, pledging secrecy with respect to all knowledge gained *quâ* medical man: "I swear, ... whatever in connection with my professional practice, or not in connection with it, I see and hear in the life of men, which ought not to be spoken of abroad, I will not divulge, affirming that all such facts should be kept secret. While I continue to keep this oath unviolated may I enjoy life and practise my art respected by all men in all times; but should I trespass or violate this oath may the reverse be my lot." And although an oath is no longer formally taken, its substance is so emphatically maintained by the profession as a whole that a recent number of the *Lancet* says "a patient's secret should be held inviolate by his medical adviser, almost if not quite as binding as the Confessional in a Roman Catholic priesthood."

It is generally held that a confidence disclosed to a medical man, as such, continues to be the property of the discloser, and not of the doctor for his own private use. His duty, it is said, is to avoid, if possible, any imminent physical danger threatening his patient, and he is in no way called upon to disclose his patient's secret. There is, it is maintained by some, a slight difference between the cases where a person voluntarily tells facts to the adviser and where the latter finds the facts for himself by practical medical examination, though where the difference actually lies it is difficult to see. The proverbial disagreement among doctors may also be an added weight of reason for the implied pledge of secrecy, for your publication, if you break the postulated pledge and disclose a faulty diagnosis you have made, will not have the justification of truth as a plea in your defence. An interesting, and to us a warning note appeared recently in the *Law Times*, in which it was remarked that the main cause of apparent difference of medical opinion, which is not seldom exhibited in the evidence given in a court of law, is due to statements of the medical witnesses based on facts other than purely medical, and to that extent *nihil ad rem*.

In passing it may be noted how aggravatingly yet advisedly vague the newspapers are when informing the public that some notable person has had "*an operation*" performed on him, or is suffering from "*a serious illness*;" a more specific statement might be to their peril.

Notwithstanding the implied pledge of secrecy, there are yet many occasions when the confidence of the patient is as a matter of fact liable to disclosure with impunity; it is the position of the medical man who thus publishes confidential communications, which publication would ordinarily be defamatory and punishable, that has to be now considered from the point of view of the Law of Defamation of Character. When and to whom, then, may a medical secret be disclosed, the discloser being innocent of defamation?

At the outset it must be confessed that the occasions and motives, justifiable or otherwise, which lead to the disclosures are very various, so various that a classification of cases based upon such motives may be conveniently made.

The occasions, then, which lead to the publication of the result of professional transactions may be either *private and personal*, or *public and forensic*, and the motives prompting such disclosures must be considered separately.

The *private or personal motives* which may lead to the revelation of facts gained by a medical man in his professional capacity are several, and it is premised that for justification in a law court their publication *must be quite innocent of malice*. We may here refer to moral motive, criminal motive, and absence of specific motive. Thus if the safety of a member of the medical man's own family were endangered by an alliance with one whom he knew as a medical man to be secretly suffering from "a bad disorder," the great moral pressure which this knowledge would exert upon him would be sufficient ground to justify a disclosure of the state of affairs, but only, of course, to the parties personally affected.

Little need be said of criminal motive, as happily examples are all but unknown, and usually take the form of a threat to levy blackmail on some knowledge acquired as a professional secret; unfortunately such cases are not so rare among abortion quacks and their victims. With regard, on the other hand, to the cases characterised by an absence of specific motive much might be said; they usually occur when thought, instead of preceding, is the tardy sequel of speech. "Shop" in general conversation should always be avoided, "shop" which deals with specific persons often becomes little better than garrulous "gossip," and this the medical man especially must avoid if he wishes to remain respected, whether his practice is in a remote village or in a large township: he should never make his patient the subject of his common conversation; he should, indeed, be ever ready with an evasive or banal reply to such pertinent yet impertinent questions as, "What's the matter, doctor?" or "How did it happen?" and, in fact, in all such cases as those in which we were instructed as little boys that "white lies" were not permissible: you may tell the truth, you may tell nothing but the truth, but you must not in some cases tell the whole truth; or, as has been neatly said, "you should tell the truth, but be careful *what* truth you tell." It is, indeed, in these cases that a medical man has to use that judgment with which nature has endowed him, and which—it is to be hoped—will tell him when he should hold his tongue.

Incidentally some minor cautions may be given: do not repeat the statements of the sick or dying,—the statements of the latter may be subsequently wanted as hearsay yet valid evidence in a law court; be very loth to express personal opinions on behalf of either side in medico-legal cases pending trial, otherwise you may find yourself subpœnaed as an unwilling witness; always keep under lock and key all letters from or to patients, all notes on actual cases, drawings, photographs, skiagraphs, etc., otherwise you may have to suffer for your presumed carelessness in allowing such matters to be technically published. In hospital and asylum practice, a patient by accepting treatment consents to the implied publicity of his case; if he is admitted when unconscious, and remains when he realises his situation, he is in a similar position.

There are occasions when *public or forensic motives* lead a medical man to disclose his special knowledge; such occasions are privileged—if at all—on the all-sufficient ground of public policy, absolutely, *i. e.* malice does not affect the case; for it must be continually borne in mind that you are primarily a citizen, and after that a registered qualified medical man, and hence, to some extent, a species of civil servant. In dealing with these public motives for disclosure our tread will not be so firm, as our ground is not so sure as elsewhere; much difference of opinion has been manifested in the discussion of the privileges relative to this part of the subject. The forensic view often cannot be seen from the medical man's standpoint.

Arguing from analogy with other professions, we find that the communications between a client and his legal adviser, and between a clergyman and a member of his flock, are recognised as being absolutely privileged, and their publication must not be demanded even in a court of law, arguing from various national customs, we find, *e.g.*, that in France and many of the U.S.A. the relations between the medical adviser and advisee are absolutely privileged; in Scotland secrecy is a condition of the contract, and in New Zealand secrecy is enforced in civil cases at least; arguing from general practice, it is not usual for medical men or medical institutions to act as informers, and hospitals, for instance, have been exemplified as a relic of the ancient idea of sanctuary, although in them the victim is often the party protected, and the sanctity of such institutions and the secrets deposited therein should not, it is said, be violated. But I am informed that the practice at this hospital is for the Steward to report such cases—as are reported to him!—to the Snow Hill police. This practice agrees with the highest legal opinion sought by the Royal College of Physicians some five years ago, but curiously and certainly unexpectedly Lord Brampton opposed this view, and stated that it would be "*a monstrous cruelty*" to report one such case which he instanced.

In his public capacity a medical man may be called upon either to act as an *informer* or to give evidence as a *witness* in legal proceedings.

Should a medical man act as an informer? There are those who declare that if a medical man conceals what he discovers and knows to be criminal, he renders himself liable, *ipso facto*, to penalties as an accessory to the crime which has been committed; and, say these folk, cases of murder or attempted suicide, or abortion, or infanticide, or slow poisoning, or the carrying on of an illegal occupation, which may come under the medical man's special clinical notice, should be forthwith reported to the Public Prosecutor. There seems to be no definite statement possible, but the tendency seems to point to the fact that, even assuming it is not your recognised duty to see that a criminal is punished, it is your duty to see that a planned crime of which you have information is not effected; and it is your duty, though you find the facts in question as a medical man, to inform the proper authorities if you learn anything which involves the actual commission of a crime now *in future*, or if you are reasonably suspicious of an intended illegal act. The only definite advice which can be given in addition to this indefinite statement is that you should appeal personally to men recognisably high up in the profession for their opinion as to what course you should adopt in the matter which causes your doubt.

A medical man is, of course, compelled to act as an informer under penalty in cases where a public necessity, formulated in an Act of Parliament, declares *salus populi* to be *suprema lex*, notably in the notification of certain mental and infectious diseases; but in the Acts compelling such information only such specific maladies as are enumerated and clearly denominated within their meaning are privileged.

Turning now from the cases where a medical man may be expected upon public grounds to *volunteer information* he may acquire during his professional work, we come to a final class of cases, including all those bearing on the subject which we have not hitherto mentioned—viz. where the publication of facts otherwise held in confidence is *compulsory*, and as such is *absolutely privileged*, so that not even proof of a special bias in the publication made is sufficient to render the medical man liable to conviction for defamation of character. These are the cases of medical men called as witnesses in legal proceedings (including, of course, those of the coroner's court). There is an historical background to this matter, which shows that with changing times ideas have also changed.

In 1776, in a case of bigamy, Lord Mansfield held that a physician must reveal to the court what would in private be considered as *a breach of honour and a great indiscretion*. In 1862 it was decided that communications from patient to doctor describing symptoms *were not* admissible as evidence, whilst later in Lee *v.* Hamerton, a confidential medical report to an insurance company *was* allowed to be inspected during the trial.

It is, of course, agreed that the medical witness may absolutely refuse to reply to any question which would in any way incriminate himself, this being a general rule of evidence with all classes of witnesses. *Nemo tenetur prodere seipsum.*

Some authorities have asserted that a custom is growing, aided both by judges and by coroners, to use the medical evidence as a means of indirectly obtaining facts for the ulterior prosecution of the ends of justice. This is not a satisfactory tendency, as it also tends to make the medical man—unconsciously, perhaps—think less of the professional confidence placed in him in other cases. Any attempts to destroy this privilege and responsibility of secrecy should be zealously resisted and the prevalent conditions cautiously guarded, more especially after the amusing, if surprising, *obiter dictum* of Lord Brampton in the case of Kitson *v.* Playfair. His lordship inquired of Sir John Williams (a special witness) if he, in the event of a case of malpractice (criminal abortion) coming under his notice, would report it to the authorities. The witness said he thought that would be the proper course to take. "Then," said the judge, "*I shall be very careful what medical man I consult in the future.*" This was *his* way of expressing the opinion that it is not the duty of a medical man to report to the Public Prosecutor a case of malpractices. In the same case he made another dictum, *obiter*, which, though not the law, is at least a great lawyer's view of the law: a medical man is not bound to give evidence in a court of law, though this, Lord Brampton agreed, would depend upon the judge's personal views, and in any case a committal for contempt of court would be highly improbable if he refused to act as a witness.

The late Dr. Tidy, writing many years previously, stated that he should advise a medical witness either to hand written evidence directly to the judge, or to refuse to give evidence, accepting the consequences of his contempt of court, if his action in this particular was so deemed to be.

Before concluding, may I remind you of a few cases which illustrate the application of the statements preceding?

The case of Dr. Edwards, of Hounslow.—E. and W. were in partnership. E. had been deceived by his partner as to his share in the concern, and had complained to W. W. requests E. to retire, owing to a charge of immorality alleged (just after E. had complained) by an hysterical and erotic female patient. E., worried about the partnership and outraged by the gross slander, took HCN, having lost mental balance, and died. Here, of course, a law court was the place in which the sordid tangle of events should have been unravelled.

An "infant" (under twenty-one) gets into physical trouble, and applies to a medical man for assistance. Subsequently he repudiates the account rendered for professional attendance. Can the medical man apply to the parents or guardians for settlement? If he does so he will be in peril of defaming the infant, though it is presumed that the medical advice was a necessary "within the meaning of the Act," and the infant himself is held liable for any such debt which he may contract.

Mrs. A. sends her servant girl to you and asks you, under cover of a letter enclosing your fee, to examine the bearer, and report in writing on her condition. You will comply with this request at your peril; your course will be either to return the girl and fee, or examine her and send a letter saying that the only action allowed to the profession is for the patient herself to make a voluntary statement of her condition to her mistress; and that for that purpose you have carefully explained to the girl the facts concerning herself. It is even unwise to allow a stranger other than a professional nurse—to be present while you make the examination and draw up a diagnosis, unless the patient actually consents to the publicity of the proceedings.

A medical man issues a report on the present state of health of X., which statement is entered on a certificate, and passes through the hands of a number of people, and X. suffers in consequence; both X. and the medical man know that it will be technically published; X will have no legal or moral right to complain of the facts, for he wittingly lays the facts open to publicity, knowing as he does that the certificate is to some extent a public document. This line of argument would apply to a hospital patient who is made the subject of a lecture by one of the staff.

M.D. is called to attend a patient who he strongly suspects is being slowly poisoned, presumably from some criminal motive. What course should he adopt? Baron Martin thought he should inform a near relative of the patient of his suspicions, and if that was of no apparent avail he should lay the facts privately before a magistrate. Prof. Christison thought the patient should himself be informed of M.D.'s suspicions. The only alternative and final course which might be adopted appears to be to have the patient removed to a hospital, or ensure that he is placed under trustworthy nurses; M.D. must then wait for and watch the results of such environment.

In Southport a few weeks ago, a newly born infant was found in a garden dead from exposure. The police, hitting on what seemed to them a happy idea, issued a circular to all the medical men in the town, suggesting that as a woman, lately delivered of a child, unaccompanied with the child would probably be under the care of a local practitioner, they, the police, would be pleased to be put into communication with the mother, *vid* (and this of course strictly confidential) the attending medical man. The medical men of Southport refused to be caught in this trap, apparently believing that if medical confidences were to be divulged in such a case as this many lives would be jeopardised, for many people would rather suffer to the death than court the publicity which seeking the advice of a medical man might gain them, under these conditions.

These instances would not be complete as a series were the well-known case of Kitson *v.* Playfair omitted. The details would take too long to enumerate. The following is a brief summary:

The libel complained of was one in which the defendant, Dr. P., attributed adultery to Mrs. K., and, as a consequence of the libel, she lost an allowance of £400 a year, which had been voluntarily made to her by her brother-in-law, Sir J. K. Dr. P.'s opinion of her adultery was formed solely upon the result of medical examination of Mrs. K. while in professional attendance upon her, added to the fact that she had not been in the society of her husband for over a year. The verdict of the jury that there was "publication *with interested motive* and *express malice* on the part of Dr. P.," or rather the amount of the damages they awarded, viz. £12,000 (being thirty years' purchase of the lost annuity), was probably not a little influenced by the fact that Dr. P. formed his opinion and communicated it to his wife, and then at his instigation she informed Sir J. K., her brother, solely on the knowledge he had gained as a doctor, and without giving Mrs. K. any opportunity for explanation—an opportunity for which, in fact, she had pleaded in vain.

The question whether a medical man may reveal professional facts to his wife was not in this case raised nor discussed, and still remains to be adjudicated upon when an appropriate occasion arises.

In conclusion, the meagre sketch of the subject here given might be amply extended, but I fear your patience has not the same ductile property. I have endeavoured to make it clear that there are events forensic which occur in a medical man's everyday practice which may at least force from him monetary reprisals, even if they do not forfeit his professional prestige.

Two Cases of Herpes Zoster with a generally distributed Eruption.

By JOSEPH A. ARKWRIGHT, M.D.

CASE 1.—W. J—, æt. 23 years, was first seen on September 3rd, 1898, complaining of sores and painful spots on the back of his right shoulder, on the front of the chest, and on the right arm.

There was a typical eruption of herpes zoster in five patches.—(1 and 2) the oldest part of eruption, composed of inflamed ulcers, was situated over the outer half of the spine of right scapula; (3) a long-shaped oval patch reaching from just above the middle of the right clavicle to a point about three inches above the right nipple; (4) an oblong-shaped patch with pearly vesicles over the outer and anterior surface of upper part of the right upper arm, over the biceps; (5) a small patch of spots, mostly papular, in the centre of the anterior aspect of the right elbow-joint.

There were a few spots of much the same character as these constituting the patches of herpes scattered over the body: two papules just below and behind the lobule of right ear; one vesicle, just like an ordinary herpetic vesicle, over the middle of the sternum, at about the level of nipple; one vesicle just like a varicella vesicle, with scarcely any surrounding redness, over the sixth rib in the left axilla.

5th.—The herpetic patches are getting well; there are no fresh patches of herpes. Another single vesicle is seen at the lower part of abdomen on the left side; this is beginning to dry up.

The two chief points of interest in this case are—

1. The sparing but distinct general eruption of spots resembling herpetic spots. This I have seen in two other cases, but I have only notes of one besides this case.

2. The distribution of the herpes, which certainly does not correspond to the area supplied by any one nerve, as is generally the case; the area involved is supplied by parts of the following nerves according to the anatomy text-books:—the clavicular and acromial branches of the supra-clavicular nerves, the circumflex nerve, and the internal cutaneous nerve.

The herpes is partly situated on two of the areas which Dr. Head mapped out for herpes and referred visceral sensation, viz. his fourth cervical and fifth or perhaps sixth cervical areas, and these areas are very inadequately represented in this case of herpes.

CASE 2.—J. K—, æt. 60, nailmaker.

December 20th, 1897.—Pain in the right side of head.

21st.—Herpes zoster appeared on the right side of forehead and on the top of head; one spot also at the junction of cornea and conjunctiva of right eye.

23rd.—A profuse crop of herpes, which has extended on to right upper eyelid and right side of nose. There is much pain in the right side of head and below right mastoid process, where the glands are very tender. The eruption is confluent on the forehead; the conjunctiva of right eye is much swollen.

25th.—No sleep; temp. 102°; scalp is much swollen and boggy near the eruption. There is most pain now in the left side of neck, due to inflamed glands below left mastoid process.

To-day and on December 23rd a *general eruption* has been noticed composed of some spots very like varicella vesicles; each consists of a clear vesicle with a red line round the base, and each vesicle is about the size of a large hemp-seed. These vesicles are scattered sparsely over the chest, neck, arms, and abdomen. To-day there are more than yesterday, about twenty spots in all, some dried up, some purulent, some fresh and clear: a few of these scattered vesicles have a slightly purpuric base.

26th.—Temp. 101·8°. Both eyelids much swollen, cannot open either eye; a few vesicles have appeared on lower limbs, and a few more elsewhere.

January 1st, 1900.—Headache on left side; can open eyes. There is extensive ulceration in right frontal and parietal regions.

March 11th.—Convalescence is slow; severe pain in right forehead, and burning pain in right eye; ulceration of right cornea, and congestion of conjunctiva. Entropion of right lower eyelid.

The interesting points of this case are—

1. The *general eruption*, which is better marked than in the last case and of the same character.

2. The distribution of the herpes. This is very extensive; the limits are—

(*a*) The middle line of the nose, forehead, and vertex, almost as far back as the occipital bone, though the herpes passes over the middle line a little here and there all along.

(*b*) A line from the inner canthus of right eye along the base of nose of right side, and then along upper lip near nostril to columella.

(*c*) From inner canthus of eye along free margin of lower lip to external canthus.

(*d*) A line from external angle of the eye dipping down a little towards malar prominence, and from there including most of temple backwards and upwards to meet the median limit at junction of occipital and parietal bones.

The eruption, therefore, occupies nearly the whole area supplied by the ophthalmic division of fifth nerve; part of distribution of supra-maxillary on ala of nose and of lip, and about outer angle of eye; also part of the area supplied by the auriculo-temporal on the temple and side of head.

The areas named by Dr. Head which are included in the eruption are the vertical, rostral, fronto-nasal, mid-orbital, temporal, fronto-temporal, and also parts of the naso-labial and parietal areas.

The distribution of herpes is often hard to account for by any rules; it seems to have a tendency to exceed limits in various directions if the attack is a severe one.

The fact that the eruption in a case of herpes usually occurs in the distribution of at least two (often more) spinal or cranial nerves is of itself sufficient to make it highly probable that the primary disorder is in the spinal cord or brain, and not in the nerves themselves. Herpes often maps out areas which coincide with, and very much resemble, Dr. Head's areas, but the limits of these areas are often exceeded in different directions; and on the theory of spinal origin this is not surprising, so long as the additional area of skin involved is represented in the cord in a region adjacent to the part mainly affected.

The erratic vesicles which were scattered about the body in these cases are very difficult of explanation; similar cases have been described (see *Brit. Med. Journ.*, 1899, vol. i, p. 388).

In Summer.

ON this high field
Which late its scented crop of hay did yield,
By the dark belt of girdling trees is made
A stretch of shade,
Fanned by the breeze which all the long hot day
Dies not away,
But gently now, and now more boldly stirs
The great Scotch firs.

The Summer's prime,
Like a brief blossom on the tree of time,
Too exquisitely fashioned and too frail,
Begins to fail,
Changed into ripeness by the sobering hours,
Like those bright flowers
Whose consummation is to pass away
And taste decay.

And now the year
Pauses as one who feels contentment near,
And smiles to miss the restless eager fire
Of youth's desire,
Bending a wistful meditative ear,
If he may hear,
Like echo faint from Spring's impassioned throng,
A robin's song

The clouds at rest
Along the brooding margin of the West
Hang poised like waiting sentinels that keep
The gates of Sleep,
And from their airy battlements behold
Long leagues outrolled
Of drowsy woodland, and the distant gleam
Of Ocean's stream.

The moving air,
Peopled with ghostly memories everywhere,
Has breathed for ages every summer-time
In every clime,
And not from out the sunset or the dawn
Now is it drawn,
But from old years that in oblivion deep
For ever sleep.

From far away
It blows into this quiet summer day,
A wanderer from eternity, alone,
Yet not unknown;
Familiar as the scent of dewy flowers
In morning hours,
And friendly as the flood of noonday light,
Or sacred Night.

F. C. POYNDER

Notes.

WE would draw our readers' attention to Mr. Gordon Watson's very interesting letter from Kroonstad. It contains valuable and concise observations on so many matters that we are quite sure our readers will join us in thanking Mr. Watson for the labour of writing so fully.

* * *

THE Opening Address of the 105th Session of the Abernethian Society will be given in the Anatomical Theatre on October 11th, at 8 p.m., by Mr. A. A. Bowlby, whose subject will be "Reminiscences of the War in South Africa."

* * *

MR. W. J. MCDONALD has been appointed one of the Government Medical Officers at Montserrat, West Indies.

* * *

WE much regret to announce the death of Capt. J. S. Stevenson, of the Indian Medical Service, which took place suddenly at Lucknow, from cerebral hæmorrhage. Stevenson was the son of Colonel Stevenson, R.A.M.C., and had been in the I.M.S. just four years. He was not quite twenty-eight years old. He entered Bart.'s in 1889, and qualified in 1895, passing fifth into the I.M.S. in February, 1896. Since his arrival in India, in September of the same year, he had seen a large amount of service in connection with the plague, and was selected last year to go on plague duty to Mauritius. There was an extremely severe outbreak in the island, and he did a great deal towards combating it and inoculating the inhabitants. After leaving Mauritius he received a letter from the Colonial Secretary expressing the thanks of the Government for his very valuable services. On returning to India he was appointed Deputy Sanitary Commissioner for the North-West Provinces, a very responsible billet. He vacated the post a fortnight before his death, being obliged to return to military service. Stevenson was very popular amongst his colleagues in the Service, being always cheery and full of energy. He served in the Tirah Expedition in 1898, and was present at Dargai, receiving the Frontier Medal and two clasps.

We are indebted for these particulars to Capt. C. H. Hopkins, a personal friend of Stevenson's, and with whom he was staying at the time of his fatal seizure.

* * *

ON July 10th the Kildonan Castle arrived at Southampton with no less than 1400 sick and wounded on board. This, we believe, is the largest number of invalids as yet brought over in one transport trip. With this large number on board only three deaths occurred during the passage. The chief medical officer in charge of the invalids was Dr. C. M. Welburn, an old Bart's man.

We have received Part I of Mr. J. Kingston Barton's *Records from General Practice* (John Bale, Sons, and Danielsson, Limited; price 2s. 6d. net). Mr. Barton, in his preface, offers an apology for "inflicting on the reading public another periodical of medical literature;" and we fear the offer leads us to consider under what conditions the non-acceptance of an apology may occur without discourtesy; for surely the fact (if it be a fact) that "so few men in general practice find time to take written notes of, and observations upon, their patients" could readily be dealt with by the many periodicals now extant. To us it is not the *dearth* of medical literature which calls for lamentation—quite otherwise. It is true that Mr. Barton has followed a very successful example in Mr. Jonathan Hutchinson's *Archives of Surgery*, but, without being thought invidious, we do not hesitate to say that the example is one not to be followed rashly. There are few men whose practices are sufficient to maintain a journal which can justify its existence long. We wonder, for instance, how many of the promised "future parts" of "Barton's *Records*" will appear, and how often, when already in the first part the author includes an article entitled "Holidays, with Notes on the Life-history of Salmon." Now both holidays and the life history of salmon are subjects worthy of study and recorded results of study, but—they are not "medical literature." Are we to expect articles upon "golf," or "Alpine climbing," or "the rearing of orchids" as padding in future numbers? If so, we cannot accept Mr. Barton's apology.

Amalgamated Clubs.

CRICKET CLUB.

ST. BART.'S *v.* HEATH ASYLUM.

Played at Heath Asylum on Saturday, June 23rd, and won by the Hospital. Heath Asylum batted first, but owing chiefly to the bowling of W. G. Mignon, one of the West Indian team, who kindly played at the last moment, and so prevented us from being one short, were all out for 132. The Hospital made 256 for 4 wickets, when time was called. Scoones, Boyle, and Fowler were the chief scorers. Boyle made his runs very quickly, and did some good hitting. Scores:

HEATH ASYLUM.	
W. Benser, c Fowler, b Turner	42
C. P. Keenan, c sub, b Mignon	2
H. Mitchell, not out	21
Pollitt, c Mignon, b Nicholas	8
Haycraft, run out	22
T. Hart, b Boyle	4
W. Fripp, c and b Mignon	0
Dr. Wanklyn, b Mignon	3
A. Connell, b Mignon	9
H. Smith, c and b Boyle	2
Extras	19
	132

ST. BART.'S	
H. E. Scoones, run out	40
C. F. Nicholas, c Pollitt, b Mitchell	66
G. H. Adam, b Keenan	11
H. E. G. Boyle, b Keenan	56
T. H. Fowler, not out	35
C. H. Turner, b Keenan	22
W. Mignon, not out	7
T. M. Body, H. T. Wilson, C. Elliott, J. Gray — did not bat.	
Extras	24
Total (for 5 wickets)	256

ST. BART.'S *v.* DUNSTABLE GRAMMAR SCHOOL AND MASTERS.

Played at Dunstable on June 30th, and won by the Hospital just on time. We won the toss, and went in first, but began very badly. Scoones being unfortunately run out before he had played a ball. The feature of our innings was the partnership of Fowler and Boyle, who became associated when the score was 41 for 4 wickets, and were not separated until the total was 239. Both batted well, and particularly Fowler, whose innings was quite the best he has played since he has been at the Hospital. It was unfortunate that he did not quite reach his hundred. Boyle gave a couple of chances, but otherwise his innings was a good one. He is to be congratulated on obtaining his second century for the Hospital this year. Thring batted exceedingly well for the School, but thanks to some excellent bowling by Adam they were all out for 155. Scores:

ST. BART.'S	
H. E. Scoones, run out	0
C. A. Anderson, st Alderson, b Thring	8
W. S. Nealor, b Thring	5
G. G. Ellett, b Thring	25
T. H. Fowler, c Alderson, b Colbey	92
H. E. G. Boyle, not out	140
C. F. Nicholas, not out	0
L. Orton, G. H. Adam, H. T. Wilson, T. M. Body — did not bat	
Extras	6
Total (for 5 wickets)	278

DUNSTABLE GRAMMAR SCHOOL.	
L. C. R. Thring, b Adam	100
A. C. F. Colbey, c Boyle, b Anderson	0
E. C. Green, c Adam, b Anderson	1
H. E. Holloway, b Boyle	0
W. F. Brown, c Scoones, b Wilson	24
J. H. Alderson, l b w, b Adam	4
J. G. Schunck, b Boyle	3
C. M. Robinson, l b w, b Adam	0
J. Cavanagh, b Adam	7
H. J. Allport, not out	0
E. V. Watkins, b Adam	0
Extras	10
Total	155

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
H. E. G. Boyle	10	2	29	2
C. A. Anderson	8	2	23	2
W. S. Nealor	4	2	6	0
C. F. Nicholas	5	2	23	0
G. H. Adam	9	3	20	5
G. G. Ellett	5	1	26	0
H. T. Wilson	3	0	18	1

ST. BART.'S *v.* HAMPSTEAD.

Played at Hampstead on July 7th, and won by Hampstead. Hampstead made 288, of which A. E. Stoddart made 128. For the Hospital Nealor played by far the best innings. Scores:

HAMPSTEAD.	
A. E. Stoddart, b Mignon	128
A. R. Trimen, b Nealor	23
T. M. Farmiloe, c Adam, b Boyle	16
D. Danby, c Nealor, b Mignon	31
H. Greig, c Adam, b Mignon	16
H. Woodall, not out	24
R. C. Griffith, c Boyle, b Nicholas	0
J. C. Dickson, not out	2
S. F. Fradd, T. J. Self, A. N. Other — did not bat.	
Extras	48
Total (6 wkts.)	*288

* Innings declared closed.

ST. BART.'S.	
H. E. Scoones, b Stoddart	11
G. H. Adam, c Other, b Stoddart	9
W. S. Nealor, b Stoddart	48
J. C. Sale, b Stoddart	0
G. G. Ellett, b Woodall	0
T. H. Fowler, l b w, b Fradd	15
H. E. G. Boyle, c Stoddart, b Fradd	7
C. F. Nicholas, not out	8
E. Read, run out	12
W. Mignon, b Stoddart	1
H. T. Wilson, run out	1
Extras	19
Total	131

SWIMMING.

St. Bart.'s v. *Richmond S.C.*—These teams met at Richmond Baths before a fair attendance on June 29th. The Hospital winning the toss elected to defend the deep end. Bart.'s were first on the ball, and after some good passing Thorne got away and dribbled up to goal, but failed to score. Richmond now attacked strongly, but were unable to break through the Hospital defence. By a weak pass Bloxsome was let in, and sending the ball to Thorne the latter scored. Directly after this Watkins added another point for the Hospital. Marx now attacked, but being unsupported was unable to score. Scott passing up to Thorne the latter secured another goal, and on crossing over St. Bart.'s led by 3—0. Hughman, who unfortunately turned up late, took the place of his substitute. Richmond now came dangerously near scoring, Marx and Hughman becoming very conspicuous, and, as the result of some fine combined play on their part, the latter scored. On the return of the ball to the water Richmond again pressed, Dix clearing several hot shots finely. The Hospital then got away with the ball, and Thorne added the fourth point. When time was called the result was a win for Bart.'s by 4—1.

Team: C. Dix (goal); L. B. Scott, M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, J. G. Watkins (forwards).

Referee.—Mr. P. Grenville.

St. Bart.'s v. *Oxford University.*—These teams played their return game at St. George's Baths, Buckingham Palace Road, an excellent match being seen. In the first half the Oxonians combined better than the Hospital men, and, thanks to this combination, led at the interval by 2 goals to 1. On crossing over, however, the Hospital got together, and played so well that they soon drew level, and eventually won a thoroughly good game by 4 goals to 3. W. H. G. Thorne (3) and D. M. Stone scored the goals for the winners, whilst H. G. D. Turnbull was responsible for all three 'Varsity goals.

Team: C. Dix (goal); L. B. Scott, M. B. Scott (backs); A. H. Bloxsome (half-back); W. H. G. Thorne, D. M. Stone, J. G. Watkins (forwards).

Reviews.

HERNIA: ITS ETIOLOGY, SYMPTOMS, AND TREATMENT. By W. McADAM ECCLES, M.S.Lond., F.R.C.S.Eng. (London: Baillière, Tindall, and Cox. Price 7s. 6d.).

This book is a practical guide to the management of hernia. It opens with a general account of the ætiology of hernia, and then follows with a description of each variety of hernia, according to its clinical manifestation. One of the most prominent features of the book is that devoted to treatment. In the chapter on strangulated hernia the question of taxis or operation is fully discussed, and the dangers arising from the former method of treatment enumerated. A full account of the operation of herniotomy is given, and how to deal with the bowel when it is doubtful whether it will recover or not from the strangulation. No mention is made of the method of treating strangulated herniæ in young children by elevation of the pelvis and suspension of the legs. We are surprised at this omission, as it is an efficient method, and one readily carried out. The author being on the staff of the City of London Truss Society, we expect to find the application of trusses to herniæ fully dealt with, and such is the case. The chapters devoted to this part of the subject are amongst the best in the book. A full description of each kind of truss is given, how to measure and how to apply the instrument, the text being greatly enhanced in value by a series of excellent photographs of the trusses, as well as the position they should occupy when properly applied in order to keep up or restrain the hernia. At the same time the treatment of a hernia by a truss does not end with its proper application. In infants with congenital herniæ means must be taken to prevent the accumulation of gas in the intestinal canal, causing increased abdominal tension. This can be done by careful dieting and attention to the bowels. Similarly in umbilical hernia, if the patient is obese the amount of adipose tissue must be reduced as far as possible. It is well to have these points brought forward, as often a truss is ordered, the instrument maker supplies it, no directions are given to the parent or patient, and the results being unsatisfactory the truss is condemned unjustly. Every student would be well advised to read these chapters; they contain a mass of information not to be found in the ordinary text-books of surgery, and every practitioner who follows out the teaching of them will find the treatment of hernia by trusses more satisfactory than it usually appears to be.

In the treatment of hernia by operation no attempt is made to describe the numerous operations which have been devised for the "radical cure" of hernia. The method the author has found most useful is given in detail, and the main features of such operations as those of Bassini, Halstead, and one or two others. Attention is called to the fact that all herniæ are not alike, therefore no one operation is suited to all cases. Each case must be judged on its merits, and the particular operation used which would appear most likely to give the best chance of cure in the particular case. It is the more important that this should be emphasised, as one constantly hears of one surgeon always doing a "Bassini," another surgeon a "Kocker," and so on, often quite unnecessarily. The main point in all operations is that the mouth of the sac should be completely obliterated. The other details of the operation depend on the particular case. Other points which are carefully discussed in connection with this part of the subject are those relating to the wearing of a truss after operation, and the cases suitable or unsuitable for operation.

Another feature of the book is that relating to the diagnosis of swellings which simulate hernia in its various manifestations, the distinguishing features being set out in tabular form.

The last three or four chapters of the book deal with the rarer varieties of hernia, and hernia in its relation to life assurance and the public services. The latter contains much that will be useful to medical men generally and examiners for the services and life assurance.

Mention has already been made of the excellent photographic reproductions; the drawings are equally good, and the book is well printed.

MANUAL OF SURGICAL TREATMENT, Vol. III, by W. WATSON CHEYNE, F.R.C.S., and F. F. BURGHARD, F.R.C.S. (London: Longmans & Co.). Price 12s.

The third volume of this work, which treats of the surgical affections of the bones and amputations, is equal, if not superior, to the first two. In reading this volume we are much struck with the up-to-date treatment of fractures, all the more antiquated methods being eliminated; consequently the book is an excellent one for reference, and the treatment advocated can be followed out with every confidence of the best possible result.

The complications of fractures are divided into two main groups, (*a*) immediate and (*b*) remote, and are exceedingly well described. Great care has been taken in the article on the various operative measures for uniting the ends of a broken bone, and we are glad to see that the indiscriminate wiring of fractures is strongly deprecated, such treatment being limited to certain specified cases. We differ, however, from the authors when they state that the chance of bony union in fractured olecranon is slight. The nature of the union is entirely dependent on the position of the fragments. When a large piece of the olecranon is broken off we have frequently seen firm bony union with a perfectly useful arm. We also view with some suspicion the statement that "it is scarcely possible to obtain satisfactory movement of the knee and elbow without operation in a T-shaped fracture of the lower end of the femur or humerus."

The chapter which deals with fracture of the patella is perhaps the most interesting and instructive in the volume. In these fractures wiring is advocated for practically all cases. As there is no mention of a drainage tube we conclude the authors do not use one. We should, however, like to have seen the advisability of using one discussed. Many surgeons always use one. The article on Pott's fracture is also good.

Section 2 treats of the diseases of bone, and several excellent tables are given for the dietetic and hygienic treatment of infants.

The second division of the book is on amputations, only the more common operations being discussed, so that the general result is good and concise.

When the work is completed the literature of surgery will have received a valuable addition.

A MANUAL OF MEDICINE. Edited by W. H. ALLCHIN, M.D.(Lond.), F.R.C.P. Vol. I—General Diseases. (London: Macmillan and Co. Pp. 442. Price 7s. 6d. nett.)

This work is advertised to consist of five volumes, and is included in Messrs. Macmillan's admirable "Manual" Series. There are

some twenty contributors besides the editor, and the selection of these seems to have been very fitting. The bulk of the volume deals with the various specific fevers, but includes a useful chapter on diseases due to atmospheric influences, and another on the infections—the former by the editor, the latter by Prof. Sims Woodhead. Those who know much of Dr. Allchin's powers as a clinical teacher and as a physician will agree with us in anticipating considerable success for his venture. The editor's long experience of students, both in the hospital wards and, of still greater significance perhaps, in the examination room, will doubtless stand him in good stead in his selection of material likely to be of greatest service in a Manual of Medicine. The present articles afford but little scope for criticism; they are to the point, carefully brought up to date, but not unduly spread out into regions where observed facts yield to unconfirmed opinions. And this last is a distinct gain to the average student.

The general "get-up" of the book is, of course, unimpeachable; we are already familiar with it in Stonham's Manual of Surgery.

TUBERCULOSIS, ITS NATURE, PREVENTION, AND TREATMENT, by ALFRED HILLIER, B.A., M.D., C.M. (London: Cassell and Co. Pp. 243. Price 7s. 6d.)

"Tuberculosis is the nemesis of overcrowding, of squalor, of departure from the conditions of a healthy animal life. Immunity from tuberculosis is a large portion of the reward which a community may hope to derive from good sanitation, from light, from air, from all that is sound in the progress of civilisation, and all that is conducive to the material and moral welfare of the masses. It is thus a social as well as a medical problem." Thus the author, in his preface. And the general principles thus laid down cannot be too often reiterated. This little book is exceedingly *apropos*, coming at a time when the public interest would seem to be at last thoroughly aroused in the national question of the prophylactic and curative treatment of tuberculosis.

The book is written with special reference to the open-air treatment of phthisis, and contains the best detailed account of this that we have come across. In an appendix are reprinted two leaflets issued by the National Association for the Prevention of Tuberculosis, an account of the Tuberculin Test in Cattle, and the Recommendations of the Second Royal Commission on Tuberculosis.

Examinations.

UNIVERSITY OF LONDON.

Intermediate Examination in Medicine.

Honours List.—A Hamilton (third class in Anatomy), H. R. Kidner (third class in Physiology), T. P. Baldwin and C. C. Robinson (second class in Materia Medica and Pharmaceutical Chemistry), S. B. Atkinson (third class in Materia Medica and Pharmaceutical Chemistry).

Pass List.

Entire Examination; Second Division.—G. E. Aubrey, J. Burfield, A. F. Forster, T. H. Harker.

Excluding Physiology; Second Division.—R. A. S. Sunderland, W. P. Yetts.

Physiology only; Second Division.—D. C. Evans.

Intermediate Examination in Science.

First Division.—E. E. Maples.

Exempted from examination at the Preliminary Scientific Examination in Biology. T. W. H. Burne.

Preliminary Scientific Examination.—Pass List.

Entire Examination.

First Division.—W. G. Ball, C. B. D. Butcher.

Second Division.—R. H. Bott, C. Clarke, A. F. Perl, J. E. Pratt, M. B. Reichwald.

Chemistry and Physics.—F. Gooding, H. Mc. C. Hanshell, W. H. Jones.

Biology.—C. J. Armstrong-Dash, A. Barber, C. H. Fielding, G. S. Morse, H. R. Prentice.

CONJOINT BOARD.

The following have completed the examination and received the diplomas of M.R.C.S., L.R.C.P.—F. C. Shrubsall, H. S. Ward, J. F. Jennings, R. H. Paramore, C. C. I. Turnbull, C. H. Turner, P. H. Ross, T. P. Allen, W. H. W. Attlee, T. E. C. Cole, R. Bigg, M. G. Winder, R. A. Lloyd, H. Clarke, E. C. Hepper, T. W. Brown, C. L. Chalk, H. E. Ashley, A. E. Soden, F. Coleman, F. H. Wessels, C. J. Macdonald, H. J. Weston, A. E. J. Lister, P. C. Barham.

First Examination.

Chemistry.—C. D. M. Holbrooke, H. H. Rolfe, P. Lang, E. C. Hayes, C. Elliott, L. Gray, J. P. Griffin, C. B. Hambling, A. M. A. James, C. Loddiges, R. C. P. McDonagh, J. E. Smith.

Practical Pharmacy.—E. B. Aylward, C. D. M. Holbrooke, H. H. Rolfe, P. Lang, E. C. Hayes, H. B. Scott, W. A. Aldred, J. B. Binns, C. D. A. Dowman, G. D. Drury, W. S. Edmond, D. C. O. Finigan, V. H. J. Giragosian, H. Gray, T. B. A. Haggard, W. H. Hamilton, M. Herzhelm, G. P. Jones, J. R. Kemp, E. B. Lathbury, A. F. C. Pollard, M. B. Scott, G. T. Verry, A. R. Wade, J. G. Watkins.

Elementary Biology.—D. E. S. Davies, D. M. Stone.

Births.

AUDEN.—On July 5th, at 76, Bootham, York, the wife of George A. Auden, M.A., M.D.Cantab., of a son.

BOYTON.—On August 3rd, at Grove House, Vauxhall Road, Birmingham, the wife of A. J. H. Boyton, M.R.C.S., L.R.C.P., of a son.

CROSS.—On June 19th, at The Limes, Wallwood Park, Leytonstone, N.E., the wife of Ernest W. Cross, M.R.C.S.Eng., L.R.C.P.Lond., of a son.

Marriages.

CHURCHILL—NUNN.—On August 8th, at All Hallows, London Wall, Joseph Henry, son of R. T. Churchill, Esq., of S. Dunstan's, Mayfield, Sussex, to Ethel Mary, daughter of T. Nunn, Esq., of Hetton House, Loughton, Essex.

WALDO—EXTON.—On July 14th, at the Parish Church, Hampstead, by the father of the bride, Frederick Joseph Waldo, M.D., barrister-at-law, to Marion, elder daughter of the Rev. R. B. L. Exton, formerly Vicar of Strood, Kent.

New Addresses.

BARKER, J. C., Marbury, Clarendon Road, Watford.

PATERSON, H. J., 7, Lower Seymour Street, W. (from No. 19).

PRATT, ELDON, 36, Windsor Place, Cardiff.

SIMMONDS, E. G., 91, London Road, St. Leonards-on-Sea.

ACKNOWLEDGMENTS.—*London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Nurses' Journal, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review, The Practitioner, University College Magazine, The Student, The Hospital, Transactions of the Students' Society of Dental Hospital, The Therapist, The Medical Magazine, University College of Wales Magazine, Magazine of the London School of Medicine for Women, Giornale della Reale Società Italiana d'Igiene, L'Echo Médicale du Nord.*

St. Bartholomew's Hospital Journal.

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NOTICE.

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St. Bartholomew's Hospital Journal,

SEPTEMBER, 1900.

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

Sunstroke.

A Clinical Lecture by DR. CEE, *delivered June 22nd,* 1900.

Reported by DR. T. J. HORDER.

THE great height of the thermometer during the past few days (up to 88° in the shade), and the admission of certain cases of indeterminate fever, raise the question of sunstroke in England. My remarks to-day are based upon the experience of a person who has never practised out of England.

Whenever the temperature in the shade reaches 90° you may expect cases of sunstroke. Some prefer the name of heatstroke, because the direct rays of the sun are not always present; which is a fact:—the attack may occur indoors. But, after all, the heat does come from the sun; so it matters little.

The occurrence is undoubtedly aided by two conditions—(1) Fatigue and (2) drink. As a matter of fact, sunstroke is much associated with these; they predispose persons to it.

The symptoms are two—(1) High fever; the temperature must really be high. (2) Disturbance of cerebral functions. The form taken by (2) is either (*a*) coma, (*b*) delirium, or (*c*) both.

(*a*) The Greeks called the combination of coma and fever *lethargos*, lethargy, The combination of delirium and fever was *phrenitis*, frenzy. Phrenitis with coma was called *typho-mania*. These are useful terms enough, but are now never employed.

In all diseases coma is a more dangerous symptom than delirium. It is quite possible you may find that aphorism in Hippocrates; if not, it is true as a large general statement. Indeed, the danger of delirium is that it may *end* in coma. "Febrile coma," or "heat apoplexy," is not a bad name, because "apoplexy" does not mean hæmorrhage into the brain, but coma coming on suddenly.

The facts I am about to mention are the result of actual experience. As regards the first case I shall quote, if it was not sunstroke I am at an utter loss to say what it was.

CASE 1.—Young man, brought to hospital July 22nd, 1868. Weather excessively hot: 90° in shade of Royal Exchange. Was wheeling baker's truck along sunny side of Fleet Street, staggered and fell; brought to hospital. On admission: deep coma, temp. 109·5°, livid, universal livid mottling, like the subcuticular rash of typhus, all over body; loud systolic murmurs at base of heart. Unfortunately cold was not used, and he died half an hour after admission. *Post mortem*, no definite lesion found. The mottling disappeared after death.

Cases of high fever like this always die very quickly unless properly treated, that is if the temperature is not brought down by the application of cold.

CASE 2.—The second case I shall mention is that of a

porter in the General Post Office, who was attacked at 2 p.m. on a day in July when the maximum temperature in the shade registered at Camden Town was 92° F. He was seen to stagger in coming downstairs at the Post Office. On reaching the bottom he lay down, but did not fall, and was convulsed—striking out, clutching his necktie, etc. He had been previously working in a very hot room, but not exposed to the direct rays of the sun.

He was brought to the Hospital at 2.30 p.m. (and even before he entered the ward, as he was being brought upstairs, hearing his loud and stertorous breathing, I was able to say, "Here clearly is a case of apoplexy coming in"). He was then unconscious; pupils fixed, left rather larger than right. No paralysis of any kind could be made out. Breathing stertorous, 36; pulse 140, fair volume, regular. Heart's apex in natural situation; no dulness to percussion in the hypogastrium. Axillary temperature, 107·5°. He was at once placed in a bath at 70° F., and kept there for about a quarter of an hour. The water could not be cooled below 70° F., though large lumps of ice were placed in it. His bowels were moved in the bath. Rectal temperature when placed in the bath, 109·8°; when removed from the bath, 109·4°. When placed in bed again he was very blue, and respirations 40, laboured and shallow; pulse 160, small and irregular. Six minims of ether were injected under the skin of the arm, and an enema of beef-tea and brandy given, which was immediately returned. Rectal temperature at 3.45, 104·5°; pulse, 132, regular, stronger. Ice-cap put on. Temperature at 4.30, 101·8°, but general condition remained unaltered. Slight convulsive movements of the face and hands were noticed at this time. (You can reckon upon the temperature always falling as much *after* the bath as before it. It is bad practice to keep the patient in the bath until the temperature is normal, so as soon as the temperature is reduced a few degrees or less, take the patient out of the bath, and let him lie on the bed covered with sheet only.)

9.30 p.m. Has passed urine and three loose motions under him. Three ounces of turbid urine, withdrawn by catheter, were found to be highly albuminous. Temperature had risen to 104·2°; pulse, 130, moderate volume, regular; breathing, 36, quiet; heart-sounds natural. Has vomited twice. Now lies with his head and eyes persistently turned to the right side. Still unconscious, but has been able to swallow small quantities of milk, brandy, and beef-tea. (Note that the fall of temperature had no immediate effect upon the other symptoms.)

July 6th, 1.30 a.m.—Head and eyes still turned to right. Arms flexed and rigid; slight rigidity of legs also. Swallows badly. Eight ounces of a mixture of beef-tea, brandy, and milk were administered by means of a tube passed through the nose. Temperature, 100·2°; pulse, 120; respirations, 32; no stertor.

5 a.m.—Slept fairly; has said "Yes," but not in answer to a question. Pulse, 120; respirations, 32. Face, eyes, and arms as before. Temperature at 3 a.m., 100·2°.

10 a.m.—Temperature, 99°; pulse, 112; respirations, 30. Still unconscious; the rigidity of the arms and deviation of the head and eyes remain as before. Has passed two loose motions under him. Fundus natural in both eyes.

10 p.m.—Knows his sister, and has answered questions. Pulse, 108; respirations, 30. The deviation of the head and eyes and the rigidity of the arms have ceased. Considerable inflammation of the conjunctivæ (due to bath).

July 7th.—Slept fairly, but tried once or twice to get out of bed. Answers questions quite coherently, but in a thick voice. Motions and urine still passed under him. Temperature, 97°; pulse, 90, fair volume.

July 8th.—Some delirium last night, but on the whole slept fairly. Rational this morning. Pulse, 60, regular; temperature, 97°. No longer passes motions and urine under him. Urine acid, specific gravity 1027, no albumen. Very little muscular power.

From this time till July 19th he remained much in the same state—occasionally troublesome at night and stupid, but capable of answering in the day. His muscular power, however, increased. From July 9th to 19th he took 30 grains of bromide of potash every six hours.

July 19th.—Is more troublesome in getting out of bed; passes motions and urine under him; decidedly more stupid and confused. Temperature yesterday evening, 99·4°; this morning, 97°. From this time till August 9th he slowly improved, and even began to read the paper, but very often held it upside down, and would seldom give any account of what he had read. The speech gradually became less distinct. He still, however, frequently passed his motions and urine under him.

From July 19th to 26th he had 10 grains of iodide of potassium four times a day. On the 26th the dose was increased to 15 grains, and so remained until September 14th.

He gradually improved until his discharge on September 23rd, when the following note was taken:—He is now quite rational, and able to get about very well. Speech is still a little indistinct, and manner somewhat fatuous; but he seems well able to understand what he reads and hears, and is quite willing to make himself useful about the ward.

To repeat a few points this case illustrates. Besides coma there were other nervous symptoms—(1) *slight convulsions*; (2) *rigidity of the limbs*; (3) *lateral deviation of the head and eyes*; (4) *diarrhœa and vomiting*; (5) *albuminuria*. Diarrhœa and vomiting occur in many acute brain diseases; they are cerebral symptoms. Albuminuria, again, may be present in all apoplectic diseases; no matter what the cause may be, there is great congestion of the lungs and all the abdominal organs. An eminent physician was wont to say that he could distinguish the lungs from a case of apoplexy in the post-mortem room by their great congestion. It is so also in epilepsy, which is a kind of apoplexy. I think this explains the albuminuria,—it soon passes off. The congestion of the lungs shows itself as the lividity. It is important to know of the occurrence of this albuminuria, especially if associated with coma and slight convulsions, otherwise one may be led to say, in the presence of such a condition, "Here is a case of uræmia, obviously;" whereas, it may really be nothing of the kind.

It is very important to note the persistence of the cerebral symptoms, even though the temperature be reduced to normal, and remain normal for weeks. The brain is injured, and does not soon recover. Many cases *never* completely recover. The patients are never quite the same afterwards; the cerebral functions are not what they were before the attack.

CASE 3.—The last two cases were both very rapid ones. The next one was less rapidly fatal. It was that of a little girl, aged 6½ years, who was attacked at 2 a.m., the temperature in the shade having been 91° F. the day before. She went to her nurse's bed complaining of cold and shivering; at 2.15 a.m. she vomited, and soon afterwards became hot. The vomiting was repeated, and the bowels soon became relaxed. At 6 a.m. a solid, natural stool; 8 a.m. another stool, watery; vomited at same time green water (some people, including Hippocrates, think there is a tendency to green vomit in brain injuries and diseases); took some bread and milk, brought it up again almost instantly curdled. 10 a.m., quite rational, listened to reading; castor oil given; bowels open soon after, dark brown, watery, not fœtid. 11 a.m., fell asleep for half an hour; on awakening was mildly delirious, talked nonsense, picked at bed-clothes. Soon after, severe convulsions, lasted four or five minutes, followed by coma so deep that she could not be roused. 1 p.m., pupils largely dilated, immovable. 4 p.m., saw her with Dr. Metcalfe; looks dying; comatose, but can be roused somewhat; drink put into her mouth remains there until she is made to sit up; lips livid, but rubbing them gently makes them florid; skin everywhere injected, mottled, livid; temperature in armpit 105°, feet and hands cold; any part of body becomes cold on exposure; pulse 200, very weak; breathing deep, regular, air enters lungs well; no physical signs of disease in chest, no dyspnœa, no action of nares, no tache cérébrale; eyes half shut, pupils largish; not wholly insensible, equal; no strabismus; slight nystagmus; abdomen retracted; has just passed a scanty mucous yellowish motion; rigidity of limbs, and somewhat of back. Ice was applied to head, and warmth to rest of body. 9 p.m., died comatose. No otitis at any time.

I should not have brought this case before you if we had not had an opportunity of examination by a post-mortem, my note of which runs as follows:

Examination of body twenty-two hours after death.—Rigor mortis well marked. Blotchy purple discoloration of skin all over body, not removable by pressure. Eyeballs singularly sunken. Removing scalp, much blood oozes from sutures. Calvaria natural. Small black clots in sinuses of dura mater. Arachnoid sticky, no effusion. Vessels of pia mater decidedly full of blood, but no exudation whatever anywhere; no tubercles. Brain looks swollen; convolutions much flattened; ventricles remarkably empty; on careful examination it seemed otherwise natural, not soft. Heart, lungs, kidneys, liver, spleen, stomach, natural. Intestines natural; nothing in them but air, and not much of this.

The fourth case which I shall read to you was even less rapid still in its course.

CASE 4.—A needlewoman, employed at a large drapery shop in Holborn. She was attacked on the same day as the man whose notes I read just now,—on a day when the temperature was 92° F. in the shade. Admitted July 27th with the following history:

On July 5th, while at work in a room into which the sun was shining, she suddenly complained of headache and pain in her left side. Soon after she became unconscious, and her skin was noticed to be very hot. She remained unconscious eighteen hours, and was convulsed during part of that time. She was treated with huge doses of calomel. On the following day she was seen by a medical man, who found her temperature to be 104·5°. She remained in a drowsy, semi-unconscious state for two days more, then great improvement began; her mind cleared, and she was able to converse rationally. Three days afterwards she relapsed; her mental condition seemed dull; her speech also thick, and frequently incoherent. There was no elevation of temperature. For a day or two she passed her motions under her, but did not habitually do so. In this state she was admitted.

Fundus of both eyes natural. No albuminuria.

August 3rd.—Has certainly improved in intelligence since admission; all movements and speech are slow but rational. No longer passes motions and urine under her.

From this time until August 12th she continued to improve, but from August 13th to 21st was very incoherent, and had delusions. Her temperature during this time was not elevated, and her general condition remained good.

She then began slowly to improve again, and on August 30th her conduct and conversation were noted as quite rational. A final note before her discharge on September 14th is to the effect that she does needlework and reads, and is going about the ward all day, being to all appearance as clear-headed and capable as she ever was.

Here was a case, then, which was not treated,—unless huge doses of calomel can be called treatment,—a patient admitted with the *effects* of sunstroke, and we were treating these effects, not the attack itself.

Treatment.—This consists of one thing: cold. If the patient is too weak for a bath, or this is not available, strip

him naked, place him upon a mackintosh, and bathe the body with the coldest water procurable, or with ice, rubbing the body with it. This is provided the temperature is high, and is high all over the body. The principle is the free application of as much cold to the skin as can be managed. If the extremities are cold, this application of cold becomes dangerous. This was so with the little girl whose case I mentioned, where we were afraid to use the cold bath, but instead used ice to the head. This rule was laid down by the man who first systematically and intelligently used cold applications, Dr. James Currie, of Liverpool. He introduced a method of treating patients with scarlet fever by pouring buckets of cold water over them.

Pathology.—Quite unknown. I am not discussing cases of high fever with delirium,* because the pathology in them is quite different,—it is a meningitis, cerebral or cerebro spinal. Sunstroke may have something to do with them, but the whole course of these cases is quite different from those I have described to-day.

The After-treatment of Abdominal Sections.

By T. P. LEGG, F.R.C.S., Surgical Registrar and Tutor, King's College Hospital.

THE success of an abdominal section depends largely on the after-treatment, and as sooner or later every medical practitioner is sure to have such a case under his care, some account of the line of treatment which may be adopted may be useful.

In this paper it is proposed to deal with cases which run an uncomplicated course: such cases comprise the majority of laparotomies. Still, every case requires the most careful attention and watching, as serious complications may arise at any time, and in the promptness of the treatment lies the only hope of success. The most common of these complications are hæmorrhage, intestinal obstruction, and septic peritonitis. Their diagnosis and treatment would require a separate article. In an uncomplicated case, *i. e.* in one where these graver conditions do not arise, any or all of the following conditions may require treatment.

(*a*) *Immediate treatment at the end of the operation.*—The patient is placed in a bed which has been warmed, and is covered by warm blankets, and two or three hot bottles covered with flannel jackets are placed under the clothes so as not to be in contact with the patient. As the effects of the anæsthetic pass off there is sometimes considerable restlessness, which can generally be controlled by gentle persuasion, and soon the patient passes into a quiet sleep or dozes. Smarting pain may be complained of in the wound, but it is not often severe enough to call for active treatment. In other cases the restlessness and pain are more marked; the patient throws himself about, and is never still. If the restlessness is such that harm may result from it, morphia must be given hypodermically, and usually a small dose—$\frac{1}{10}$ gr.—is sufficient.

A much more important case is one in which there is considerable collapse at the end of the operation. This collapse may be due to several causes: (1) the length of the operation and its severity; (2) the amount of blood lost; (3) the patient may be very ill, or old and feeble at the time of the operation. The ultimate result in these cases depends very much on the progress of the first few hours following the operation. In these patients an enema given before the patient leaves the operating table is very useful; such an enema consists of half a pint each of hot water and beef tea, with one or two ounces of brandy, given at a temperature of 105°, and through a tube and funnel; hot coffee is by some surgeons used in a similar way. In addition to the enema, strychnine hypodermically is valuable, specially when the collapse is due more to shock from the severity of the operation rather than loss of blood. The enema is usually rapidly absorbed, and may be repeated in an hour or two, according to the condition of the patient. If the patient is not sick, and can swallow, small doses of brandy and hot water by mouth are valuable. In the worst cases, when there has been hæmorrhage, infusion of saline solution into a conveniently placed vein, usually the median basilic, is the best treatment; two or three pints, with or without brandy, may be injected. An important point is to have the fluid hot (110° or 115°) in the funnel, as the temperature rapidly falls in its passage through the tube. If the patient is going to do well the pulse will improve, and continue to improve, becoming slower and increasing in volume and force; the colour of the lips will deepen, and the extremities will be warm.

(*b*) *Pain.*—One of the commonest things a patient after an abdominal section complains of is "pain in the back." This pain is a constant ache in the loins. Its severity varies; some patients complain bitterly, others have it only very slightly or not at all, even when asked the direct question. Fortunately one can comfort the sufferer by the assurance that it generally passes off in twenty-four to thirty-six hours. A firm pillow placed under the loins, or turning the patient on to one side, supporting the back with pillows, generally gives relief.

In the wound and abdomen there is often a sharp cutting pain, made worse by coughing or drawing a deep breath. In many cases this is so slight that treatment is not called for. In other cases it is so severe that the patient cries out, is restless, throwing his arms about, and does not sleep. The best remedy is morphia hypodermically in a small dose, $\frac{1}{10}$ to $\frac{1}{6}$ gr., repeated if necessary. This leads to the question of giving morphia after an abdominal operation. Some surgeons give it as a routine, others are strongly opposed to its use at all, maintaining that it produces sickness and intestinal distension. The best rule to follow is to give the drug when pain is so great that the patient is very restless, unable to sleep, and it appears more likely that harm will result by not giving it, especially if the pulse is being affected. Under such circumstances morphia is very beneficial. It should always be given in a small dose, and should be given with strychnine if the pulse is weak. A large majority of cases can be perfectly well treated without it.

(*c*) *Thirst* is best relieved by giving hot water in small quantities by the mouth, or by injection of hot water into the rectum. The latter method is the most valuable means of treating thirst. The fluid is rapidly absorbed and acts as a stimulant. It has the further advantage of keeping the stomach empty and thus preventing vomiting. The quantity to be given depends on the degree of the thirst, and whether it is retained or not. A pint or more may be injected by means of a funnel and tube passed as high into the rectum as possible and repeated as required. Mere rinsing of the mouth with hot water, or water and lemon juice, is very grateful to the patient. Many patients ask for ice, but it is not advisable to give it, as it does not do much good, and often makes the patient sick, the cold water accumulating in the stomach and then being rejected.

(*d*) *Sickness.*—The vomiting which occurs may be of two kinds:—(1) that which comes on immediately, and is partly due to the anæsthetic, partly to the operation itself; (2) that which comes on later, three or four days after the operation: this latter is the more serious, and causes more anxiety, as it may mean the presence of peritonitis; the former is less important, unless it is very persistent and severe. Often the patient is not sick more than once or twice; in other cases vomiting or retching may go on for twelve to thirty-six hours, consisting of mucus, bile-stained, or mixed with what has been taken by mouth. In another class of cases the vomiting will cease for a time, and then begin again; this generally happens if the patient has been fed too early by mouth, or in too large and frequent amounts. Provided the pulse is not increasing in frequency or diminishing in volume, and the patient's general condition is satisfactory, this early vomiting is not of much importance; it ceases spontaneously, or yields to treatment. The first thing to do is to give nothing by mouth for the first twelve hours; this alone is frequently sufficient. In other cases really hot water in doses of ʒj or ʒij will be successful, and if constantly small amounts of mucus are being brought up, washing out the stomach with hot water is most efficacious. The easiest way to do this is to give Oʒ—Oj of hot water at one draught, with or without the addition of gr. xx Sodii Bicarb., which serves to dissolve the mucus. Shortly after taking it the whole is vomited, and the patient is much relieved, getting several hours' freedom from vomiting. If the first washing out is not sufficient it is repeated. Ice is not advisable as a remedy, but succeeds sometimes when other remedies have failed. Champagne in doses of ʒj to ʒiv is useful, specially if the pulse is feeble. Of drugs, Bismuth Subcarbonate in large doses (gr. xx—xxx) is the most reliable. It is best given in wafer papers; patients will often retain it when so given who have vomited when it has been given by the usual method. If the sickness is due to the food being given too early, or in too large quantities, a change in the quantity and quality will usually effect the cure, or total cessation of all food by mouth for a time may be necessary.

Sickness coming on later—after the third or fourth day is always a cause of anxiety, and may be due to—1, mechanical obstruction; 2, peritonitis; 3, distension with flatulence.

(*e*) *The use of the catheter.*—Many patients cannot pass their urine voluntarily after the operation. Too early use of the catheter should be avoided, as it has dangers of its own, and should only be used when the patient is in actual discomfort from being unable to pass the urine. Change in position will sometimes enable the urine to be passed naturally. Whenever a catheter is necessary special care must be taken to sterilise the instrument and cleanse the urethral orifice.

(*f*) *Feeding the patient* is one of the most important factors in the after treatment of an abdominal operation. Certain general rules can be laid down, but each case has to be treated on its merits. In the first place it is advisable to give nothing by the mouth for the first twelve hours; thirst can be relieved by other means. If the patient is feeble, nutrient enemata should be given from the outset. A suitable enema is one composed of equal parts (ʒij) peptonised milk and beef tea, with brandy ʒij to ʒviij, according to circumstances added, and given every four hours. Larger enemata are not often retained; in a few cases much larger ones are retained; in other cases much smaller ones may be required. The yolk of one or two eggs may be added to each enema. The brandy may so irritate the rectum that the enema is not retained; diminution of the quantity or removing it altogether overcomes the difficulty. During the time the enemata are being given the bowel should always be washed out at least once every twenty-four hours, as there is always some débris left. As soon as possible feeding by mouth should be commenced, the rectal feeding being continued till sufficient food is taken, and in a large number of cases rectal feeding is not called for,—as, for instance, when the patient has been in good health up to the time of the operation, and afterwards vomiting is not severe. My usual plan has been to begin with peptonised milk or milk and barley water in equal quantities—ʒij to ʒiv every hour, and gradually

* See a paper entitled "Phrenitis Æstiva," 'St. Barth. Hosp. Reports,' vol. xii.

increase the amount. As the amount is increased the time between each feed is lengthened. If milk cannot be taken, or is not digested, beef tea in similar amounts may be given. Many patients object to peptonised milk on account of its flavour, but will take readily plain milk and hot water. Whey and albumen water are also useful substitutes in some cases. All food should be given hot, and it is better not to give soda water—it increases flatulence. Women especially like tea, and there is no objection to its use if it is freshly infused: occasionally it seems to make the patient vomit; if it does not there is no reason why it should not be given. By gradually increasing the amounts of food the patient is taken on to custard or an egg beaten up in milk. On the evening of the third or fourth day (if no operation on the intestinal tract has been done) a purgative is given, the most useful purgative being half or an ounce of castor oil, followed if necessary by an enema of soap and water; and after the bowels have been opened, bread and butter and a lightly boiled egg are allowed, then fish, and so on to light diet.

(*g*) *Abdominal distension.*—After an abdominal operation considerable distension may come on, not due to obstruction. If there is obstruction the pulse rate rapidly rises; in simple flatulent distension the rate does not increase, and the volume and regularity is maintained. In the latter a rectal tube passed as far as possible, and retained some time, may do all that is required. A better method of treatment is to give a turpentine enema—℥j or ℥ij beaten up with the yolk of an egg to the pint of soap and water; a quantity of flatus is passed with obvious relief. If this fails a saline purgative followed by an enema is given. In slight cases change of position is useful, and in the more severe cases hypodermic injections of strychnine (mv or more) are valuable in addition to the other remedies. To prevent the recurrence of the distension the bowels should be kept regularly opened by means of salines and small doses of belladonna.

Carcinoma of the Œsophagus.

A Paper read before the Abernethian Society, February 14th, 1900.

By L. B. RAWLING, F.R.C.S.

THE time at my disposal does not allow me to go as fully into this disease as I should wish. Still, I trust that in spite of many defects the subject will be of interest to you. It is written from cases under my own observation, and from 100 cases admitted to this hospital within the last seven years.

Gurlt shows from over 11,000 cases that the absolute frequency of cancer reaches its maximum between the ages of forty-one and fifty. Malignant disease of the œsophagus, however, seems to be rather later in its onset. Between fifty and sixty is the commonest period of life during which this disease manifests itself, as the following table will show:

Between	20—30	...	...	1 case
„	30—40	...	...	1 „
„	40—50	...	...	22 cases
„	50—60	...	...	32 „
„	60—70	...	...	22 „
„	70—80	...	...	5 „

The earliest case was at twenty-eight, and the latest at seventy-four. I could not satisfy myself that the age of the patient had any marked influence on the rate of growth and duration of the disease.

In this situation cancer is about twenty times more frequent in the male than in the female.

Without entering into the much-discussed question as to the origin of cancer, one cannot but be struck by the fact that here we have an organ essentially the same as regards development in the two sexes, yet one so frequently the seat of malignant disease in the male, and so rarely in the female. As I shall show later on, three main sites are almost exclusively the parts attacked, and these three sites are where the lumen is most narrow, and where friction is consequently the greatest. It appears, therefore, probable that long-continued mechanical irritation is an important factor, with subsequent ulceration and downgrowth of epithelium.

No explanation as to the greater frequency in the male is forthcoming, and the whole subject is beset with so many difficulties that it is quite beyond the scope of this paper.

Family history.—There is a marked absence in the family history of any form of malignant disease, and in no case was I able to find any history of this particular variety. Some writers have also stated that tuberculosis was unusually frequently co-existent with œsophageal new growth. I could find no basis for this statement.

Symptoms and Diagnosis.

(1) *Dysphagia.*—A gradually increasing dysphagia is present in the very large majority of cases, but in some few cases the onset was acute, all the later symptoms dating from one particular meal, at which a bolus stuck in the patient's throat, there having been previously not the least sign of any organic lesion. In some few also dysphagia was completely absent. There is frequently no definite relation between the degree of dysphagia and the amount of stricture present. In one case no bougie of even the smallest size was ever passed beyond eight inches, and yet the patient was able to swallow comparatively well till quite the end. Other cases illustrate just the reverse. The amount of dysphagia varies also sometimes from time to time, probably due to proliferation towards the lumen, with subsequent destruction of the proliferating mass.

(2) *Regurgitation of food.*—Present in a greater or lesser degree in almost every case. The vomiting occurs, as a rule, within ten to fifteen minutes of the ingestion of the food. Rarely vomiting occurs after some two or three hours. This is, I believe, entirely dependent on the amount of pouching of the œsophagus above the growth. Pouching of any extent is rare, consequently regurgitation is early. Now and then the œsophagus is much dilated and pouched, leading to a large sac, in which the fluids accumulate till the œsophagus, wearying, as it were, of its efforts to force the food on, gets rid of it by regurgitation upwards. In one case a sultana raisin (given for experimental purposes) was retained for nineteen hours, and then vomited. Here the post-mortem revealed marked pouching.

The character of the regurgitated food proves that it never entered the stomach, the reaction being neutral or alkaline, and milk uncurdled.

The *fæces*, as tested in two or three cases, contained no starch granules, much fat and general *débris*, and little or no bile-pigment.

When much stricture is present the "trickling sound" may occasionally be well heard by auscultation posteriorly over the region of the œsophagus.

(3) *Pain* is on the whole not a marked symptom, except during deglutition. In some cases it was entirely absent. When present it was commonly referred to behind the episternal notch or lower down, occasionally behind between the scapulæ. When, however, the growth implicated the cardiac end of the œsophagus the pain was a more prominent symptom, and was referred to the epigastric region.

In not more than 10 per cent. of cases was pain of such a severe nature as to so direct the patient's mind to the fact as to induce him to seek medical advice.

Vomiting of blood.—A rare symptom. Present only in three or four cases, where the growth had ulcerated through into the arch of the aorta or into the thoracic aorta.

Loss of weight.—As a rule rapid and progressive, at times the loss averaging one stone in weight per month. Marked retraction of the abdomen is generally present.

Dysphœna and aphonia are often present, due either to direct pressure on the trachea, or to involvement of one or both of the recurrent laryngeal nerves. Dyspnœa from second pulmonary complications I do not include under this heading.

Implication of nerves.—Present in quite 28 per cent. of all cases. It is generally stated that the left recurrent laryngeal nerve is almost exclusively the one which is involved. I was rather surprised, therefore, to find that this was not the case.

The left was involved in 12 cases.
„ right „ „ 5 „
Both were „ „ 3 „

So that out of a total of twenty cases in which the recurrent laryngeals were involved in the growth

the left was affected in 15
and the right „ „ 8

—a relative proportion of two to one. Both recurrent laryngeals can obviously only be affected when the growth is high up; the paralysis of the left is generally due to its being buried in a mass of secondarily affected lymph-glands.

I need hardly remind you that this results in abductor paralysis, the cord being fixed nearly in the middle line, leaving but a narrow respiratory gap.

The vagus was involved in one case only, no cardiac symptoms resulting.

The sympathetic was involved in three or four cases, leading to contraction of the pupil, ptosis, and flushing of the face on the affected side. Interesting experiments were tried in these cases by means of the subcutaneous injection of atropine, etc. Results, however, were variable, and of no diagnostic value.

Enlarged glands in neck.—These are frequently enlarged, in about 30 per cent. of all cases; most commonly those just above the clavicle in the supra-clavicular or subclavian triangle are first felt.

Some writers state that enlargement of glands above the clavicle is very common. Prof. Moritz Schmidt, who has had an extensive experience of these cases, considers that such enlargements are in reality very uncommon.

When the growth is in the region of the cricoid, the local swelling can often be felt, and as it frequently involves the trachea the latter organ is impeded in its movements, both from side to side and up and down during deglutition. In these cases enlarged glands are usually present in the neighbourhood of the ulcer.

Mucoid and frothy expectoration.—A very common and distressing symptom, present in nearly all cases where the growth involves the œsophagus in the region of the cricoid. The expectoration is frequently tinged with bright arterial blood.

Diagnosis may be confirmed (1) by seeing the growth by means of the laryngoscope or the œsophagoscope; (2) by feeling the growth—

(*a*) Directly by means of the finger.
(*β*) Indirectly by means of bougies.

Although the bougie is diagnostic of œsophageal obstruction, it does not afford reliable information as to the exact site of the ulcer. Thus, according to the bougie, in—

20 per cent. cases the ulcer was situated at level of the cricoid cartilage.
64 „ „ „ opposite the bifurcation of the trachea.
4 „ „ „ at the cardiac end.

Whilst post-mortem results showed that in

11 per cent. cases the ulcer was situated at the level of cricoid.
77 „ „ „ „ opposite the bifurcation of the trachea.
11 „ „ „ „ at the cardiac end.

This discrepancy is explained in three ways:

(1) That in many cases the ulcer was two to three inches long, and therefore led to error as to its exact origin.

(2) That there is frequently a second ulcer above the primary growth.

(3) That the œsophagus varies in length.

Erichsen states that growths opposite the cricoid are the most common. This, however, I was unable to verify. From the cases I have examined the ulcer was situated in 75 per cent. cases opposite the bifurcation of the trachea, and in 11 per cent. cases each in the region of the cricoid and at the cardiac end of the œsophagus.

The diagnosis is easy when a combination of the above symptoms is present, but now and again a correct diagnosis is practically impossible, as the following cases will show.

1. A. W—, admitted with symptoms of peritonitis and a history of nine weeks' abdominal pain. No other symptoms. The abdomen was opened, pus was found in peritoneal cavity and growths in the liver. The post-mortem examination showed a malignant œsophageal ulcer opposite the bifurcation of the trachea, around which an abscess had formed, the contents of which had tracked downwards into the abdomen.

2. W. W—, aged 71, was walking downstairs when he slipped and fell, injuring his leg. Previously he had been perfectly well with the exception of "rheumatic pains" in the right thigh. On examination the right femur was found fractured at about the middle. He gradually sank and died. The post-mortem showed an epitheliomatous ulcer completely surrounding the lower 4½ inches of the œsophagus, with extensive secondary growth in the right femur.

3. H. P—, 28, admitted with a history of eight years difficulty in swallowing. This dysphagia was not continuous, but recurred from time to time. Lately he had suffered from hæmoptysis and persistent cough. A bougie was passed with ease. Patient died suddenly, and a large epitheliomatous mass was discovered three inches below the cricoid cartilage, involving the lungs.

I have here the notes of other similar cases, but these few will suffice to show how difficult the differential diagnosis occasionally is.

The *duration* of the disease is on an average about eight months. The longest was eighteen months, and the shortest two weeks. The important relation of the œsophagus to the trachea, bronchi, heart, and great vessels explain the rapid course of the disease, death usually resulting from ulceration into one of these vital organs.

Extension of growth and termination.—The growth invades any of the neighbouring structures, and as the ulcer is most common opposite the bifurcation of the trachea, perforation in that direction is the most usual termination. The great tendency to perforation into the left bronchus, which one reads of and which one would anatomically expect, was by no means apparent, as out of 16 cases in which perforation into the air-passages took place only 3 were into the left bronchus; 2 were into the right, 2 at junction of trachea and bronchus, and 9 well above the bifurcation of the trachea. The ulceration follows the general rule in avoiding the highly resistent cartilaginous rings and plates, and eats its way between them. This termination was the most common, leading rapidly to septic pneumonia. The next most frequent termination was direct extension into the substance of the lung, in about 13 cases leading also to septic pneumonia.

The heart and blood-vessels were involved in 9 cases.

There was perforation into left auricle in 1 case.

The growth was adherent to the pericardium and gave rise to pericarditis in 2 cases.

The arch of aorta was embedded in new growth in 2 cases.

The descending part of the arch was perforated in 1 case.

The descending aorta was involved in 1 case.

The descending aorta was perforated in 1 case.

The innominate artery and its branches were surrounded by new growth and innominate vein (right) compressed and occluded in 1 case.

The vertebræ were eroded in 4 cases only. Thus this disease follows the general rule of cancer to grow in the direction of least resistance.

From these facts one may come to the conclusion that death from epithelioma of the œsophagus when not due to simple starvation results in order of frequency from—

(1) Perforation of air-passage (especially of trachea above bifurcation).

(2) Direct destruction and involvement of lung.

(3) Involvement and perforation of heart, pericardium and great vessels.

Secondary growths.—According to many writers secondary growths are rather the exception than the rule. This I did not find to be the case, for out of 35 cases in which a post-mortem was held, secondary growths were found in all but 7.

The most common situations were in the glands of the neck and in the lungs and pleura. Next in order of frequency came the liver in 9 cases, and the glands of the posterior mediastinum in 8.

Erichsen narrates a case where secondary growths occurred in several bones. Spontaneous fracture occurred in the humerus on each side and in one clavicle.

Other rarer sites were the kidney, pancreas, mesosigmoid, femur, lumbar glands and glands of gastro-hepatic omentum. These last are, according to Bland-Sutton, affected in 50 per cent. of cases of pyloric cancer, and in the two or three cases in which it occurred in cancer of the œsophagus the growth was near the cardiac end, proving that the lymphatics of lower end of œsophagus pass to the liver.

In some few cases the ulcer of the œsophagus was quite small and gave rise to no marked symptoms, whilst the liver was enormously enlarged and a mass of secondary new growth, causing much difficulty in the diagnosis.

Some months ago on doing a post-mortem examination, the history of the case being unknown to me, I found the liver a mass of new growth, and searched for a primary source all through the alimentary canal from cardiac orifice of stomach to rectum, and all abdominal viscera and found nothing. As a last resource I examined the œsophagus and found a minute ulcer, the size of a sixpence, which on microscopic examination proved to be epitheliomatous. Since then I have seen two or three other similar cases. The primary ulcer in these cases gave rise to no marked symptoms.

The primary growth is nearly always of the squamous celled variety; it is probable, however, that spheroidal-celled carcinoma may occur, as in some few cases the secondary growths were of that nature, and as a rule the secondary tumours are of the same structure as the primary.

Cell-nests are common, but not so well marked as in epithelioma linguæ.

The stricture is in the majority of cases of the *annular* variety; in some the contraction is very marked, practically obliterating the lumen, but as a rule a fair-sized bougie will easily pass through the stricture if the attempt be made during the post-mortem examination.

Direct extension up and down the œsophagus by means of the lymphatics in the submucous tissue is an almost constant feature, giving rise to a chain of beads of new growth, one or more of which may invade the mucous coat, ulcerate, and so lead to multiple epitheliomatous ulcers. Such cases when examined are at first sight rather puzzling, and occasionally it is not always easy to determine which is the primary growth.

TREATMENT may be classified under three headings:

i. Palliative and symptomatic,
ii. Mechanical, and
iii. Operative.

1. *Palliative and symptomatic.*—It is especially important that the diet should be most carefully regulated. All irritating and spiced edibles and drinkables must be absolutely prohibited, and all foods should be soft. The best nourishment is always milk; other articles of diet are weak tea, cocoa, powdered meat, peptonised soups, Valentine's meat juice, Brand's beef jelly, eggs, milk puddings, and jellies. Eggs should be lightly boiled or raw. Food should be given frequently, small quantities at a time.

Alcohol should either be entirely withheld, or only given in the smallest quantities.

Morphia is often needed, but should be kept as much as possible for the last few weeks.

During the earlier stages bismuth, as recommended by Schmidt of Vienna, is often very useful, mechanically protecting the ulcer and easing the pain during deglutition. This drug is but seldom given for this disease, which I think is a mistake, as the results sometimes obtained are really excellent. Cocaine lozenges also are useful, as the cocaine-impregnated saliva accumulates above the stricture, and so gives time for the drug to act.

These two drugs, given before meals, will be found efficient in some cases in not only lessening the pain, but also in diminishing the excessive secretion of tenacious mucus, which is one of the most distressing features of this disease. Atropine is also occasionally useful in diminishing the amount of mucus.

2. *Mechanical treatment.*—Under this heading I include (1) gradual dilatation with bougies; (2) Symons' tubes.

The former method does not commend itself to many on the ground that one has to deal with a malignant ulcer, as to the position, size, and condition of which we are quite in the dark, and which may be nigh to perforation into some neighbouring viscus. Cases are by no means rare, indeed, where such untoward results have occurred. The difficulty in passing the bougies, which is so often very marked, must enormously increase the danger of perforation. Consequently it would seem to be advisable that when once the diagnosis is verified no further attempts should be made to enlarge the lumen of the œsophagus.

When all operative interference, however, is refused, it will become necessary to pass occasionally *soft* bougies, through which the patient may receive a good meal.

2. *Symons' tubes.*—In some cases these tubes are undoubtedly efficacious in relieving the dysphagia, and in some exceptional cases are appreciated by the patient; but they have also many disadvantages, which, in the opinion of many, outweigh the advantages.

(α) If the growth is at the level of the cricoid they frequently lead to so much laryngeal irritation that the patient's life is made a greater burden to him even than it was before. If, on the other hand, the growth is far down, one can never be sure whether the end of the tube is through the stricture, as the mass of growth is frequently three to four inches long.

(β) Occasionally the tube becomes bent on itself.

(γ) The threads become soon sodden and destroyed, leading to difficulty in the withdrawal, and even in the complete swallowing of the tube. I have notes of cases illustrating all these points.

(δ) Lastly, there is the important objection—which applies equally whether the growth be at the level of the cricoid or of the bifurcation of the trachea—that the tube irritates continually the ulcer, and increases the rate of growth and the risk of perforation.

An early inguinal colotomy for rectal carcinoma is advised by many on the ground that the passage of fæcal masses over the malignant ulcer increases the rate of growth, and so hastens the end.

On similar grounds it seems advisable to open the alimentary canal below the seat of stricture in the œsophagus, and also to avoid all unnecessary irritation, such as is caused by Symons' tubes.

OPERATIVE TREATMENT.

Œsophagectomy was first suggested by Billroth, and carried out successfully by Czerny in 1877. Since then this operation has deservedly fallen into disrepute, and, as Mr. Butlin points out in his 'Operative Surgery of Malignant Disease,' "it can scarcely be a matter of surprise that the operation has not hitherto been practised by British or American surgeons."

Œsophagostomy.—This operation has only been performed twice in the cases I have examined, and in each case with a fatal result. The difficulty in every case is to be certain of getting below the growth, and unless the case is taken quite early the extent of the ulceration and the wide submucous infiltration would contra-indicate any attempt to open the canal below the disease.

Gastrostomy.—It will, I think, be generally conceded that this operation is the only one which should be discussed. This treatment was carried out in seventeen cases, with the following results:

Died from or soon after the operation 11 = 65 per cent.
Recovered and did well ... ... 6 = 38 "

This mortality agrees fairly closely with the statistics of Zesas who estimated it from 162 cases at 78 per cent. Gross, however, from 205 cases puts it as low as 29·47 per cent.

In the successful cases the prolongation of life was on an average eighty-two days.

Dr. James Murphy, however, reports a case in the *British Medical Journal* of October, 1888, where the patient lived 403 days after gastrostomy was performed.

I propose now to analyse this high mortality of 65 per cent. Of the eleven cases—

(1) Four died from perforation into the trachea, which took place very soon after the operation.

(2) One died from peritonitis from involvement by direct extension of the stomach, with extravasation of gastric contents.

(3) One died from pneumonia.

(4) One died from abscess around the œsophagus, leading at the time of operation to pyrexia and general symptoms of sapræmia.

(5) One died with growth around the stomach.

(6) In two the cause of death was unknown. No post-mortem.

(7) One gradually sank, the operation failing to relieve the symptoms of starvation.

I think I may fairly assume that (excluding the two cases where the actual cause of death was uncertain) the patient would have succumbed whether the operation had been performed or not, although possibly the operation hastened death by a few hours.

In only one single case was the operation a failure, the patient gradually sinking, and dying of exhaustion and inanition, and quite unrelieved by the operation. I would urge that it is only in such cases as this that one should argue as to whether gastrostomy is or is not a good operation. In the six favourable cases I have been unable to find out how long the patient lived after leaving the hospital. One case, however, was seen six weeks after discharge, and was reported as having benefited greatly, and as being able to work in a grocer's shop. All, however, during their convalescence put on weight, experienced less pain, and lost that awful sense of sinking and hunger which had previously caused so much distress.

The cause of failure is best summed up in Mr. Treves' own words: "One thing is certain, and that is the operation is usually carried out too late. The condition of malnutrition, into which the patient is allowed to sink, is eminently favourable for the growth and progress of a cancerous mass. The stomach is allowed to pass into a state of atony before any attempt is made to introduce food into it."

Summing up now on the treatment of this disease, it seems advisable that when once the diagnosis is made no further attempts should be made to pass bougies, but that the patient should be carefully dieted, and weighed once a week; and as soon as the weight begins to steadily fall that gastrostomy should be performed, whilst the patient is still strong and able to undergo what is then not so serious an operation.

The question now arises as to what is the best way of performing gastrostomy. The only two methods in practice are Frank's or Alberts, and the more simple one which goes under the name of Howse's operation.

The former method was devised to lessen the escape of gastric juice, but is complicated, and was only performed twice, whilst the more simple operation was carried out eighteen times.

It is usually recommended that a portion of the stomach near to the lesser curvature should be chosen to allow a fair quantity of fluid in the stomach without overflow.

It is best to leave the stomach unopened till the fourth or fifth day, by which time firm adhesions will have formed, the patient in the meantime being fed with nutrient enemata.

A small hole is then made into the stomach with a tenotomy knife, large enough to admit a No. 9 red rubber catheter, through which the patient can at once be fed; the tube is left in, clamped with bull-dog forceps, and loosely packed around with gauze.

No definite rules can be laid down as to the after-treatment, except that the stomach must be gradually accustomed to the new mode of nutrition, and that it is advisable that the fluids introduced should be at first partially peptonised.

Later on milk puddings, jellies, and even meat pellets can be introduced, a probe being used, if necessary, to aid the introduction. After three weeks the patient can be taught to feed himself.

The main complication is the leakage of gastric contents, with consequent irritation and ulceration of the skin around. In many cases, however, this is so slight as to cause no serious inconvenience, a little boracic ointment smeared around being quite sufficient.

If it does occur, my own experience leads me to believe that it is most inadvisable to continually insert larger tubes to prevent the leakage. It is far better to use the patent valves recommended by Mr. Harrison Cripps in his work on 'Ovariotomy and Abdominal Surgery.'

An Amateur Path. Lab.

By JAMES L. MAXWELL, M.D.(Lond.).

IN venturing to write this description of how I have gathered the materials of an amateur pathological laboratory, I must allow myself a personal explanation to excuse my temerity. I do not for a moment profess to be a pathologist; however attractive that branch of science has been, I have had neither the opportunities nor the talents to aspire to such a position. I merely desire to show how a practitioner, after leaving his medical school, may still be able to keep up all the essentials to scientific diagnosis that are usually performed by or for him in the laboratories at hospital.

I do not mean to suggest that if every one carried out this idea, the need for special pathologists would be decreased, as a matter of fact it would be only increased: but the common everyday pathological work being accomplished by every man for himself, the special pathologist would be called in only for the decision of all doubtful morbid sections, unusual morbid phenomena, or difficult bacteriological problems. In this way the cause of scientific discovery would be made much easier by taking from our present pathologists a vast load of almost purely mechanical work which prevents their having the time to develop the higher branches of the science.

I have a further reason for writing this short paper; when a member of the Resident Staff, we often discussed the possibility of carrying scientific pathological methods into diagnosis in general practice. I would remind many of my colleagues that they only scoffed at my hopes of being able to continue all the ordinary scientific work when I left the hospital, and am glad here to be able to affirm my success.

Pathological work necessarily falls into two great divisions—the sectional study of morbid tissues and bacteriological diagnosis.

I. *The sectional study of morbid tissues.*—It is simply ridiculous that after all the trouble, work, and expense that is wasted over a modern medical education, a practitioner should remove a piece of cervix and then not possess the requisites for its examination, with a view to the diagnosis of malignant disease. And in the same way with all other doubtful tissues, a small portion can very often be removed from the edge of any doubtful ulcer or growth under cocaine, and a diagnosis thus arrived at; and I am very strongly of opinion that every morbid growth should be examined after, when not so done before, removal; this would no doubt clear up the anomalous behaviour which cases of disease, diagnosed as malignant, sometimes exhibit.

There is no doubt that the most satisfactory, and in the end the cheapest, method of cutting sections is by the paraffin method, using a Cambridge rocker microtome. This implies an incubator for the melted paraffin, the microtome itself with its lesser appendages, as razor, etc., and bottles containing suitable hardening and clearing materials. This sounds very simple, and is so in fact. The hardening and embedding of specimens may be said to be done without any waste of time whatever. A row of bottles with the various reagents is kept on a shelf, and the specimen can be changed from one bottle to the next two or three three times a day, when a minute is to spare. And the same way one takes the specimen through the bottles of melted paraffin. After that the methods of cutting, fixing—which is done best in the paraffin incubator,—and staining are familiar to all, and can also be done at any odd half-hour,—*e.g.* the whole staining and mounting process can be carried through most successfully while dressing in the morning, the stains and clearing reagents being all kept in small tubes or covered solid watch-glasses, into which the cover-glass with section can be dropped and left for the required number of minutes. It is really surprising how little time is wasted over the whole thing, after a little mechanical skill has first been acquired.

II. We now come to *bacteriological diagnosis.*—Of course in this we include the staining of tubercle bacilli in sputum and urine.

The more difficult question comes with regard to reactions, such as Vidal's reaction for typhoid, diphtheria cultures and the culture of organisms from abscesses, in cases of septicæmia and others; one need hardly point out the absolute need of the latter if, for example, the antistreptococcus serum treatment is ever to get out of the horrible muddle that clinical diagnosticians of septicæmia have left it in. The question here arises with regard to media for cultures; an incubator is a comparatively cheap thing, but to buy media at the ordinary market price for anything like extensive use would be quite beyond the resources of many. Just for example, the ordinary media are sold at from 4d. to 6d. per tube, and often very much higher than this; now I find myself able to make my media at very considerably less than ¼d. a tube, remembering of course that the tubes once purchased can be used any number of times, and only require the media to be renewed. But then when I faced the question of making media with all the various stages and paraphernalia described in the books my heart failed me. Happily I have now learnt to make it so simply as to take all the terrors away from its production. I do not claim that my media will compare, either for clearness or perhaps for usefulness, with those prepared in a first-class hospital laboratory, but for all the practical purposes I have named, and for cultivating any or all of the germs commonly cultivated in the laboratory, they do very well indeed.

I need hardly remind my readers that most of the common media have one necessary ingredient, viz. peptonised beef broth. Many and most complicated ways are described for making it. The following is the way in which I make mine.

Beef tea (Liebig's), peptone (Witte's), salt and water are mixed in the proper proportions, which can be obtained from any text-book. I usually make a litre or a litre and a half at a time. This is then heated in a steriliser for half an hour. It is then markedly acid, and 10 per cent. solution of potassium hydrate is added till the reaction is faintly alkaline to an alcoholic solution of phenol-phthalein. The flask is then allowed to stand for a few hours, by which time the precipitate caused by neutralising the solution will have sunk and the clear supernatant fluid can be poured off, the residue being thrown away. The broth in the flask is then sterilised by three heatings in the steriliser on successive days. It will now keep for any length of time, and with very little trouble we can prepare from it the ordinary media—broth, agar-agar, and gelatine.

Broth is prepared by pouring from the flask about 3 c.c. into

each of as many tubes as are required; then sterilising the broth tubes as before, and re-sterilising the stock broth which has been unstoppered to pour out into the tubes.

Agar-agar is prepared by pouring a required quantity of broth, say 150 c.c., into a small flask, and adding to it the proper proportion of agar which has been previously softened by soaking for half an hour in slightly acidulated water, and then wrung out in fresh water. The mixture is then heated in the steriliser till all the agar is melted. There is now a good deal of precipitated matter present, and, of course, the orthodox and most successful way to deal with this is to filter it through a hot filter. Now this is both difficult and likely to waste much time to the unskilled amateur, and for our purposes it is sufficient to pour the mixture into a beaker and leave to stand till cool. It is now a jelly in which all the precipitated material has settled to the bottom; all that is required, therefore, is to turn out the mould of jelly and cut off a thin section from the bottom, which will include all the precipitated material and can be thrown away. The rest is returned to the beaker, remelted, and poured into test-tubes which are sterilised as before.

Gelatine can be prepared in the same way as agar, but the precipitation is often so slight that it can be neglected.

Another very useful medium, especially for throat cultures, is obtained from ascitic fluid by adding to it 3 per cent. of potassium hydrate solution and 2 per cent. of agar-agar, and then heating as in the preparation of agar-agar tubes.

I feel that I render myself liable to at least one serious charge, that is of encouraging a slovenly method of working. My answer is that this would be true if we were preparing media for special bacteriological research; but we are preparing media for use for specific purposes only, and in ordinary experience media thus prepared appear to be capable of quite satisfactory use.

I have tried to briefly describe the preparation of media to save my readers the dismay that I have suffered in viewing the endless descriptions in text-books. For myself, I prepare about half a gross of tubes of each material at a time; they thus last me several months. I cap each with a little piece of silver-paper, which prevents the medium drying at all; and I find that for my purposes the medium does not depreciate appreciably in that time. Putting all the odd times spent in the preparation of a few months' culture tubes together, I doubt if it exceeds three hours.

I have mentioned my steriliser, but said nothing of it in the way of description. It is of the simplest description possible, and gives absolutely no trouble to work. It is called the New Patent Steam Steriliser (Gallenkamp), and consists of a basin below for water, a compartment fixed on to this by screws in which the articles to be sterilised are placed, and the top fixed also by screws, and with weights which placed on the steam escape regulate the temperature within up to 110° C.

It only remains for me to give a rough idea of expense. Taking the section-cutting part first:

The Cambridge Rocker with everything else necessary for cutting sections costs about £5.

My incubator for paraffin work with gas-regulating apparatus cost less than £3.

With regard to this latter I had to learn a lesson rather dearly. I procured a metal incubator, tinned, I believe, but without any warning from the makers of the dangers of rust destroying it, and lost it in less than a year from being completely rusted through. I have learnt now the fact which no text-book condescends to tell one, that the addition of some washing soda to the water completely obviates all the dangers of rust.

The expenses of the bacteriological apparatus were—For the incubator with gas-heating apparatus about £2 10s. For the steriliser about £3; and for test-tubes, other glass apparatus, and chemical reagents about £1 10s. Total for apparatus for cutting sections £8. Total for bacteriological apparatus £7, making the pathological laboratory up for the very small sum of £15. In addition to this, as one would hardly manage to start everything at once, the expense, as in my case, may be spread over a considerable time.

With regard to the heating of the apparatus I have so far used gas for both my incubators, but I have acquired a spirit-regulating stove which I hope to find as effective for the incubators.

To heat my steriliser I have always used a wickless paraffin air-pressure stove, which heats the steriliser in about ten minutes, and can be left without any attention the whole time any article is being sterilised.

I have tried in this paper just to encourage others who are situated as I am to try and keep more or less up to date in the scientific diagnosis of morbid conditions. We are said, and I fear rightly, to be far behind our Continental and Transatlantic neighbours in our use of scientific methods in the everyday diagnosis and treatment of disease. If we are to be able to rebut this reproach, it will not be by the exceptional brilliancy of our leading scientists, which we believe our country will always be able to show, but by every thorough man in general practice striving to use his scientific attainments in all the opportunities which his practice allows him. I have not mentioned either examination of urine or blood examination in this paper, because the former, we trust, every one carries out; and the latter, though not used as it should be, presents much smaller difficulties in the matter of apparatus than do the subjects to which this paper has been devoted.

Medical Extracts from Devonshire Folk-lore.

THERE is no more old-fashioned corner of England than the West Country—a district full of large tracts of almost uninhabited moorland, with few large towns, and, from its very position, out of the main road of progress and knowledge. It is a country, moreover, full of memories of the past; when Devon men were found wherever there was fighting to be done; now, as then, men and superstitions die hard there. Perhaps, too, the remains of that Celtic race who once lived there help to keep alive the old traditions and superstitions. It is not so very long ago that a woman was burnt for a witch just outside Exeter. The late Sir John Bowring wrote: "Astrologers, reckoners of nativities, sellers of love philtres, herbalists supposed to be acquainted with the mysterious powers of plants, both creative, curative, and destructive, exist in many parts of this county, and to this hour are consulted by the peasantry." Although charms and cures form but a small part of the science of folk-lore, yet it is from these two classes of superstitions that the following extracts are taken, as being more appropriate for a hospital journal. I am indebted for most of the following examples to that invaluable collection of Devonianisms past and present—the *Transactions of the Devonshire Association*.

An old farmer related the following anecdote from his own experience: He had kept his bed for some time, and his illness had quite baffled the doctors; in fact, he was thought to be dying. Those about him advised that he should be laid in a grave newly dug for a young woman. (The witching hour of midnight is the correct time for this ceremonial to take place.) An opportunity occurring, he was taken from his bed to the churchyard, and placed for a short time in this melancholy receptacle. Strange to say, from the time he was taken out he began to revive, and was a hale old man at the time he related the story (1868). (It is interesting to note that it was from the time he was taken *out*—not from the time he was placed *in*—the grave that he began to recover. But that is a mere detail!)

R. W., of Ashburton, at one time was very unwell—("Afflictions sore long time he bore; Physiciäns were in vain")—till one evening, on entering the door of his cottage, he saw a "girt twoad" (toad), which he killed with a pitchfork and threw into the fire. The next evening he saw another toad in the same place, which suffered the same fate as the first. They were the largest toads he ever saw; he believed that they were witches. Formerly he had had "a heart to work, but no strength;" but he soon after this recovered, and has not suffered the like since.

When a young infant is afflicted with rupture, a small "maiden" (*i. e.* self-sown) ash is split for a length of five or six feet down the middle as it stands growing in the wood. The split halves being forced asunder, the naked infant—squalling, as becomes him—is passed three times in the same direction through the opening. Henceforth the defect is cured. The tree is then restored to its natural shape; and as it thrives, so the child thrives.

The person who related this custom instanced several well-known young men of the neighbourhood who had been subjected to the process and had grown up strong and healthy. In one case, in which the tree had evidently suffered from the experiment, he referred to the deformity and sickly growth of the youth who had been passed through it.

In a case which came before the magistrates, in which a woman was accused of swindling people by professing to be a white witch, a witness, thinking to convince the magistrates once for all that the woman's power was genuine, declared that she was the seventh daughter of the seventh daughter of a seventh daughter. The magistrates were, curiously enough, not convinced.

An ancient charm for the cure of worms in a bullock's tongue:

"When our blessed Lady set and sewed,
Her sweet Son he set and played.
There come a tin-worm from the onder-growth
That stinged her sweet Son by the foot.
The bladder blawded but didn't bust.
He that shall on him call by his name Cobere
In the name of the Father and of the Son and of the Holy Ghost.
(Say the Lord's Prayer afore and after.)"

A poor woman, near Morwenstow, attributed a sort of stroke, which had affected one of her children after whooping-cough, to the moving of the parsley bed; and it was believed in a neighbouring parish that the parish clerk had been bedridden "ever since the parsley mores were moved."

A barbarous custom near Morwenstow was to bury three live puppies in the corner of a field to rid it of weeds.

A charm for fits.—Walk into a church at midnight; walk up to the Communion table and turn round. This is seldom known to fail.

Cure for bad eyes.—Beg penny pieces from males only, neither saying "Please" nor "Thank you" meanwhile, till sufficient has been collected to buy a pair of ear-rings. If these be constantly worn the eyes are cured. (N.B.—The wearing of ear-rings to cure ophthalmia is common all over Devon.)

To cure a sty in the eye.—Borrow a widow's wedding ring: dip this in milk and rub the sty, which will soon disappear.

A charm for boils.—To creep under an arched bramble which takes root at each end; and if the two ends are in two different proprietors' lands, so much the better.

Another certain cure for boils.—Poultice for three days and nights, and then place the poultices with their cloths in the coffin of anyone lying dead and about to be buried. The poultices must remain in the coffin.

Two charms for thrush.—1. If a child who does not yet know its father by sight has thrush, the father must blow three times into its mouth. This, however, has been known to fail! 2. An ash tree growing by a running stream is selected. A thread is then tied round one of its twigs by three knots. Make three more knots on each of the two following days, then pass the string through the child's mouth.

Cure for bad eyes in a boy.—A woman who has never seen her father must blow on to his eyes through a hole in a nettle leaf for nine successive days. She must perform this before she "has put her hand to anything for the day." If a girl has bad eyes, a man who has never seen his mother must perform the cure.

Cure for "girding" or "shingles" (herpes zoster).—The patient must be taken in the morning to running water, where the attendant must pick seven rushes growing *by*, but not *in* the water, and lay them on the part affected (which must be bared), drawing them across it. As soon as they have been used the rushes must be thrown into the stream to wash away the disease. This to be done on three succeeding days.

Cure for *any* affection of a child's eyes.—The child is to be taken in its ordinary clothes and laid in a newly dug grave.

Three cures for warts.—1. Take a living slug and impale it on a thorn. In two days the warts will have disappeared, and will never come back any more. 2. Steal a piece of meat—no matter from whom, but preferably from the person who gives the advice,—and bury it in the ground. As the meat rots the warts disappear. 3. Hold a mole in the hand affected, and make its nose bleed. Keep it in the hand till it has bled to death, when the warts will disappear.

Charm for erysipelas.—Name the patient's name; then say, "Erysipelas I see! Erysipelas I find! With red cow's milk and a white thorn and the black yolk wool. In the name of the Trinity. Amen." The place is then to be anointed with the "red cow's milk" five or seven times a day, bathed in warm water, and rubbed with soap liniment.

For whooping-cough.—Early, while the dew is on the ground, turn a sheep away from the place where it has been lying, and lay the child face downward on this spot.

Infusion of petals of the common marigold is recommended for "keeping out the measles"!

Cure for an abscess.—Nutmeg given by a person of the opposite sex is a certain cure.

To prevent chilblains.—Wash the child's feet in water melted from the first snow that falls after its birth.

A farmer's son, living at Exminster, had an attack of bleeding from the nose. The father laid the boy on his back and filled his nostrils with "unsavoury extract of farmyard." The treatment was effectual.

Dr. Karkeek, of Torquay, writes in the Transactions "*De Rebus Obstetricis*:" "The very high value placed by seamen on the child's caul is well known; and advertisements of this infallible preventive from drowning being for sale may occasionally be seen in the London papers now. The origin of this myth is difficult to discover; but it may be that because the child floats *in utero* in the liquor amnii, therefore the amnion ought to enable its possessor to float in after life.

A very old (*sage*) *femme* in Torquay, of immense experience, recently told me that the placenta should always be placed in a perfectly dry vessel, because, if the vessel contained any fluid whatever, the child would sooner or later die by drowning.

A sty in the eye can be cured by striking the eye with the tip of a cat's tail.

A preventive against toothache.—Carry a potato in the pocket.

An infallible cure for shingles.—Take some raw "ream" (*i. e.* the first skimming of cream from the surface of new milk); also get a cat of the opposite sex to the patient. As the informant expressed it, "a ram cat for a woman, and a yow cat [ewe cat] for a man. Bleed it by cutting the ear. Mix the blood with the ream till the mixture is pink, and then anoint the part affected."

SIMON WETHERELL.

Notes.

THE Opening Address of the Winter Session of the Abernethian Society will be delivered in the Anatomical Theatre on Thursday, October 11th, at 8 p.m., by Mr. A. A. Bowlby. Subject: "Reminiscences of the War in South Africa."

* * *

THE Bradshaw Lecture will be delivered this year by Dr. Archibald E. Garrod, on November 6th. Subject: "The Urinary Pigments in their Pathological Aspects."

* * *

DR. J. S. EDKINS has been appointed an Examiner in Physiology to the Conjoint Board.

* * *

MR. T. FISHER UNWIN announces the publication, on October 15th, of a story entitled 'A Thoroughbred Mongrel,' by Mr. Stephen Townesend.

* * *

THE Assistant Demonstrator of Physiology (*sic*) received the following letter recently:

DEAR SIR,

I should be much obliged if you would kindly have the sputum sent herewith examined for me. May I ask that more than ordinary care may be exercised, and that several of the "pellets" may be examined, as if there is even a *suspicion* of tubercle in it the matter becomes one of very urgent importance . . . I enclose the fee of 2/6, and I am sure you will let me ask that unusual care may be taken. I am, etc.

In this brief note are many thoughts that do lie too deep for tears—and smiles. Of the other aspects of the question, however, we shall have something to say next month.

* * *

ADDENBROOKE'S HOSPITAL, CAMBRIDGE.

DEAR SIR,—A patient in this hospital presented me with the enclosed prescriptions in the hope they might be

of service to me in my practice. As I do not wish to be selfish, I send the remedies to you to dispose of as you may see fit.

Believe me, yours truly,
G. S. HAYNES.

For the plursey, a peice of brown paper and the white of an egg spread on it then spread it thick with flowrey brimstone then stick it on the side when nearley well give a good dose of salts.

For deafness get a red onion take the inside out then fill it up with oil of armonds let stand some time drop a little in the ear then stop it with a peice of undressed wool.

For astma cough boil houround and liqurice toghether when it is near cold Put a little salt in it dose four times a day one table-spoonfull.

For the diredræa one penneyworth of petermint one penneyworth loderham one penneyworth ſpicæskunnia wine one penneyworth rubub half a pound of golden surup one pint warm warter stand till cold dose one table spoon full three times a day.

* * *

A CORRESPONDENT tells us that the Harrogate doctors seem to have discovered a novel means of ad——, making themselves known. In a fashionable photographer's window near the baths many of their portraits are exhibited, each with the original's name appended. There would certainly appear to be great possibilities here, for we know how much recommendation a "striking personality" carries with a certain class of patients. Whole-length pictures would have the advantage of being able to suggest a "good bedside manner." Indeed, it requires but a little flight of fancy to imagine the indigent poor of Harrogate, if such there be, crowding this same photographer's window, and feeling their diseases vanish before the healing influence of such an array of medical talent. One man certainly scores by the business, a sorry one though it be, and he is the photographer.

To Candidates for the "Prel. Sci."

THE SYLLABUS.

TO begin with Protozoa,
I should rather like to show a
Paramœcium or Amœba—
That's the simplest of them all.
But they're both so very small
That you'd not see them at all;
So perhaps we'd better go a
Little further on our way.
And commence the Metazoa
Without any more delay.
In the group Cœlenterata,
The authorities who cater
Give us "hydra" for our type-o,
With its epiblast and hypo.
And then, a little later,
We reach the Cœlomata,
With it's layer mesoblastic—
Ah, you grow enthusiastic!
Lumbricus is a Chætopod,
With nerve and blood-vess-el;
His nerve cord is a solid rod,
With ganglia as well.
Of the Molluscs, there is Anodon;
And while this subject I'm upon
I'd rather like to say:
'Tis a mussel of fresh water.
And it usually oughter
Be bigger than the mussel that you meet with every day.
There's Astacus, the Arthropod;
You'd better mind how you are shod,
Or else it on this beast you trod
With naked toes,
As one who goes
A-paddling in the sea,
With chelæ's grip on toes so bare,
He'd make you do a little swear—
Which never ought to be.
Then Scyllium Canicula;
You mustn't be particular—
A little fishy smell you'll have to stand.
There is Rana Temporaria,
And Lepus, which is hairier
That's all; so now step up and try your hand!

ANON.

Amalgamated Clubs.

CRICKET CLUB.

A RETROSPECT.

THE results of the Season 1900, although not so good as we should have liked them to be, are nevertheless a considerable improvement on last year. Both the batting and bowling averages are distinctly better, and the team as a whole was a much better one.

On turning to the batting averages it will be seen that T. H. Fowler is easily first with an average of 67·1; this, we think, is a record average for the Bart.'s Cricket Club, and we heartily congratulate Fowler on his performance. At the beginning of the season he seemed unable to score, but having once made a start he scored consistently and well, and finished by making 140 not out and 113 in two consecutive matches. It is to be hoped that next season will find him in as good form as this, and if not top of the averages, at any rate within the first few; this we feel quite sure he will do if only he plays as well as he has done during the latter half of the season.

W. S. Nealor, who is second with an average of 39·7, has proved himself to be an exceedingly good bat. This is his first cricket season at the Hospital, and he has been a most welcome addition to the team. On several occasions when wickets were falling fast he has stayed in and played perfect cricket, notably at Henley, Hampstead, and Surbiton, and we look forward to seeing several large scores to his name, not only next season, but for a very long while to come.

H. E. G. Boyle, who is next, with an average of 38·5, has shown considerable improvement on his form of last year, and has in fact proved himself very useful this season. To Fowler and himself fall the honour of having made all the centuries that were made, each of them having scored two; and it is a curious coincidence that they should both have made 140 not out as their highest total.

G. G. Ellett, who comes next, is another newcomer to the team, and also a very great addition to it. Throughout the season his fielding has been particularly smart, but with the exception of his score against Richmond he hardly batted up to his true form, and we confidently expect to see him make far more runs next year than he has this.

L. Orton has unfortunately only played a few times, and it was a great pity that he did not play more often.

G. H. Adam has also only played a few times, but we hope to see him playing regularly and well next season.

H. E. Scoones, who it may be remembered was top of the averages last year, comes next with an average of 18·8. We do not know if this fall in order is due to the responsible position of captain, but it will, no doubt, be agreed to by all that if he did not make as many runs as we should all have liked to see, he made up for any shortcomings by his skill as a captain.

J. C. Sale has not played up to what we consider his true form, and although he has not played often, yet we should like to have seen a return to the form of his first years at the hospital.

On turning to the bowling, it will be seen that H. E. Stanger-Leathes heads the list; it was unfortunate that he did not play more than he did. His bowling in the Cup Match *v.* Mary's was particularly good, and it was mainly owing to him that we got Mary's out for the score that we did.

C. A. Anderson, who is next, has bowled well, and we only wish that he had played more. In his cricket for the Hospital he seems to be particularly unlucky, as his batting was distinctly below his true form. Next season, however, we look for improvement.

It will be noticed that H. E. G. Boyle has had to bear the brunt of the bowling, and has, with the exception of Sale, bowled more than twice as many overs as any of the others. When we consider the amount of bowling that he had to do, we think that his position in the batting averages is all the more creditable.

Taken as a whole, this year has been a very good batting one, but it has been decidedly weak in bowling; and the need of a couple of really good bowlers made itself felt on more than one occasion. We would, therefore, strongly urge freshmen—or, in fact, any one who has any claim to be considered a bowler—to let the Secretaries know of his existence at the beginning of the cricket season. Bowlers—and especially good ones—will always be welcomed in the team.

Whether we shall get any good cricketers joining the Hospital between this and next cricket season we cannot possibly predict; but no doubt before the next season we shall, as usual, hear rumours of wonderful men who are coming up, but who, unfortunately, never do turn up. Anyhow, let us hope that next season will prove an exception, and that we may have some really good men amongst the freshmen to choose from.

ST. BARTHOLOMEW'S HOSPITAL CRICKET CLUB.

SEASON 1900.

Matches won, 3. Lost, 6. Drawn, 5. Total, 14.

BATTING AVERAGES (not less than 6 innings).

	No. of innings.	Not out.	Total runs.	Highest score.	Average.
T. H. Fowler	11	3	537	140*	67·1
W. S. Nealor	12	2	397	81	39·7
H. E. G. Boyle	14	2	462	140*	38·5
G. G. Ellett	9	0	213	69	23·6
L. Orton	6	2	82	30	20·5
G. H. Adam	6	2	81	27	20·2
H. E. Scoones (capt.)	14	1	245	40	18·8
J. C. Sale	7	0	118	64	16·8
C. F. Nicholas	13	2	138	47	12·5
C. A. Anderson	7	0	77	26	11
H. T. Wilson	8	1	61	27	8·7
Five innings and under.					
T. M. Body	2	1	45	40*	45
H. Whitwell	1		20	20	20
L. V. Thurston	3	2	16	11*	16
C. H. Turner	5	—	74	26	14·8
C. Elliott	3	—	28	27	9·3
H. B. Hill	5	—	25	7	5
H. S. Ward	3	—	4	4	1·3

The following also played: B. N. Ash, 5; F. Connor, 0 and 2; L. Chambers, 1; H. E. Stanger-Leathes, 0; J. Corbin, 0; C. H. Perkie, 0*; H. Holbrooke, 1; C. O'Brien, 0*.

* Signifies not out.

BOWLING AVERAGES (not less than 20 overs).

	Overs.	Maidens.	Runs.	Wickets.	Averages.
H. E. Stanger-Leathes	35	7	103	11	9·3
C. A. Anderson	64	10	185	17	10·8
C. H. Turner	28	4	94	4	23·5
H. E. G. Boyle	201	29	745	33	25·6
H. E. Scoones	24	3	81	3	27
W. S. Nealor	85	8	473	17	27·8
G. H. Adam	39	5	154	5	30·8
J. C. Sale	112	28	302	6	50·3
C. F. Nicholas	59	8	241	4	60·2
The following also bowled:					
B. N. Ash	2	1	5	1	5
G. G. Ellett	12	1	82	1	82
H. T. Wilson	11	1	50	1	50
F. Connor	7	—	36	1	36
H. B. Hill	3	—	17	—	—
H. Whitwell	3	—	11	—	—
T. H. Fowler	4	1	25	—	—

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

SIR,—At a meeting of the United Hospitals' Cricket Club, held during the past summer, it was decided that the members of the winning team in the Cup Competition should be presented individually with a small memento of their victory, in the shape of a silver match-box with the name of the winning hospital, the year, and the individual player's name inscribed thereon.

It was also decided that, as a similar practice had apparently been in existence five years ago, and had then been discontinued, the winning teams for the last five years should be included.

I should therefore be glad if all those men who played for Bart.'s in the Final Cup Ties in 1896 and 1898, which we won the cup, and who have now left the hospital, would kindly let me know their addresses so that I may communicate with them.

I am, yours truly,
H. EDMUND G. BOYLE,
Hon. Sec. U.H.C.C.

UNITED HOSPITALS HARE AND HOUNDS.

GUY'S HOSPITAL, S.E.;
September 24th, 1900.

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

SIR,—I should be obliged if you would allow me through your columns to give notice to those interested in cross country running that a meeting will be held at your hospital on October 8th at 5 p.m.

The object of the meeting will be to discuss the future of the United Hospitals' Hare and Hounds Club, which for the last two years has received very little support. It is hoped that the meeting will be well attended, especially by new men just entering St. Bartholomew's Hospital. If you would call attention to this meeting I should feel much indebted.

I am,
Yours truly,
RICHARD S. ROPER,
Hon. Sec. U.H.H. & H.

RIFLE CLUB.

During the past season the club have shot three matches, winning one and losing two. The following are the scores:

ST. BART.'S *v.* DULWICH COLLEGE.

May 23rd.

ST. BART.'S.

	200 yds.	500 yds.	Totals.
T. H. Gandy	28	24	52
A. C. Brown	25	25	50
D. Finigan	22	28	50
R. J. Morris	19	26	45
P. A. Dingle	19	22	41
N. Maclaren	23	12	35
E. F. Travers	21	8	29
A. S. Petrie	20	2	22
Total			324

DULWICH COLLEGE.

B. V. Cartmael	29	30	59
H. Raworth	28	30	58
G. L. Hall	29	27	56
H. A. Clark	24	25	49
E. S. Hall	20	26	46
H. J. Dear	23	22	45
H. L. Whitaker	21	16	37
P. G. Aldew	17	17	34
Total			384

INTER-HOSPITAL MATCH AT RUNYMEDE.

June 13th.

ST. BART.'S.

	200 yds.	500 yds.	600 yds.	Totals.
A. C. Brown	30	29	23	82
R. J. Morris	26	26	27	79
C. R. V. Brown	26	27	19	72
J. Morris	22	16	25	63
N. Maclaren	23	27	11	61
Total				357

ST. THOMAS'S.

	200 yds.	500 yds.	600 yds.	Totals.
C. de Z. Marshall	28	29	28	85
N. Cartmael	26	25	30	81
— Seymour	—	—	—	75
F. D. Vaughan	26	23	23	72
— Roberts	16	27	29	72
Total				385

Scores have not been received from Guy's. A Challenge Cup has been given for the winner of this match. This year it was shot for at the Prize Meeting of the United Hospitals Rifle Club, and won by Thomas's, while Bart.'s were second.

ST. BART.'S *v.* EASTBOURNE COLLEGE.

June 27th.

ST. BART.'S.

	200 yds.	500 yds.	Totals.
A. C. Brown	29	30	59
A. C. Newman	32	25	57
D. Finigan	26	29	55
R. J. Morris	29	25	54
J. Morris	27	25	52
C. R. V. Brown	20	22	42
P. A. Dingle	26	14	40
N. Maclaren	19	18	37
Total			396

EASTBOURNE COLLEGE.

Colour-Sergeant Jameson	25	29	54
Sergeant Teape	23	25	48
Sergeant Cawston	27	21	48
Private Etherington	24	24	48
Sergeant Smallwood	14	29	43
Private Mackenzie	15	23	38
Private Bartlett	19	15	34
Lance-Corporal Lake	26	2	28
Total			341

Unfortunately matches against Cooper's Hill, King's College, and Whitgift Grammar School had to be scratched.

Three Silver Spoon Competitions were held during the season at Runymede in conjunction with Thomas's and Guy's. The Bart.'s contingent were always to the fore in numbers.

An account of the Prize Meeting will appear next month.

Abernethian Society.

SESSION 1900—1901.

OFFICERS.

Presidents:—G. E. Gask, E. Talbot.
Vice-Presidents:—E. M. Niall, G. V. Bull.
Secretaries:—N. E. Waterfield, J. Corbin.
Additional Committeemen:—L. J. Pickton, I. J. Faulder.

PROGRAMME OF THE SESSION.

1900	*Author's Name.*	*Subject of Paper.*
July 5.—	Sir Dyce Duckworth, M.D.	The Pursuit after Novelties in Medicine.
Oct. 11.—	Mr. Anthony Bowlby, F.R.C.S.	Reminiscences of the War in South Africa.
„ 18.—	Dr. W. H. Hamer	Casual Coincidences in Medical Statistics.
„ 25.—		Discussions, Clinical and Pathological.
Nov. 1.—	Mr. F. A. Bainbridge, B.A.	The Relation of the Tissue to Lymph Formation.
„ 8.—	Dr. Paterson	Observations on Syphilis.
„ 15.—	Mr. H. D. Everington, M.B.	Some Points in the Management of Sick Children.
„ 22.—		Discussions, Clinical and Pathological.
„ 29.—	Dr. Langdon Brown	
Dec. 6.—	Dr. J. Morrison	Cæsarean Section.
„ 13.—	Dr. Drysdale	Leukæmia and Pseudo-Leukæmia.
1901.		
Jan. 10.—	Mr. T. Butlin, F.R.C.S.	
„ 17.—	Mr. Shrubsall, M.R.C.S.	Pre-historic Medicine and Savage Medicine of To-day.
„ 24.—		Discussions, Clinical and Pathological.
„ 31.—	Mr. W. McAdam Eccles, F.R.C.S.	Irreducible Inguinal Hernia, Illustrated by Lantern Slides.
Feb. 7.—	Dr. W. J. Collins	Public Office and Public Health in London.
„ 14.—	Mr. H. Burrows, M.B.	Euthanasia.
„ 21.—		Discussions, Clinical and Pathological.
„ 28.—	Mr. T. P. Legg, F.R.C.S.	Goitre.
Mar. 7.—	Dr. F. W. Robertson	Some Common Skin Diseases of Children.
„ 14.—		Annual General Meeting.

Volunteer Medical Staff Corps—No. 3 Company.

IN spite of the absence in South Africa of many enthusiasts of this Company, the attendance at Aldershot showed no falling off this year. Bart.'s men were very much in evidence at Thorn Hill camp, and in spite of the weather, which was phenomenally bad, they earned the commendation of their officers by their smartness on parade, and the way in which they made the best of very bad circumstances when off duty.

There are in the Corps men who have annually visited Aldershot for nearly twenty years, and they asserted that this year holds a record for bad weather; the second day in camp was a revelation in what this part of the country can do in this way, storms of rain and wind sweeping over the lines and doing considerable damage.

One night during the first week set in so boisterously that the commanding officer called for a party of twenty men to volunteer for the purpose of patrolling the camp till the morning, and looking after any tents which seemed inclined to collapse, and it is gratifying to know that the whole patrol was made up in less than ten minutes by members of No. 3 Company, who volunteered in a body; the two officers in charge being well-known Bart.'s men.

This spirit of self-sacrifice for the public weal is very creditable to No. 3 Company; of course, some ill-natured persons grumbled next day about that beastly patrol hammering their tent pegs right out of sight into the ground, often making bad shots and hitting the occupants of the tents through the curtains instead, "spoiling their night's rest!" The same people also remarked that "they did not know that patrol duty consisted in taking possession of the officers' quarters; condescendingly sleeping on their sofas, drinking their whisky, and smoking their cigars, eating their provisions, and using up a considerable quantity of their notepaper to write graphic descriptions of the campaign home to their relations and friends, occasionally going round the lines with a mallet hitting inoffensive people on the head through tent curtains;" but the fact cannot be denied that No. 3 Company kept the camp standing that night, and have a right to consider themselves heroes.

In past years the Aldershot camp has lasted only a week, but this year, being a special occasion, men were asked to volunteer for at least fourteen days, and twenty-eight days if they possibly could do so. All the men of No. 3 Company remained for the fourteen days, and a considerable section, undaunted by the elements, put in the whole month, and were rewarded by a fortnight's perfect weather.

Surgeon-Captain Miles, commanding the Company, expressed himself as being greatly pleased with the enthusiastic way in which the Company did their work, and the readiness which they always showed to undertake the special duties which stress of circumstances called upon them to do, and it must be owned that in spite of the weather and the inconveniences which it entailed, the spirits and joviality of the men did not for one instant flag, so that the summer camp of 1900 can be counted as among the pleasantest and most successful of these annual trainings.

The Corps as a whole mustered considerably over 50 per cent. of its strength; this is very satisfactory, especially as eighty of its members were away in South Africa with the army, and although the parades were not so long as in former years, a good deal of useful work was got through.

The Doctor.

(From *Bartholomew Ballads*, by F. W. Gale.)

A DOCTOR is a man who is everybody's man—
He never seems to have a moment's rest.
His system often feels the want of several meals;
He's forgotten how to get undressed.
He's out about all day, and he's up full half the night,
He's supposed to know all things beneath the sun
He's a "Whiteley" and a "Quain,"
With an automatic brain
And a British Museum in one—
In one;—
A universal everything in one.

(*Chorus.*)

Send for the Doctor, dearest!
Don't be a bit afraid—
We shan't get his bill till Christmas-time,
When he probably won't get paid,
My dear!
Send for the Doctor, dearest!
Tell him to come here, straight;
We shall *have* to pay the baker.
And perhaps the bonnet-maker;
But the Doctor can very well wait,
My dear!
I've a notion he'll have to wait.

He's supposed to give advice
On the ways of catching mice,
The pathology of whooping-cough and mumps;
And the kind of paint to use,
And the day they ought to choose
For painting up the parish pumps!
Then he gets a cordial greeting
At the local science meeting,
And unanimously put into the chair,
And expected to assist 'em
To discuss the Solar System,
And enumerate the microbes in the air—
In the air!
He must show a close acquaintance with the air.

(*Chorus.*)

And the pitfalls to be found
In his usual daily round!
There's the maiden aunt who says she's growing thin:
She's the last of his relations,
And he has some expectations,
So he dare not say, "It's owing to the gin!"
And the squire who tells him that
He is growing far too fat;
But the Doctor cannot bring himself to say
That the squire would grow much thinner
If he modified his dinner,
And took a few less lunches in the day—
In the day!
And confined himself to *two*, p'raps, in the day.

(*Chorus.*)

When he crawls into his bed
To rest his weary head,
There comes a furious ringing at the bell.
"If you please, sir, missus says,
Won't you come along at once?
She's afraid the baby's going to be unwell."
And he picks up from her tattle,
That the baby's lost his rattle
"And he swallowed it," she thinks the Missus said.
And the doctor tramps a mile,
And he's met with such a smile,
And he hears they've found the rattle 'neath the bed—
'Neath the bed;
They're sorry, but they found it 'neath the bed.

(*Chorus.*)

Reviews.

CATECHISM SERIES: SURGICAL ANATOMY AND OPERATIONS. Parts I and II. (Edinburgh: E. and S. Livingstone.) Price 1s. each.

Commencing as we did with a prejudiced view against such publications, our critique may perhaps be justly considered biassed; yet we doubt if any one will differ from us in condemning these "short cuts." Even the lazy student, hoping one week before the exam. to cram up skeletal facts, must needs be muddled often by such "aids," and, indeed, at times actually misled. Anatomy is not a subject that at the last moment can be "got up," nor is it easy to understand without an intimate acquaintance with the dissecting-room; and, when complicated by undecipherable diagrams and inaccurate text, becomes an insuperable task. Moreover, exams. are not the ultimate goal.

"Temporal" is frequently written for "superficial temporal artery." The angle of Ludwig is said to "correspond to the highest point of the arch of the aorta." Sections of limbs have no note as to which side they belong, or whether they are seen from above or below. A diagrammatic section of the carotid sheath does not in the least represent the overlapping of the artery by the vein. The posterior belly of the digastric is drawn as passing between the internal and external carotids. Much space is devoted to puzzling drawings of collateral circulation, whilst one third at least of the bulk of each volume is advertisements. It would be easy to add more defamatory criticisms did the work merit it. Perhaps the description of some operations is better dealt with, but most of these are so abridged as to be of little use. We are in no way favourably impressed with this style of literature, and cannot recommend it. It is to the qualified man useless; to the student a delusion and a snare.

Several other volumes of the Series are to hand, but of none of them can we in justice to our readers say anything more flattering than we have said of these.

ELECTRICITY IN GYNÆCOLOGY, by RICHARD J. COWEN, L.R.C.S.I., L.R.C.P.I. (London: Baillière, Tindall, and Cox.) Pp. 132, price 3s. 6d. nett.

Probably there are no two subjects in our art more difficult to manage than the treatment of disease by electricity and the treatment of gynæcological cases by any method. When, therefore, we come to the combination of electricity and gynæcology we come to a land of much debate. Of the two the gynæcological conditions so treated must first occupy our most serious attention in reviewing such a work as that before us, and no criticism of the actual electrical technique is called for unless the former be agreed upon as regards their pathology, and the bearings of general principles involved. Now this is just what we cannot agree to. We cannot agree that pus can be liquefied in suppurative salpingitis by the action of the posterior pole, or that the attempt should even be made; nor that pelvic exudations can be properly treated by puncture and the application of galvanism by means of the puncturing needle. Our knowledge of general principles refuses to believe a hæmatosalpinx can be absorbed at all safely by the same pole; and we should quite expect to hear the candidate, even in the year of grace 1900, had been plucked for saying he would prevent "further hæmorrhage" (in hæmatosalpinx) by the "astringent effect" of one or the other terminal. For ectopic gestation we read that attempts may be made to kill the fœtus, and that an anæsthetic may be required in "nervous patients;" "the sittings may be repeated twice a week until the cessation of the growth shows that death of the fœtus has taken place"! Shade of Matthews Duncan! *Rusticus expectat dum defluat annis.* Can Mr. Cowen judge satisfactorily in a week or two whether the sac is increasing? and what about the patient's risks during the interval of possible uncertainty? The controversy over the electrical treatment of fibroids needs no repetition, and nothing in the book alters the view that the treatment is too tedious, too expensive, too distasteful, and is scarcely less risky than the usually quite successful surgical treatment that ensues in bad cases when medicinal and expectant treatment, which, be it noted, usually accompanies electrical treatment, has failed. This, in fact, sums up our view of most of the treatment by electricity advocated for gynæcological cases. Possibly there is less to be said against it in certain cases of amenorrhœa, superinvolution, deficient involution, and endometritis. But even in these we doubt its necessity in the

first instance. The electrical departments of our leading teaching schools get few such cases. There is no reason why they should not. Such schools are anxious to cure their cases well and expeditiously. Yet they stay away therefrom!

The book is "particularly directed" to the general practitioner. Poor man! We think he generally succeeds in his time-honoured remedies Suffice it for him to know there is an electrical treatment of his gynæcological cases, and that Mr. Cowen is its sincere and enthusiastic prophet. Such a special branch of a specialised subject is fitted more for his friend in Harley Street, on whose bookshelf may the book rest in peace—not to say "shied." Still there can be no doubt there is a future for electricity in this connection, and Mr. Cowen's effort must be appreciated as an honest and praiseworthy attempt to grapple with it. But we are not quite in touch with his gynæcology, although his electricity may be, and probably is, less open to question. The electrical apparatus and preparations are great—*parturiunt montes, nascetur—ridiculus mus.*

MEDICAL MONOGRAPH SERIES.—No. III—APPENDICITIS, by A. H. TUBBY, M.S.Lond., F.R.C.S.Eng. (Baillière, Tindall, and Cox. Price 2s. 6d.).

This little book of 92 pages is well worth perusal, even if it may not be considered quite as exhaustive as its title suggests. The contents are arranged in eight chapters, and we are glad to note that but little space is allotted to the history of the disease and its treatment, which can seldom be more than merely interesting, and not pertinent to the discussion. Chapter II, "Anatomy of the Parts Concerned," is well treated, but we should have thought "Contents of the Appendix" were better described under pathology. Statistics of some 500 examinations are quoted No allusion, however, is made to the development of the appendix as a possible explanation of its abnormal position. Chapter III, "Morbid Anatomy and Pathology," is good. It is rather surprising though in the present year of grace to hear of "pus laudabile." Chapter VIII, "Treatment," might easily have been lengthened. The question of infecting the general peritoneal cavity in a case of abscess, whilst operating, is not sufficiently considered. Nothing is said of appendicectomy through the right abdominis muscle as prophylactic against herniæ, although some interesting percentages are given on subsequent herniæ. We should also like to have had some accurate observations upon wearing a truss after abdominal section.

In addition to the author's own ideas the volume contains a wealth of references and quotations, and not the least admirable is the fair balancing of the virtues of medical and surgical treatment of this *fin de siècle* disease.

OPERATIVE AND PRACTICAL SURGERY, for the use of Students and Practitioners, by THOMAS CARWARDINE, M.S.Lond., F.R.C.S. (Pp. 661; 550 Illustrations. Bristol: John Wright and Co. Price 10s. 6d. net).

Within a space of 630 pages the author attempts to deal not only with general surgery, but also with the surgery of the nose, larynx, ear, and eye. It is evident therefore that the subject must be treated in a brief manner, and, in fact, the book is meant to be used only in conjunction with other works on surgery. But a book of this size takes some time to read; as a practical guide it fails just where it would be most useful, as will be presently shown.

One has not to read much of the book before coming to the conclusion that the author's "note-book" has been largely drawn upon without modification, *e.g.* in the table setting out the differential diagnosis between cerebral and toxæmic states, the first point mentioned is the history that alcoholism and hysteria usually occur on Saturday nights. Why not Sundays and Bank Holidays? But at the bottom of the table is a piece of excellent advice, "Never discharge a patient for some hours, unless you are quite sure all the symptoms are due to alcohol or hysteria, and nothing else."

In the chapter on fractures most of the methods which have ever been used in the treatment of these injuries are mentioned and described. There is much that could be deleted in this chapter, and some statements which are certainly wrong. In the after-treatment of Colles' fracture it is recommended "that the splints in adults should be removed at the end of four weeks when impacted, and five weeks when not impacted (!) Occasionally passive movements may be commenced earlier. Great care should be taken to break down any adhesions which may form in the fingers and wrist. . . . . The patient should be warned that probably another six weeks will ensue before she has free use of the fingers." If such a line of treatment is adopted the wrist and fingers will be probably permanently stiff.

We question very much the advisability of including the surgery of special organs in such a book as this, even when dealt with by specialists in those branches.

In the section devoted to diseases of the iris and glaucoma, two of the most important affections in ophthalmic surgery, the ordinary symptoms and signs are not mentioned. Under the former heading a long list of mydriatics is given, without any indication how they are to be applied, the strength of the solution to be used. There is a description of the operations of iridectomy and sclerotomy for glaucoma which the general practitioner does not usually perform without the indications for the operations and the results to be expected. Very brief accounts of such common diseases as corneal ulcers, granular lids, and ophthalmia are given. Yet a page is devoted to pterygium and its treatment—an uncommon disease, and nearly two pages to the operative treatment of extropion.

Many of the illustrations could be discarded, and the additional space thus gained used to amplify the more important parts of the subject, which are dealt with very imperfectly.

Examinations.

THE following Bart.'s men were successful at the recent examinations at the University of Durham, September 17th to 22nd:

M.D.—M. C. Sykes, of Barnsley, Yorks, M.R.C.S., L.R.C.P., D.P.H.; Surgeon-Major C. J. Hancock, Assam Valley Light Horse, M.R.C.S., L.R.C.P., L.S.A.

M.S.—Major F. P. Maynard, I.M.S.

M.B., B.S.—C. M. Pennefather, M.R.C.S., L.R.C.P. (Second Class Honours), P. M. Perkins, R. Walker, M.R.C.S., L.R.C.P.

3rd M.B.—C. Fisher, M.R.C.S., L.R.C.P.

Appointments.

PRATT, ELDEN, M.D.Lond., appointed Honorary Anæsthetist to the Cardiff Infirmary.

* * *

PRIDHAM, A. T., M.D.Lond., appointed House Physician to the North-Eastern Hospital for Children.

New Addresses.

COCHRANE, A., c/o King, Hamilton, and Co., Calcutta.
FINCHAM, E. C., 36, Addison Road, Kensington, W.
PRATT, ELDEN, 36, Windsor Place, Cardiff.

Birth.

PEARSON.—On September 8th, at Alicedale, Cape Colony, the wife of Maurice G. Pearson, M.B., B.Sc., F.R.C.S.Eng., of a son.

Marriage.

STAWELL—KEY.—On September 5th, at Cushendun, by the Rev. Charles P. Greene, Rector of Clapham, Rodolph de S. Stawell, M.B., F.R.C.S., of St. Mary's Court, Shrewsbury, youngest son of the late Sir William Stawell, K.C.M.G., Chief Justice of Victoria, to Maud Margaret, second daughter of the late Admiral the Right Hon. Sir Astley Cooper Key, G.C.B., F.R.S.