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# St. Bartholomew's Hospital



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### St. Bartholomew's Hospital Journal,

OCTOBER, 1900.

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

### Reminiscences of the War in South Africa,

being the Opening Address delivered before the Abernethian Society, October 11th, 1900.

By ANTHONY BOWLBY, F.R.C.S.

**T**HIS seems a peculiarly appropriate date on which to speak of reminiscences of South Africa, for it is just one year to-day since the war in South Africa commenced, after the receipt by Great Britain of the only ultimatum ever sent to her by any country. The audacity of the Dutch Republics was the subject of very general comment, and it was difficult for Englishmen to understand by what possible hopes of success it could be

justified. No one here entertained the slightest doubt of the result of the war, and a cheap and easy victory was generally foretold when it was decided to send so large an army as that of 40,000 men. On the whole we certainly at that time despised our foe, and I think many of us would have been much surprised, as well as mortified, to find that they, for their part, despised us even more. Let me occupy your time for a few moments with this aspect of the subject, for to a large extent it explains how the Boers came to fight us.

I have spoken on this matter to various men who have spent their lives in the Dutch Republics, and they very justly say that the experience of the present generation of Boers largely justifies their contempt. They attacked and beat us at Majuba, and our troops then undoubtedly yielded to panic, and ran away. They had previously trapped and shot down a small force at Bronker's Spruit, and finally we yielded to their demands rather than fight to a finish. The natural conclusion was that we were afraid of the results, and that we had not enough troops to afford to lose more. Needless to say, our losses were exaggerated, and the great ignorance of the majority of the people left them quite satisfied that the Boers had defeated the whole British army, ridiculous as such an idea may seem to us. From that time forward the regular troops, or "rooibattjes," were literally despised, and then, when the colonial troopers of Jameson were also defeated and captured with practically no loss to the burghers, each Boer felt that he was a match for any number of British. This feeling was always most marked amongst the Transvaalers, for the more enlightened Free Staters were certainly not so arrogant, and undoubtedly treated our fellow-countrymen better than did their neighbours.

We can better enter into the feeling of the Transvaal Boers at the commencement of the war when we come to know what were their avowed intentions. They proposed to march straight to Durban, to occupy and annex Natal, and drive the English into the sea. That they entertained no doubt of their ability to do so is proved by the fact that

some of them arranged amongst themselves to celebrate their success by a ball in Durban on October 28th, for which purpose they provided themselves with dress clothes and spare cash. The latter was occasionally of more service to our men than to themselves, and one Tommy found himself the possessor of £70 as the result of fishing a dead Boer out of the Tugela.

A Boer commandant who was wounded at Talana Hill provided a still more striking example of the certainty of success entertained by the Transvaal executive as well as by the individual Boers. This man had been under the charge of one of our captured surgeons at Dundee, and, being grateful for his care, said, "If I can help you when you come to Durban I shall be very glad to do so, as I am going to be the Port Captain there." My friend expressed a mild scepticism, whereupon the commandant produced a document with his official appointment as Port Captain. He further explained that, though he did not know anything about ships, he had no doubt he should soon learn all that was necessary for his new career.

Such was the confidence of the Boers; let us see whether there was anything to justify it.

It is now, I suppose, common knowledge that for many years the Dutch Republics have been arming to oppose Great Britain, and it is generally believed in South Africa that they would have liked to postpone the struggle for another two years, so as to complete their arrangements, and arm the Colonial Dutch who sympathised with them. Events, however, marched too rapidly for them, and in the summer of 1899 they found themselves in a position in which they had to either yield to the just demands of this country, or show their hand and refuse all concessions. They decided on the latter course, and at the same time decided on declaring war before we could bring sufficient troops across the sea, and I heard in the Free State how arrangements for mobilisation and concentration were commenced in July, so that before the end of September large numbers of Boers had been massed on the Natal frontier, and also at Boshof, near Kimberley, and all sorts of warlike stores were collected at convenient places on the rail, and were augmented by large purchases in Europe. In the meantime President Kruger continued to hold us in play till preparations were complete for a sudden attack, and till the early rains of September should have provided the first spring grass needed for transport animals. It thus happened that at the end of September everything was nearly ready, and most fortunately for us all was not quite ready. It had been intended to declare war a fortnight earlier than October 12th, and in that case the struggle would have been commenced before the arrival of the 10,000 troops from India, so that beyond the troops under General Symonds in the north of Natal, and a garrison at Pietermaritzburg, there would have been nothing to oppose the Boer army. It must, indeed, be conceded

that the Boers were only too well justified, as events proved, in anticipating an easy conquest of Natal, for in spite of the arrival of the Indian troops we were shut up in Ladysmith, and despite the further arrival of additional reinforcements from England the Boer army came fully half way from the frontier to Durban. Had they been able to attack at the end of September, it is difficult to believe that they would have failed to reach Durban, with disastrous results to us. As it was, although the Indian troops were insufficient to roll back the tide of invasion, they were able to check it, so that Talana Hill, Elandsplaagte, and Ladysmith effectively held the Boer armies in check till still further reinforcements rendered Natal safe.

Turn next to the position in Cape Colony. Here we were placed at even greater disadvantage had the Boers only known how to make the most of their opportunities. Here were even fewer troops near the frontier than in Natal, and only about 3000 in the whole colony; and, considering that the Boers would have had no difficulty in crossing the Orange River with 10,000 men, it is curious to notice how for two or three weeks they held back, and even then only advanced in small numbers and in a half-hearted manner. Had they boldly invaded the colony on October 12th they would have gathered force as they advanced, and, with their army constantly joined by fresh Colonial Dutch, could have over-run the whole of Cape Colony along the main line of railway, and have captured all our accumulated military stores at De Aar and Naauwpoort, and might possibly have reached Cape Town itself.

I have always found it difficult to get an adequate explanation of such neglect to take advantage of opportunities, but it is pretty generally said that the Free Staters were much more afraid of the possible consequences of war than were the Transvaalers, and were very disinclined to invade British territory until the news of Boer successes round Ladysmith, and the still more tempting successful looting in Natal, decided them to attack. It is true that the temptations to capture Mafeking and Kimberley delayed many, but the commandoes which besieged these were mainly composed of Transvaalers, and the Orange Free Staters were the men who were slow to begin.

But although the Boer leaders neglected many opportunities that never again occurred, we know only too well what many successes were theirs in the early days of the war; and these successes in their turn resulted in a still further extension of that confidence in victory to which I have already alluded. Thus, after the battle of Magersfontein many Boers came back to Bloemfontein and its neighbourhood and announced complacently and confidently that now the whole British army had been destroyed; and the curators of the Bloemfontein Museum—educated men—issued a circular to the Boer commandoes, which I read, asking the men not to forget their national museum, but to bring to it relics of the defeated English soldiers, so that future generations of

Boers might have evidence of how the British had been driven into the sea.

Of course as the war progressed all these illusions were rudely dispelled, in spite of the efforts of the Boer leaders to keep the rank and file in ignorance; and the very heavy losses sustained in the attack on Waggon Hill, outside Ladysmith, on January 6th, did more to shake the confidence of the enemy than all the fighting that preceded that event. They still, however, confidently expected that the town would fall into their hands, for the capture of Ladysmith was to be the tangible proof to all doubting rebels that the Boers could beat the English and turn them out of the country; and their failure in this respect not only prevented a further rising of the Colonial Dutch, but for the first time opened the eyes of many of the burghers to the possibilities and probabilities of defeat.

Of the victorious advance of Lord Roberts from Modder River to Bloemfontein I will say nothing; but from that time forward the Boer resistance was broken, and the ultimate issue was never again in doubt.

As to the number of the Boers who took the field against us there has, of course, been the widest possible difference of opinion, and whilst I will not pretend to settle the question, I should like to tell you what I heard myself. I have been told quite confidently that the whole Boer army did not number more than 30,000 men, and I have been informed with equal assurance that it was not less than 90,000, whilst some of the newspapers were of the opinion that the foreign legion alone numbered at least 10,000. The best piece of evidence I had was the number of the identification card of a Boer who was commandeered at Bloemfontein in February. It was 65,700, so that we may assume that there were at least that number of fighting men, excluding rebels; and, as this man was one of the last to be commandeered, we may further assume that there were not many more than this number. Our Intelligence Department has in this matter been very unjustly blamed, for I believe that its information was that the Boers numbered from 60,000 to 65,000, and that it also supplied a complete and correct list of the Boer artillery. With regard to the Foreign legion, I had some direct information from one of its Commandants, and, from his statements and from others, I feel sure it never numbered more than 2000 men. The said Commandant was a German, who was shot through the thigh near Thaba 'Nchu, and subsequently lost his leg. He had a very poor opinion of the foreign legion, and said that they were composed of "the scum of Europe," and were scoundrels and blackguards. I think he was fairly accurate in his estimate. The numbers of the Cape and Natal rebels were also very uncertain; but, after hearing the most different opinions, I think they must have amounted to about 4000 to 6000 men.

The Boer losses are as differently estimated as are the

Boer armies, and I will not pretend to give any figures. I think, however, they were really very heavy. The greatest loss in any one day was at Waggon Hill, where about 300 were killed, and another 400 to 600 wounded. They also lost heavily at Pieter's Hill, Elandsplaagte, and Driefontein, as well as at Belmont, Modder River, and the siege of Mafeking. In the later stages of the war they lost many men in the numerous small engagements which marked the advance of the army to Pretoria, as well as round Thaba 'Nchu and De Wet's Dorp, and in the fighting in the Transvaal itself. The real total we shall never know.

As to sickness, it is certain that the Boers did not lose so heavily as we; but, on the other hand, their losses were by no means very slight. There was a great deal of dysentery at one time, and at Jacobsdal we found many sick Boers. Many died of what they vaguely called "the fever," and this was almost certainly enteric, from which, of course, they are not exempt; for it is well known that many of the Boer prisoners died of this disease at Simon's Town, and the percentage of recoveries amongst them was decidedly low. Why more of them do not die of illness in some form is certainly rather a mystery, for the ground at Colenso on which their camps had been pitched still smelt horribly when I visited it six months after they had left, and the habits of many of them were filthy to the last degree.

Of the Boer army itself, and of its commanders, very much that is contradictory has been written.

One fact is, that the Boer is neither so bad as some would make him out, nor so heroic as he is described by some of his Continental admirers. As fighting men they showed much of that stubbornness in defence which characterised their forefathers when the Hollanders, under William the Silent, were content to "die in the last ditch" rather than yield to the Spanish oppressor, and they held their position in silence at Colenso, Belmont, and elsewhere, under an artillery fire that was calculated to shake the nerves of even a veteran army. Their tenacity, however, was always to a large extent dependent on the fact that their retreat was secured if things became too hot for them, and the sight of a flank attack, or of the close approach of bayonets, always resulted in a retreat to their horses and a gallop to the next defensible position. They practically always declined battle in the open unless in overwhelming force, and they, as an army, completely lacked that disregard of death which in warfare has always made our own race such a formidable foe. Compare for a moment the behaviour of the two opposed armies when either of them was in face of an entrenched position. At Belmont, Modder River, Colenso, Driefontein, the British never hesitated to attack with a recklessness of consequences that was sometimes blame-worthy, and in every case they carried the positions, though not always at the first assault. Mark this: We never failed to ultimately take every position we attacked, at whatever

cost, and even though, as at Spion Kop, we had afterwards to abandon it.

Now consider the different behaviour of the Boers. At Mafeking, Kimberley, Wepener, Elands River, though in overwhelming force, they never were prepared for the necessary sacrifice of life required to take these places by direct attack or assault. Had they hardened their hearts and been prepared each man to be killed, if so be the position could be won, their success would have been assured; and although they did make one gallant attack on Waggon Hill and Caesar's Camp, here, again, their failure to capture these positions from an inferior force was due, not only to the extraordinary tenacity of our own troops, but to the fact that the several thousand burghers who were wanting to support their own men, already on the hill, never plucked up courage to send reinforcements across the open country under fire. Even when, as at Magersfontein, Colenso, and Lombard's Kop, they had hurled back our forces with heavy loss and temporary confusion, they lacked the initiative to turn a repulse into a defeat, and never seemed inclined to leave the safety of their own trenches and risk their lives to attain a great victory. No campaign was ever won by such tactics, and they have paid the penalty.

Of the Boer Generals I will say but little. They proved themselves generally capable men, though with the same lack of initiative in attack which characterises their armies. They thoroughly understood how to make the best use of their knowledge of their own land and were, as a rule, wisely placed in those parts of the country which each knew best. They had the inherent ability of recognising the best positions for successful defence, and were always quick to seize upon points of vantage. It is quite an error to suppose that the Boer armies were commanded by foreigners; this was certainly not the case. They had one or two expert artillerymen, sent by the Creuzot firm and other gun-manufacturers; but the guns were commanded and worked by the Boers, and that to the surprise and admiration of all beholders.

The Boer generals as a whole certainly played the great game of war according to its recognised rules; and there are plenty of our troops, both officers and men, who bear willing testimony to the behaviour of Joubert, Delarey, Botha, De Wet, and many others. Many of the wounded I have seen were in the hands of the Boer troops for some time, some of them for weeks or months, and almost all of them had been kindly treated and well cared for. It is, however, true that some of the generals certainly abused the use of the Red Cross, and utilised ambulances to conceal guns and ammunition, and many burghers without doubt kept Red Cross armlets in their pockets so that, if in danger of captivity, they could throw aside their rifles and cartridges and appear as hospital orderlies.

As to using the white flag in a treacherous way, I believe

that no Boer commander was ever guilty; but it is, of course, certain that on very many occasions it was so used by the Boer troops, when it seemed safe to employ it, for the Boer, who is naturally deceitful and tricky, no doubt looked upon the trapping of some unwary soldiers as a very meritorious act, and would in all probability be ready to boast of his success, and would be looked upon by many of his countrymen as a clever fellow; but for this their generals could not justly be blamed.

I would now ask you to turn your attention from the Boers to our own army, which was far the largest that has ever left our shores. The transport of the troops and their disembarkation went on day after day with the regularity and precision of a machine, and thousands of men passed northwards in a constant stream during January and the greater part of February. The weather was excessively hot, and the further north the hotter it became. I do not think the men minded it a bit. They were always in the best of spirits, ready to cheer every passing train, and exchanging chaff with the men who guarded every yard of the hundreds of miles that lay between the Cape and the frontier. I regret to say that much of Cape Colony was virtually the enemy's country, and that many attempts were made to destroy the line and to derail trains with troops, all happily without effect; but many thousand troops were required to obtain this result. It took about four days to get troops as far as De Aar, so that arrangements had to be made for feeding them at regular intervals at wayside stations, and abundance of food was everywhere collected and rapidly distributed at places where, only a few weeks before, you could not have fed half a dozen people. I am sure that the difficulty of sending up troops, stores, horses, guns, ammunition, etc., along a single line of railway, is even now not the least appreciated by many, even by those who have been at the Cape. Remember this. Any individual train of stores could only accomplish about three or four journeys between Cape Town and Bloemfontein in a month. Here was the great difference as compared with Natal, for Buller's camp at Chieveley was only about 150 miles distant from Durban, and a train could get there and unload and return in a day. Then the enormous bulk of the hay, and the service wagons, and the number of trucks required for horses, combined to make it difficult to supply sufficient trucks, whilst the steep gradients prevented engines from taking any long trains. Fresh engines and trucks could not be bought ready made in any part of the world, for the gauge of the Cape railways is different from that of any other line. In spite, however, of all these obstacles and difficulties, everything went right, and troops, horses, and stores passed from the sea to the battle in a steady stream.

But besides the transport by sea and rail, there yet remains to mention the horses, mules, and oxen, and the transport by road. Most of the horses and mules were imported, for those in the country were all too few. They

came from the uttermost parts of the earth, and were of all sorts and sizes. They travelled best in cattle ships, where they were not crowded in small boxes, and could be exercised in calm weather. Most of them were stiff and with swollen legs when they disembarked, and then had to spend one or more days in railway trucks before they got properly on land again. At Stellenbosch, near Cape Town, was the first of the remount depôts, and at Durban and the other ports were similar establishments, as well as higher up country, e.g. at Naaupoort and Springfontein, and at Pietermaritzburg and Mooi River. At such places the horses were kept in large camps, and exercised and fed for several weeks before they were in condition to be of any use for hard work, and then they were sent up as occasion required. These remount depôts were interesting and picturesque places, and there were often as many as 4000 horses or more at one of them. Each was superintended by several officers, and under them were a motley crowd of natives from India and from South Africa, in dresses of all sorts and kinds, and talking the strangest mixtures of languages. In the earliest part of the war the horses at these depôts were mostly English or Argentine, the latter being short thick horses, just like those depicted in Roman chariots, and quite unmistakable. Almost all the battery horses, and those used for wagons, etc., came out of the London and other omnibuses, and none did better than these, or stood hard work so well. Later came horses of a good class from Canada and Australia, smaller horses from India, and sturdy Burmese ponies so small that the rider's feet nearly touched the ground on either side, and well-bred looking horses from Hungary, and Basuto ponies, thickly built, and characterised by their small feet and low withers, and no doubt others besides. Never was such a collection of horseflesh. It is sad to recall how many of them died, and the reasons why they suffered so much more than the Boer ponies are not difficult to find. In the first place, they had on the whole much harder work in the hottest weather than fell to the lot of any of the Boer ponies. When French marched to the relief of Kimberley it was on the very hottest day of the year; the ground was very heavy and sandy, and for more than thirty miles between the Riet and the Modder rivers there was no water. On that day, February 13th, in one battery alone eighteen horses died, and in one cavalry regiment over sixty, and this more from the heat and want of water than from the mere work. My own horse was one of the comparatively few who still survived when our troops reached Bloemfontein. Next as a cause for our horses knocking up came the inevitable effects of the long voyage and the change of climate and food. It is estimated in South Africa that it takes at least six months to acclimatise a horse when imported there, but ours had frequently to be put in work within a few weeks of landing. Then came the unavoidable difficulty that horses which left England in

our spring or summer arrived in Africa with their summer coats in the middle of the Boer winter, and had to stand out in the open, often with many degrees of frost, all night, so that in the early morning they were often stiff and miserable. The food did not suit all of them, and in wide-reaching cavalry marches food was often very scarce, whilst after Paardeberg and the loss of our convoy the horses were nearly starved. Finally, the horses were called upon to carry great weights, for the kit and equipment of a cavalry soldier weighs from 4 to 6 stone, and many of them were not light riders. The riding weight of the cavalry was from 17 to 19 stone. From all these causes the mortality amongst the horses was very high, and the roads were marked with their bodies wherever our troops had marched. It must not, however, be supposed that the horses were neglected. Such was far from being the case. Efficient veterinary surgeons were supplied, and sick lines and convalescent camps were established. The best known of the latter was at Fischer's Farm, six miles from the Portland Hospital at Bloemfontein, and here some thousands of sick or hurt horses were sent during the months of April, May, and June. More than a thousand had to be shot, but many were either got fit again and returned to the front, or else were sent to the colony to be sold to the farmers. We were all of us at Fischer's farm many times, and it was always a pleasure to see how well everything was done, and what care was taken of the horses that were sent from the front. It will give you some idea of the loss of horses if I remind you that it is estimated that our mounted troops here had at least three horses each on an average. In one cavalry regiment I know of only two of the original horses remain, and one of these has been wounded six times and is going strong. He is a grey horse, and was perhaps more shot at for that cause, as grey horses show up more plainly than dark coloured animals. For this reason many grey horses were dyed "khaki colour," the whole of the "Scots Greys" being thus altered by the application to their coats of strong Condy's fluid. It produced the desired colour at the time, but the troubles of horses and of human beings were in this respect alike. Once they took to dyeing their hair, they had to go on with it and repeat the process, for the dye was constantly wearing off, and the grey hair beneath insisted on growing up.

Almost as important as the horses were the oxen and the mules. These did all the wagon work of the commissariat and transport departments, horses being reserved for more purely military purposes. The ordinary ox wagon is about sixteen feet in length, and is built mainly of large and heavy pieces of wood, very little iron being employed in its construction. It is both very heavy and very strong, and is capable of carrying several tons; some of them have springs, but most are springless. Such a wagon when loaded requires a team of sixteen or more oxen, for the roads are merely tracks, and are often deep with mud or dust, and

the banks of the "drifts," or fords across streams and water-courses, are often exceedingly steep and stony. In some such places, indeed, sixteen oxen are all too few, and it is quite a common thing to use double teams of thirty-two to pull a wagon over a difficult place. The oxen are guided by a boy leading the first pair, whilst another Kaffir, armed with a whip like a salmon rod, both guides the rest of the team and keeps them up to their work; no reins are used.

The custom is to let the oxen graze by day, and to begin their journey a little before sunset, as in this way they both feed better and escape the hottest part of the day. Their ordinary pace is two and a half to three miles an hour; but for short distances they can travel much faster than this. It was by these oxen and wagons that the greater part of all stores were sent to the front and to the camps, and several thousands must have been in use. The oxen themselves are large animals with long spreading horns, and each of them is known by name, and has his place in the team. The Kaffirs know their own oxen amongst a thousand others, and it is quite extraordinary to see how quickly they recognise their own animals in such a huge herd, and get them into their places. It is significant of the estimation in which our countrymen were held in the Transvaal and Free State before this war to learn that the worst ox in the team, and the one which was most beaten, was commonly named "the Englishman."

The cost to the army of a team or "span" of sixteen oxen with an ox-wagon and two Kaffirs was either £2 5s. or £2 10s. a day: and it will help you to realise the cost of a war when I tell you that the ox transport alone for the heavy howitzers of the siege train was at the rate of £30,000 a year for four guns. I was told that the little bill which had to be paid to the contractor for the loss of the convoy of 116 wagons near the Riet River on the march to Paardeberg was £66,000; and the raids of the enterprising De Wet on Rudeval station, the railway line, and our convoys must have cost us several hundred thousands. I only wonder that the war bill is no larger than seventy millions at present.

There is really a great deal more that might be said about the transport service, but I must pass to other matters. Of the Commissariat arrangements it is impossible to speak too highly. It is quite certain that no army was ever so well supplied with food. Stores of every sort and kind came in abundance from home, and were pushed to various railway centres towards the front. We were almost entirely dependent on rations ourselves, the food was excellent, and plenty of fresh meat was generally obtainable, as well as good supplies of vegetables nearer to Cape Town. The army bakeries supplied good bread as a rule, and on the march the troops had biscuits instead of bread. They looked rather like dog-biscuits, but personally I liked them, and thought them excellent. It is, of course, the case that on many occasions our men were very short of food, but

this was practically always due to the action of the enemy in destroying bridges or railway lines, or in capturing or threatening the line of march of convoys. The rations for the sick and wounded in hospital were also excellent, and would compare favourably with the food at most London hospitals; but here, again, the action of the enemy often made it difficult to obtain at the front the rations and stores which were in abundance at the base.

I have so far put before you, as well as the limits of my time will permit, a few of the salient points which seem to me of interest in connection with the transport and commissariat departments, and will now turn for a brief space to the sick and wounded, and to those who were called upon to take care of and make provision for them. Perhaps the simplest thing would be for me to read you an extract from the evidence I gave before the Royal Commission, when at Cape Town, as it will serve to remind you of the conditions created by war. Here is the extract:

#### "THE WORK OF THE R.A.M.C."

"I am very glad of the opportunity of expressing my unstinted admiration of the R.A.M.C. From the highest to the lowest they have striven to do their utmost for the sick and wounded. The general arrangements have been excellent, and much of the work has been of the most arduous description. It is difficult now to realise the conditions under which much of the work had to be performed some months ago. A blazing sun, myriads of flies, clouds of dust, with occasional tremendous rainstorms, combined to make medical and surgical work most trying; and it must also be remembered that those who worked in the hospitals were constantly going sick, and that the proportion of illness amongst them was very great. It is easy enough to criticise and to pick holes, but it has seemed to me that it is really difficult to realise the forethought and organisation, and the personal labour and anxiety which must have been required to treat thousands of men widely scattered over an immense country with few railroads, and to maintain large hospitals in easily accessible places. Such excellent results could hardly have been anticipated as have actually been realised."

Let me give you one remarkable example of energy and promptitude in connection with the R.A.M.C.

Just before the battle of Colenso Colonel Galloway wired to Major McCormack, at Durban, that a large number of stretcher-bearers were required at once. This wire was received at 11 a.m. By one o'clock placards signed by the Mayor were displayed throughout the town inviting all volunteers to come to the Town Hall at 3 p.m.; and before 8 p.m. that night 850 men had been medically examined, given kit, and sent off by train. Before next day was over this number had been increased to 1500, and many of these men actually arrived at Colenso whilst the battle was in pro-

gress, and went straight from the train to the battlefield. It would be hard to beat this record.

\* With regard to the state of affairs at Bloemfontein, of which so much has been written, I will first say this. It is most undoubtedly true that there was much sickness and suffering, that the field hospitals were overcrowded, that at first the surgeons were all too few, and hospital equipment indifferent; but it does not necessarily follow that the medical department or anyone else was to blame, for this was a time of war, and war in an enemy's country, and war which had for the time left our army isolated and its lines of communication cut. Let us point to a few considerations which may prevent a too hasty judgment.

In the first place, it must be remembered that the first duty of an army is to defeat its enemies, and that in the attainment of this end an immense amount of suffering is likely to be entailed. To this object all else is subjected, and necessarily the transport and feeding of troops, the supply of ammunition, and the maintenance of horses and baggage animals have the precedence. To maintain an army with a single railway line is at best a difficult task, and to maintain an army as large as ours in South Africa, and to keep open at the same time more than 2000 miles of lines of communications, is a task which has never, I am told, been equalled.

In the second place, it must be remembered that the question of the movements of large hospitals to the front does not rest with the Royal Army Medical Corps alone; and that, on the other hand, nothing can be moved without the approval and orders of the Chief of Staff or of the General Officer in Command.

It necessarily follows that before one can decide whether anyone is to blame for the undoubted sufferings of our troops, we must know what were the military exigencies, and whether it was possible to move up hospitals and their equipment when there were urgent military needs to consider. It is also evident that before blame can be attached to those in charge of the medical arrangements, it must be shown that they were not ready or able to deal with these difficulties, and that the failure to supply hospitals and their equipment was not due to military exigencies, but to neglect of the necessary and obvious preparations. Only a full knowledge of the facts can enable unbiassed observers to form a just judgment, and I will merely content myself with pointing out that Bloemfontein itself was quite unable to supply anything at all to hospitals or troops. It had been practically cleared out, and for weeks after our troops arrived it was impossible to get into store more than a single day's rations for our army with the aid of the railway and the collection of stores and animals for a distance of many miles. The country was so swept of food supplies

\* The four following paragraphs are from an article by myself in the *Monthly Review*.

that the main reason the Boers never appeared in force to the west of Bloemfontein after we occupied the town was that there was no food for them or their horses in all that district. As far as Bloemfontein is concerned, it appears to me that the main question is, "Was the best use made of the railway, and were the hospitals, staffs, and stores ready to be utilised, or were necessary preparations neglected?" It is quite beside the mark to say that because there was undoubted suffering there was certainly someone to blame, though it may be admitted at once that the Boers were more to blame than anyone else, because they blew up the bridges and cut off our supplies.

The Commission, of which our senior physician is so important a member, will ere long be able to furnish more precise information, and I do not propose to in any way anticipate their report. Meantime, however, I have no hesitation in expressing my opinion of the people who seemed to consider that the military hospitals of South Africa were places where they could satisfy their idle curiosity as to war, and, being absolutely ignorant of everything concerning hospitals, nevertheless took themselves very seriously as critics. There were plenty such, and whilst some of them were content to spread scandalous statements in conversation only, others have gone further, and have traduced wholesale in print the surgeons, orderlies, and nurses. Too much attention has already been paid to them in England. If you knew the personal character of some of these people, whose real object is generally self-advertisement and not the genuine desire to make things better than they are, you would think no more of what some of them have written than we did in South Africa.

As far as wounds are concerned, you will, of course, not expect me to go into details of cases; but it may be stated in general terms that the very large majority of the wounds were caused by Mauser bullets, and that only a small proportion were caused by other bullets or by shells. I cannot speak of the wounded in the Boer army from personal knowledge of large numbers, but nearly all of their wounded who came under my notice had been hit by Lee-Metford bullets, which very closely resemble the Mauser bullets and cause similar wounds.

I have already written of these wounds in our *Hospital Journal*, and you have also had plenty of opportunities of reading about them elsewhere, so I will now content myself with saying that all such bullets cause very small wounds in the soft tissues, and that these rapidly close after the passage of the bullet in many instances, so that not only is very slight damage caused, but wounds heal very rapidly.

As to the so-called "explosive" bullets, there were but very few of them in use in the early days of the war, but later on they were much more resorted to, though the vast majority of the wounds were not inflicted by them. None of these bullets that I have ever seen were really "explo-

sive" in the proper sense of the term, *i.e.* none of them contained an explosive substance to burst the bullet, as the bursting charge of a shell explodes a shell case. The difference between them and the bullet commonly used in the Mauser and Lee Metford rifles was this. In these latter the lead of the bullet is contained within a hard casing of nickel steel, so that the soft lead does not expand on meeting with resistance. In the "explosive" bullets, which ought to be called "expanding" bullets, this hard case is incomplete, so that the lead can bulge through the aperture and spread out into a larger mass on striking a resisting object, such as a bone. Such bullets are in use all over the world for sporting purposes, and are extensively used for game-shooting in Africa. My friend and colleague Mr. Wallace, whilst attached to the 9th Division, collected a large variety of these expanding bullets when the Boers evacuated Winberg, and has very kindly sent them here this evening.

Of shell wounds I have but little to say. We saw but few of them, and I think they were more numerous in Natal than in Capc Colony and the Free State. In general terms, the wounds caused by shell fragments may be said to resemble the lacerated wounds we see in London hospitals, which are caused by machinery of different kinds, and necessarily they vary immensely, according to the size of the fragment which inflicts the injury.

All shells fall into one of two classes:—first, shrapnel; second, common shell. The shrapnel shell consists of a metal case containing round bullets of various sizes, which are packed inside in different ways. It is exploded whilst in the air by a charge, which blows off the cap or head of the shell and then the contained bullets are scattered by the momentum of the shell itself. Each shell contains from 140 bullets to 200 or more. Shrapnel shell is seldom made in sizes larger than 15 lbs.

The common shell is made in all sizes, from the one pound, "Pom-pom," to shells of several hundred pounds weight. They are hollow, conical masses of metal, and are ordinarily exploded by a contact fuse, which detonates the charge of explosive in the hollow of the shell when the latter strikes the ground. This explosive may be gun cotton, cordite, or lyddite, and the charge being a very large one, the danger of such shells is from the fragments of the metal shell case itself, which is shattered by the explosive force, and scattered in all directions. Some of these fragments of large shells may weigh ten or a dozen pounds or more, and may be large enough to tear a limb off, or to decapitate a man.

I think there can be no doubt that of men hit by shells a very much larger proportion are killed than of those hit by bullets, and very erroneous conclusions may be drawn if we estimate the damage done by shell fire according to the wounded who come under treatment. There may be few wounded to treat, though not a few men may be killed.

With regard to the effect of our lyddite shells, I think there is no doubt that in the early days of the war they proved very disappointing, and the reason for this given me by an artillery officer is worth mentioning. He said that he attributed the failure to the fact that the shells were all fused for naval use, and were intended to penetrate the armour of a ship before bursting, the result being that they sometimes did not burst at all when striking on the soft earth, or that they so buried themselves before bursting that they did little harm.

Of the British Army as a fighting machine it is quite unnecessary for me to speak at all, for everyone is now aware of the gallant behaviour of all ranks, and of the patience, and determination, and endurance, which were quite as valuable qualities as mere gallantry. Let me, however, point to the opinion of others who were not Englishmen. I had the opportunity of speaking with Albrecht, the commander of the Free State artillery, after he was captured at Paardeberg, and in discussing the qualities of our troops he said, "Your infantry are splendid fellows, and your artillery is magnificent. The only fault is that they are too brave." And I thought that this was very excellent testimony from one who has proved himself a brave man in the field.

The military *attachés* on some occasions were also most outspoken, as you may learn from what one of them said, whose opinion was best worth having. After discussing the qualities of the various arms, he summed up his opinion as follows:—"I shall always say there is no other army to compare with the British. For courage, dash, staying power, discipline, and all that makes for success with an army, there is no other like it;" whilst on another occasion a more emotional foreigner said, "Ah, your Tommy is a splendid man; he march on always, he never get tired, he fight all day; I love him like a brother," and repeating, "I love him like a brother," he fell on an adjacent Tommy and kissed him on both cheeks; but history has not recorded what Tommy said.

Of the endurance and marching qualities of our men it would, indeed, be impossible to speak too highly. Look at the record of the Guards Brigade. They fought and marched, nearly a year ago, from Orange River station to Modder River; then, at a later period, from Modder River and Paardeberg to Bloemfontein, fighting the battle of Driefontein *en route*. Thence they marched and fought to Pretoria, 300 miles away, and then did nearly another 300 miles to near Komati Poort. On one occasion they did thirty-eight miles in twenty-eight hours; and, after fighting and marching near Dewetsdorp in May, fourteen Grenadiers carried a sergeant with a fractured thigh on a stretcher forty-two miles to the Portland Hospital. When Tucker's division was pursuing Cronjé, his troops marched thirty-four miles in twenty-four hours, under a blazing sun, and although from time to time men and officers fell out

exhausted, and had to get into one of the baggage-wagons, they insisted on rejoining the march as soon as they could again get along. Again, on the advance from Kroonstadt to the Vaal our whole army marched ninety miles in six days, each man, with his rifle, rounds of cartridges, bedding, and canteen, carrying 41 lbs. Hear what the *Times* correspondent justly said of this:—"When I watched the infantry crossing the Vaal this morning, laughing, shaking each other by the hand at the birth of another invasion, I realised that, all said and done, the British infantry, as it ever has been, is the stay of the empire." The French *attaché* could not disguise his admiration, and said:—"The marvel is, you can march them at any hour of the day, all day, and anywhere, and yet they do not tire. We would never think of treating our infantry as you do yours."

So much for the marching power of our men, though many other examples might be adduced; and then consider their heroic stubbornness when in difficulties. Every one knows the details of the sieges of Ladysmith, Kimberley, and Mafeking, so of them I will say nothing. But let me remind you of what happened at Wepener. Here we had about 1500 men surrounded by 5000 Boers, with a numerous artillery. The position was one almost impossible to defend; shelter from pouring rain and sun there was none; the trenches were at times waist-deep in water, and the open ground was so exposed that no man could leave the trenches all day, and if wounded, had to wait till night-fall for aid. Not only did our men, most of whom were Colonials, and under a colonial officer, never dream of surrender, but many of them, after being wounded, insisted on returning to the fighting line. One trooper of the Scouts was shot through the cheek and neck, the bullet then passing through his chest and out at his back; yet he reported himself for duty on the tenth day, and returned to the trenches. On another occasion six men volunteered to carry ammunition across the open to men who had come to the end of their cartridges, and were in great peril. Of the six men five were shot down, more or less severely wounded, but the ammunition was brought in, and the position was saved. No wonder that after seventeen days of siege and assault the Boers gave up Wepener as too hard a nut, after losing 500 men killed and wounded.

The defence of Wepener was, indeed, one of the most gallant affairs in the war, and was only equalled, in my opinion, by the equally gallant behaviour of the Australians under Colonel Hore at Elands River, where, exposed to the fire of an overpowering artillery, and surrounded and outnumbered many times by Boers, they held their own for three days in the open, lost a fifth of their men killed and wounded, and nearly all their horses, but saved the convoy trusted to them, and were finally rescued. The defence of both Wepener and Elands River showed that the colonial troops were as stubborn in defence as they had shown themselves gallant in attack, for from the

earliest days of the war they had always done well in attack.

One of the first opportunities which the South African Colonials had for distinguishing themselves was afforded at the battle of Elandslaagte, where the Imperial Light Horse showed to the world at large, and the Boers in particular, that the outlanders of Johannesburg comprised men who were second to none in courage. They stormed the kopjes side by side with our own infantry, and lost both their own colonel and many others; but, on the other hand, they gained at once the recognition of the whole army as men fit to fight beside any troops, and one of General French's aides-de-camp who was present said to me, "I tell you they are the bravest men I ever saw—quite the bravest. They raced our own infantry to get up to the Boer positions, and never seemed to care for bullets or to mind being shot."

Only a few weeks later the New Zealanders had their opportunity and took it, near Colesberg. A company of the Yorkshire Regiment held the point of a long hill with steep sides, and up this in the dusk of the morning several hundred Boers crept. They reached the summit unobserved, and then, rushing up to the wall of stones our men had built, put their rifles over it and fired into the midst of the Yorkshires. Down went twenty-five out of about seventy men at once, the colour-sergeant and five men killed, and others and the captain (afterwards my patient and informant) wounded, and no officer left to command. The camp of the New Zealanders was a couple of hundred yards further back. Their officer at once realised the danger, and, calling on his men to fix bayonets and charge, he caught up with him the rest of the Yorkshires, headed by a corporal, and swept the Boers over the hill edge, with a loss to them of twenty dead left on our hill, and many more killed or wounded before they escaped beyond range. The kopje is known as New Zealand Hill, but the young officer who led the charge now lies buried in the Free State.

I must not, however, go on giving you more examples of the soldierly qualities of our infantry, but I should like to refer very briefly to our gunners. None of our troops have done better than this branch of the Service, and over and over again they have saved the situation when things looked very bad. Take, for example, Magersfontein, where two batteries of horse artillery supporting the Guards Brigade alone prevented further disaster. Exposed in the open to both artillery and rifle fire they fought their guns, with heavy loss to men and horses, from early dawn at 4 a.m. till late afternoon. They were the admiration of all the troops, and one of our officers said to me afterwards, "They saved us all. I'll take off my hat to G Battery for the rest of my life." This, of course, was only an isolated instance; but the gallantry of Q Battery at Koorn Spruit, and the splendid courage shown in the attempt to save our guns at Colenso, well indicate that there were plenty of other occasions as well to which I might easily allude did time

permit. As to the guns themselves, you no doubt have seen innumerable letters from all sorts of people to demonstrate that the Boer artillery was much better than our own, and made better practice, and that our own guns were obsolete and nearly useless. There was never greater rubbish written. The correspondents seemed generally oblivious of the fact that a hundred-pounder always carries further than a light field gun, and always will; but if you compare heavy guns with heavy guns, and field guns with field guns, then the balance is on our side. It is true that the Boers had the Vickers-Maxim batteries, or, as we always called them, "Pom-poms," and that we did not get any till late in the war. But I would remind you that it is still a very open question with experienced men, who have both used these guns and fought against them, whether they are much good. They take nearly as much transport as a twelve-pounder, and the little one-pound shells they throw have so small a bursting charge that they cover a very small area, and are more like exaggerated bullets than shells. Considering the number of them used they hit very few men.

And now the time at my disposal requires that I should bring this address to a close, though not for lack of more to tell, for, truth to say, of reminiscences of South Africa I have no end, though many are too purely personal to be of interest to others. I must, however, say a very few words in recognition of the universal kindness and consideration with which my colleagues and myself were treated by all branches of the Service. A jealous medical corps might easily have been inclined to resent the intrusion of a civilian hospital, but there was actually no sort of feeling of this kind. On the contrary, we remained throughout our stay in Africa on the most friendly terms possible with army surgeons of every rank, and returned feeling that we left many friends behind.

At Bloemfontein we were in the midst of a large camp, and, partly owing to the very numerous officers we admitted, we were shortly acquainted with men in every branch of the Service. From the generals downwards they did their best to make us feel at home, and they fully succeeded in doing so. The tone of the whole army was admirable; officers and men alike did their duty, and put a good face on difficulties and disagreeables, and when we had a band and football match on a Saturday afternoon, and the Portland Hospital was the recognised rendezvous for our numerous acquaintances, it would have been difficult to find elsewhere a more genial and cheery assemblage.

You will gather from what I have said that I am a whole-hearted admirer of our army. I do not know that I have ever been anything else, but if I had been my experiences at the seat of war would have turned the scale. I am not so foolish as to think that everything in the army is perfect, or that it is not in need of reforms. I suppose there never was, and never can be, a perfect army, for it is composed of

individuals many of whom are by no means perfect. But there is infinitely more to admire than there is to criticise, and it must be remembered in reading the newspaper effusions of amateur critics that even a fool can find fault, though it needs a wise man to allot praise.

For myself, I can only say, in conclusion, that I take a legitimate pride in the fact that I have taken my place and acted my part as a unit in an army of which our nation is justly proud, and that amongst the most pleasant reminiscences of my life will be my reminiscences of South Africa during the War.

### Two Cases of Tetany.

By W. N. SODEN, M.D.

THE following cases, which have recently come under my notice, will, I think, interest some of your readers.

On September 1st, at 2 p.m., I was called to see Mrs. A—, æt. 23, whom I was engaged to attend at her fourth confinement. The pains were irregular, and almost entirely abdominal, without intervals of complete rest. The abdomen when examined revealed nothing abnormal, except that there was a good deal of flatulence. She had been awake with similar pains all the previous night, and had refused all food as she felt sick. The os would admit two fingers, but the head had not engaged in the brim. I ordered her an egg and milk with two teaspoonfuls of brandy, and left her. I returned again in the evening and found her in the same condition, the head not having advanced, and as she was tired out with the useless pains, and could take no nourishment, the egg and milk having been vomited unaltered, and her pulse having much increased in frequency, I ruptured the membranes, and after a short interval put on the forceps and delivered her without any difficulty of a full-term living child. She seemed much relieved, and was apparently better, there being no marked abdominal distension when the binder was put on. I gave her a mixture of ergot, nupentha and spirits of ammonia to relieve after-pains, and left her at about 9 p.m.

At 2 a.m. I was called up to see her as "she had gone quite stiff." I found her lying on her back, with rapid and very laboured breathing, while her hands showed a condition of tetany so typical that it would have exactly answered to the text-book description (a peculiarity I have learned to find somewhat exceptional in general practice). She complained of the cramps in her arms and legs, and of the great difficulty in breathing. Her face was fixed and anxious, with eyes staring; the heart sounds could not be distinguished, nor the pulse felt at the wrist, and her nails were blue. This I put down to the terribly laboured breathing, which was accounted for immediately on examining the abdomen, which was as large as before delivery, the upper rather than the lower part being prominent. On percussion the stomach proved to be distended with flatulence (the bowels less so) pressing upwards against the diaphragm. The tetany, I confess, I was unable at the time to account for. I gave her a mixture containing bismuth, strychnine, alkalies, and carminatives, and ordered hot fomentations to the abdomen, and an enema containing assafoetida. In the morning her condition was but little improved; the enema had resulted in nothing but the passing of a little flatus, the stomach being more distended than before, reaching from the lower border of the fifth rib in the nipple line downwards to the level of the anterior superior spine of the ilium, and the breathing was still terribly laboured. I passed a stomach tube, and drew off between three and four pints of a sour greenish fluid, and washed out with warm water, but very little flatulence escaping at the same time. This relieved her but little, and the dyspnoea increasing she died at 2 p.m., eighteen hours after confinement, with all the symptoms of asphyxia, her temperature not having risen above normal.

On September 7th, nine days after the previous case, I received an urgent message to see Mrs. S—, æt. 34, a Jewess, and therefore neurotic, who, after an attack of abdominal pain and much vomiting,

which considerably alarmed her, suddenly was seized with cramp in the hands and fore-arms. When I saw her the tetany, for such it was, as typical as in the previous case, had partially passed off. The previous case being vividly in my mind, I anxiously examined the abdomen, but found no more distension of the stomach than is usual in such gastric cases, the stomach resonance not reaching lower than one inch above the umbilicus, and there being no dyspnoea and no rise of temperature. Regarding the tetany in this case to be rather a neurosis than due to absorption of poisonous material from the stomach, I gave a good prognosis, and prescribed bismuth with bromide and a saline purge, and small quantities of liquid nourishment at intervals. The tetany passed off in about six hours from its onset, and next day she was practically well. She had previously suffered considerably from indigestion, and had just had her period.

The contrast between these two cases is striking, as also is the coincidence of seeing again so soon a case presenting the peculiar condition of tetany associated with gastric distension, and yet differing so greatly in severity.

The first case I look upon as acute paralytic dilatation of the stomach, the cause of which, so far as one is able to assign a cause, was probably exhaustion due to the want of nourishment and sleep, together with that consequent on the somewhat prolonged labour, in a woman who had previously suffered considerably with indigestion and flatulence.

When one comes to consider the cause of the tetany, as far as I could find, after the necessary reference, it is generally supposed to be due to the irritation of the nerve centres of certain groups of muscles by some unknown poison or toxin produced in the process of fermentation of the contents of the stomach.

In the second case, occurring, as it did, in a woman of marked neurotic temperament, it is difficult to tell how far the tetany was merely a hysterical manifestation, and how far it was due to absorption from the stomach, which notwithstanding the vomiting was considerably distended with gas. The vomiting shows that there was no paralysis, and it emptied the stomach of its contents, preventing further absorption of toxins, which would, presumably, if retained, have kept up the tetany.

I report these cases partly on the grounds of their rarity, and partly in the hope of hearing other opinions and criticisms on them.

### A Case of Suppurating Hydatid Cyst of the Liver, with Complications.

By F. A. BAINBRIDGE, M.B.

G—, æt. 23, was admitted to Faith Ward suffering from abdominal pain.

The patient gave a history of a number of attacks of epigastric pain, accompanied by vomiting and constipation, lasting several hours, and occasionally followed by transient jaundice; the pain extended into the back and between the shoulders, but never downwards towards the thigh. The first attack occurred nine months before admission to the hospital. There was no history of cough, expectoration, or dyspnoea.

On admission the patient looked sallow, and had rather a "muddy" complexion, but was not jaundiced. She had an intermittent temperature ranging from 99°—103° daily. Respiration (24—28) quiet and easy. Pulse 112, soft.

*Chest.*—On percussion of the right side of the chest, the line of dullness was found to begin at the fourth rib in the nipple line, seventh rib in mid-axillary line, and ninth rib behind. The air entry all over the right lung was poorer than over the left side, and at the right base expiration was prolonged, and the voice sounds increased. The heart was normal in all respects.

*The liver* was just palpable under the costal margin, and there was slight tenderness in the region of the gall-bladder.

The urine contained a trace of albumen.

An empyema was diagnosed, and pus withdrawn by an exploring needle.

On the following day the seventh rib was resected in the axillary line; with the finger a mass was felt bulging towards the wound.

A director was pushed into this mass, which was at first supposed to be a bulging empyema, and pus was found. As soon as the abscess had been fully opened a large quantity of yellow pus containing hydatid cysts poured out.

Further examination showed that a hydatid cyst of the liver had been opened through the pleura; both the liver and lung were adherent to the diaphragm, and a good deal of pus escaped into the pleural cavity. After some consideration the pleural cavity was thoroughly flushed with 1—8000 mercuric iodine of mercury until the fluid came back clear. The pleural cavity was closed by sutures, and completely shut off from the liver, abscess, and the wound. The abscess was drained, and the wound closed and dressed.

The patient's temperature fell after the operation, became normal four days later, and has not risen since then. On the day following the operation the patient's respiration and pulse became very rapid for a few hours, but she had no cough. The discharge from the abscess, though deeply bile-stained, is rapidly diminishing, and the patient is on the high road to recovery, and the right lung appears to be normal.

Apart from the diagnosis, the main interest of this case lies in the fact that no empyema followed the operation, although a considerable amount of pus escaped into the pleural cavity; this satisfactory result was doubtless due to the thorough manner in which the pleural cavity was washed out during the operation. Irrigation of the pleura is a practice which has been much deprecated on the ground that sudden death is apt to occur. But when the lungs and heart are sound such a risk must be comparatively small, and the above case certainly seems to justify the operator in subjecting the patient to such a risk rather than add an inevitable empyema to a case already sufficiently serious.

### Case of Extra-uterine Gestation: Diagnosis of Appendicitis.

By W. T. STORRS, M.R.C.S.

B—, æt. 23, admitted into President Ward, under the care of Mr. Harrison Cripps, on August 15th.

*History of present condition.*—Three weeks ago patient was suddenly seized with severe pain, referred to the lower half of the abdomen, and not localised to one side

more than the other. On the second day of her illness she felt sick, and vomited once. Pain localised to the right iliac fossa. A doctor was called in, who told her she was suffering from "inflammation of the bowel." She was in bed seven days, and up to the time of admission had never been entirely free from abdominal pain. Bowels constipated.

*Past history.*—Always healthy. Always regular in menstrual periods up to the last two months; but since then she has had hæmorrhagic discharge every fortnight. This was found out subsequent to operation. Two previous pregnancies, both normal. Last confinement about fourteen months ago.

*Present condition.*—Patient does not look ill, and does not complain of pain. Temp. 99.2°, pulse 104. Abdomen not generally distended, but some obvious fulness in the right iliac fossa. In the right iliac fossa there can be felt a firm, well-defined mass; it is smooth, and manipulation causes very slight pain. Percussion note dull over the mass. It extends upwards above the crest of the ilium towards the loin, and can be traced downwards into the pelvis.

*Per vaginam.*—Os uteri in normal position; no distinct mass can be felt, but there is some tenderness on examination towards the right.

*Per rectum.*—On the right and somewhat in front of the rectal wall there can be felt a soft swelling. Examination caused considerable amount of pain.

*Diagnosis.*—Abscess, probably in connection with the appendix. September 16th.—Patient having been anaesthetised, Mr. Cripps made an incision over the swelling about four inches in length. The abdomen having been opened, the cæcum, with a healthy appendix, and the ascending colon were found pushed forwards by a distended mesocolon. The latter was then incised, and a large quantity of dark blood-clot evacuated. The hand was then introduced into the

cavity left by the removal of the clot, and passed down into the pelvis to the base of the broad ligament. The hand was then withdrawn, inserted into the peritoneal cavity, and the pelvis examined.

A swelling about the size of a pigeon's egg was found occupying the middle third of the free border of the right broad ligament. This was brought into the wound. The broad ligament was then ligatured on each side of the swelling, and the latter then removed. The incision in the mesocolon was sewn up, and the abdominal cavity closed in the usual way.

The patient made an uninterrupted recovery. The case is, of course, an ordinary one of extra-uterine gestation, with subsequent hemorrhage into the broad ligament. The hemorrhage must, however, have been considerable, and one would have expected a secondary rupture into the abdominal cavity, rather than the blood should have forced its way to the base of the broad ligament, and so far up the mesocolon.

### Notes.

DR. A. E. GARROD will deliver the Bradshaw Lecture before the Royal College of Physicians on Tuesday, November 6th, at 5 o'clock. Subject: "The Urinary Pigments in their Pathological Aspects."

WE would draw the attention of all members of the Amalgamated Clubs to the Annual Dinner, which will take place on Tuesday, November 13th. Particulars are given upon the printed slip enclosed in this number of the JOURNAL. We trust a better show of members will be made this year than last. It was for this purpose that the time of the dinner has been changed from summer to autumn, when all new members might turn up.

ON the occasion of the Association football match between Bart's and Hastings on Wednesday, November 14th, at Hastings, the Eighth Annual Tea and Smoking Concert will be held at the Castle Hotel from 5 till 7.45, the "Old Bart's Doctors" being the hosts, and Mr. C. B. Gabb occupying the chair.

WE are asked to announce that the British Medical Temperance Association will hold the Annual Breakfast meeting at the Cannon Street Hotel, on November 9th, at 8.30 a.m. Professor Sims Woodhead will preside, and speakers will include Mr. Pearce Gould and Mrs. Scharlieb. Tickets may be obtained from the Hon. Sec., Dr. Ridge, Enfield, Middlesex.

LAST month we accidentally omitted the name of M. D. Wood in the list of those who have taken the degree of M.D. at Durham University.

DR. GILBERT SMITH has been awarded the medal for the best M.D. thesis at the University of Durham.

MR. J. E. S. FRASER has been appointed Demonstrator of Anatomy at St. George's Hospital Medical School.

In the *Gazette* of August 4th we notice the following:—"Royal Horse Guards—Surgeon-Capt. H. Rayner, M.B., to be Surgeon-Major in succession to Surgeon-Lieut.-Col. J. S. Forrester, deceased. Dated June 19th, 1900."

MR. J. A. NIXON has been elected a President of the Abernethian Society *vice* Mr. E. C. Talbot.

IT is hoped that the thirty-sixth volume of the St. Bartholomew's Hospital *Reports* will be issued to subscribers before the end of the year. It will contain articles of unusual interest: memoirs of Sir James Paget and Sir Richard Thorne Thorne; plague experiences by Dr. Sandilands; a series of cases of volvulus by Captain Bird, I.M.S., and papers by various members of the staff.

STUDENTS and members of the Junior Staff and old Bart's men who wish their names to appear in the printed list of subscribers should give notice to Mr. P. F. Madden at once.

WE have already called attention to the meagre support which the *Reports* receive from the members of the Junior Staff and others, in the hope that many may still subscribe to the maintenance of a series whose value is well known throughout the world.

WE notice that Mr. E. C. Fincham, F.R.P.S., has three charming pictures hung at the Royal Photographic Society's exhibition this year. Her Majesty recently honoured Mr. Fincham by accepting, in a very cordial letter through her secretary, three snapshots taken by him in connection with the cutting of the commemorative inscription on the granite blocks at the west front of St. Paul's.

THE HON. Sec. of the Musical Society, Mr. J. A. Nixon, would be very glad to hear of, or see, any gentlemen connected with the Hospital who have musical interests, and who would practise in the orchestra for the forthcoming Christmas entertainment.

MISS ROLLESTON (late Sister Elizabeth), on her return to England, has pointed out a couple of errors in our reproduction of her interesting South African letter in the July number of the JOURNAL. We called a "quiet time" a "quaint time," and spoke of our contributor as being the "highest" instead of the "night" superintendent.

OWING to want of space this month we are compelled to hold over several reviews of books recently received.

### Calendar.

November, 1900.

- Nov. 1.—Abernethian Society, 8 p.m., Mr. F. A. Bainbridge, "The Relation of the Issues to Lymph Formation"
- " 2.—Sir T. Lauder Brunton's Clinic.  
Dr. Hensley and Mr. Butlin's duty.
- " 3.—Association F. C. v. Old Cranleighans at Winchmore Hill.  
Rugby F. C. v. Rosslyn Park at Richmond.  
Hockey Club v. West Herts at Watford.
- " 6.—Sir T. Lauder Brunton and Mr. Walsham's duty.  
Mr. Langton's Clinic.  
Rugby F. C. v. R.I.E.C. at Cooper's Hill.
- " 8.—Abernethian Society, 8 p.m., Mr. H. J. Paterson, F.R.C.S., "Some Observations on Syphilis."
- " 9.—Dr. Norman Moore's Clinic.  
Dr. Church and Mr. Willett's duty.
- " 10.—Association F. C. v. Old Cholmeleians at Walthamstow  
Rugby F. C. v. Catford Bridge at Catford.  
Hockey Club v. Eastbourne at Eastbourne.
- " 13.—Amalgamated Club Dinner, 7.15 p.m., at Café Monaco.  
Dr. Gee and Mr. Langton's duty.
- " 14.—Mr. Butlin's Clinic.  
Association F. C. v. Hastings and St. Leonards at Hastings.  
Hockey Club v. R.M.A. at Woolwich.
- " 15.—Abernethian Society at 8 p.m., Mr. H. S. Everington, M.B., "Some Points in the Management of Sick Children."
- " 16.—Dr. Gee's Clinic.  
Sir Dyce Duckworth and Mr. Marsh's duty.
- " 17.—Association F. C. v. West Kent at Chislehurst.  
Rugby F. C. v. Portsmouth at Portsmouth.  
Hockey Club v. Ealing at Richmond.
- " 20.—Dr. Hensley and Mr. Butlin's duty.
- " 21.—Mr. Butlin's Clinic.  
Association F. C. v. London Hospital (League Match) at Lower Edmonton.
- " 22.—Abernethian Society at 8 p.m., Dr. Tooth, "Lantern Views of South Africa."
- " 23.—Sir T. Lauder Brunton and Mr. Walsham's duty.  
Sir Dyce Duckworth's Clinic.
- " 24.—Association F. C. v. Reigate at Reigate.  
Rugby F. C. v. Portsmouth at Portsmouth.  
Hockey Club v. Epping at Epping.
- " 27.—Dr. Church and Mr. Willett's duty.
- " 28.—Mr. Walsham's Clinic.  
Association F. C. v. London Hospital (League Match) at Winchmore Hill.  
Rugby F. C. v. Old Paulines at Winchmore Hill.
- " 29.—Abernethian Society, 8 p.m., Mr. Langdon Brown, M.B.
- " 30.—Dr. Hensley's Clinic.  
Dr. Gee and Mr. Langton's duty.
- Dec. 1.—Association F. C. v. Old Cholmeleians at Winchmore Hill.  
Rugby F. C. v. Old Leysians at Wembley Park.  
Hockey Club v. Crystal Palace at Crystal Palace.

### Abernethian Society.

THE inaugural meeting of the session 1900-1901 was held in the Anatomical Theatre on October 11th. There was a very large attendance of members and their friends, as well as a large number of the nursing staff. We were pleased to notice a fair number of ladies among the visitors. The attendance was so large that the main portion of the theatre was insufficient to accommodate all, and many had to find seats in the gallery.

MR. BOWLBY had consented to read a paper entitled "Reminiscences of the War in South Africa." This being, as it were, his first public appearance in the Hospital since his return from South Africa, his entry was the signal for an outburst of enthusiastic

cheering. After full vent had been given to this, the President (Mr. Gask) rose, and saying that it was unnecessary for him to introduce Mr. Bowlby, called on him to read his paper. The paper, which is published in this issue of the JOURNAL, was listened to with great interest by all, the tributes to the bravery and endurance of the British troops meeting with special applause.

AT the conclusion of the paper, SIR THOMAS SMITH said he had been greatly interested in Mr. Bowlby's remarks, and felt there was so much instruction in the paper that he felt competent to rule an army. We had all missed Mr. Bowlby during his absence and were glad to have him back, and it gave him great pleasure to propose a vote of thanks to Mr. Bowlby.

MR. BERRY said that he had had much pleasure in listening to Mr. Bowlby's admirable, amusing, and instructive address. He referred to Mr. Bowlby's foresight in taking a consulting physician, and to the excellent work done by the Portland Hospital. He considered it a privilege to second the vote of thanks.

THE vote of thanks was accorded enthusiastic support. MR. BOWLBY, in reply, said that he felt at home here, and that after listening to the remarks of Sir Thomas Smith and Mr. Berry, he had come to the conclusion that he was a very wise man, especially in taking out Dr. Tooth. He said that Dr. Tooth had been a great success, not only as a physician, but as an X-ray specialist, and, indeed, in anything he undertook.

MR. WALLACE had also been splendid as a colleague and assistant, and Mr. Calverley had been most useful in any post he had been called on to fill.

SURGEON-MAJOR KILKELLY, who represented the R.A.M.C. in the Portland Hospital, was a most capable officer, and had helped them in every way.

BEFORE he sat down he would like to thank those present for their very cordial reception that evening.

AFTER Mr. Bowlby's reply the meeting was adjourned, but there was such a vigorous call for a speech from Dr. Tooth that he eventually rose and made a few remarks.

HE said that he had been in South Africa and thought that he had seen a great deal, but felt that either this could not be so, or that he had missed a great deal, since listening to Mr. Bowlby's paper. Of course he did not mean that Mr. Bowlby had drawn on his imagination (laughter), but that he was surprised at the amount Mr. Bowlby had observed. He had noticed out there that Mr. Bowlby was always writing in the evenings when others were trying to warm themselves over a paraffin stove, and wondered at it. He thought that these must have been notes of things observed and heard during the day, and that the paper we had heard this evening was the outcome of the notes. They had all kept diaries, or begun to, but he was afraid that some of them had got sadly behind. He referred to the extreme cold at night and the hardships caused to the novel reader from this cause.

THE "camera fiend" had been rampant, and it was almost impossible to leave one's quarters without hearing the click of a camera shutter. In self-defence he had joined the ranks of the "fiends," and had collected a number of photographs, which were being converted into lantern slides, and which he would be glad to show at a meeting of the Abernethian Society if a night for this could be arranged.

AT the end of his remarks he was loudly applauded, and a movement was made to the library, where refreshments were partaken of.

AT a Special General Meeting held on October 4th, Mr. Gask (President) in the chair, the alterations in the rules suggested by the special sub-committee appointed in March last were considered and discussed. Messrs. Maxwell and Niall, two members of the sub-committee, were present, and set forth the reasons which guided the committee in making each of the proposed alterations. The sub-committee were appointed to simplify the rules as much as possible, and to bring them up to date, several alterations being necessitated by the relations at present existing between the Society and the Amalgamated Clubs. Two important changes in the rules were made, the first, by which only those members who have attended at least three ordinary meetings during the preceding year are allowed to take part in the election of officers; the second, that by special invitation the Committee of the Society may invite gentlemen who are not members to read papers before the Society. The other changes made came under the category of (1) changes made to simplify the rules, or (2) changes made to meet the existing relationship of the Society to the Amalgamated Clubs.

THE Second General Meeting of the Society was held on October 18th, Mr. Gask (President) in the chair. Dr. W. H. Hamer read a paper on "Casual Coincidences in Medical Statistics." He began

by pointing out that in many cases in which particular notice is directed to some sequence of events, no importance would be attributed to the phenomena if the chances of their occurrence under ordinary circumstances were taken into account, e.g. the apparent hereditary influence in the transmission of cancer could partly be explained simply by the fulfilled chances of its occurrence in members of the family affected by the disease. As an example of what remarkable results may be obtained by failing to estimate at each new departure the chances of a particular occurrence, he took the question of "The Third Generation of Londoners," stating that from the almost impossibility of tracing the three generations, it might be assumed that the inhabitants of the slums were on their way to racial extinction; but that this extinction is only apparent is readily seen when the chances of any particular occurrence, such as the removal of the inhabitants, demolition of the slum area, etc., are fully taken into consideration, the probability of the existence of cancer and phthisis houses, of the transmission of diseases such as diphtheria by chain infection, and of the infection of healthy children by convalescents returning from fever hospitals, was also referred to, and the possibilities of these occurring as casual coincidences discussed. In conclusion, Dr. Hamer pointed out that it was, of course, as great a mistake to refer every class of coincidence to mere chance as it is to neglect the element of probability altogether.

## Amalgamated Clubs.

### RUGBY FOOTBALL CLUB.

*President.*—A. A. Bowlby, Esq., F.R.C.S.  
*Vice-Presidents.*—J. S. Sloane, Esq., F.R.C.S.; W. F. Bennett, Esq., M.R.C.S., L.R.C.P.; A. J. W. Wells, Esq., M.R.C.S., L.R.C.P.; H. C. Adams, Esq., M.R.C.S., L.R.C.P.  
*Captain 1st XV.*—A. O'Neill  
*Vice-Captain.*—H. T. Minden Wilson.  
*Hon. Secretary.*—H. T. Minden Wilson.  
*Assist. Hon. Secretary.*—D. M. Stone.  
*Captain 2nd XV.*—W. H. Scott.  
*Committee.*—J. M. Plews, F. Harvey, W. H. Hamilton, L. R. Tosswill, J. B. Gillies, G. S. Ellett, A. R. Neligan, B. N. Ash.

### PROSPECTS FOR 1900—1901.

The prospects for the coming season look very rosy, H. C. Adams, last year's Captain, being the only man out of his year. The trial game, however, supplied very little new blood, especially in the way of outsiders, who were chiefly needed. There is, however, more keenness this season, and with the nucleus of last year's team to start with, it looks like being a good season. In our first match, with Sandhurst, the forwards, completely outmatched the embryonic generals, while some of the outsiders showed great promise.

In the next match, against Park House, the team gave a very disappointing performance, the forwards not combining till the last twenty minutes, while several opportunities of scoring were lost by the outsiders.

Of our prospective opponents in the Cup Ties, St. Mary's, St. Thomas's, and London Hospitals have begun the season badly, while Guy's alone have started with a win.

A. O'Neill, this year's Captain, and I. R. Tosswill both distinguished themselves in the Devon County trial match, O'Neill being chosen, while Tosswill is a reserve.

E. S. Marshall and W. H. Hamilton played in the Middlesex Colts' match, while A. R. Neligan was playing in the Surrey trial game.

The "A" team look like having a very successful season, as there is more talent to choose from, and although they started with a bad beating, we had only a very scratch side; but with a full side now have been doing very well, and have a very good card of fixtures to work through.

### BART'S v. SANDHURST R.M.C.

O'Neill, winning the toss, elected to play with the wind. At once it was seen that the home pack were no match for their heavier opponents, and the ball was soon worked into their quarters, where,

after a forward rush and a lot of fumbling, Wilson fell on the ball, O'Neill securing the major points. Play was still kept among the forwards, and the whistle sounded for half time.

Then, after starting, the Sandhurst three-quarters, intercepting a wild pass, scored, the kick failing. Then T. O'Neill, receiving the ball crossed the R.M.C. line, A. O'Neill again converting. Only once after this did Sandhurst look like scoring, but the ball was soon worked back into their twenty-five, and the game ended in a win for the Hospital by 2 goals (10 points) to 1 try (3 points). The following represented the Hospital:

*St. Bart's.*—E. S. Marshall (back); J. B. Gillies, H. W. James, J. Corbin, T. O'Neill (three-quarters); W. H. Hamilton, D. M. Stone (halves); A. O'Neill, L. R. Tosswill, H. T. Wilson, F. Harvey, H. E. Stanger-Leathes, E. C. Hodgson, T. Bates, H. E. Graham (forwards).

### ASSOCIATION FOOTBALL CLUB.

*President.*—W. H. H. Jessop, Esq., F.R.C.S.  
*Captain.*—V. G. Ward.  
*Secretary.*—C. W. O'Brien.  
*Captain and Secretary and XI.*—J. R. R. Twist.  
*Committee.*—H. N. Marrett, W. S. Nealor, L. Orton, C. H. Fernie, G. W. Miller.

### PROSPECTS FOR SEASON 1900—1901.

The prospects for this season of the Association Football Club are, perhaps, not quite so bad as they seemed at first. In goal we are just as well off as we have been for the last two or three seasons, as we still have the services of our tried man, H. Butcher.

At back we recently experienced a great loss in T. H. Fowks' departure from the Hospital, but we are able to fill his place with a very capable substitute in the person of W. S. Nealor. L. Orton, a tower of strength in himself, still has another year to assist us.

When we come to the half-back line we find our best weakness. Last year we lost our best halves, and they have not been replaced by any very useful Freshmen. Still we have hopes of seeing some improvement in this department as the season advances.

In the forward line we still have the services of three of last year's team; and, as two or three very useful Freshmen have come up, we ought, if anything, to be stronger forward than we were last year. Taken on the whole, we think the team is quite as good, if not better, than last year's, and at all events quite up to the average; and we think, when we get going properly, we ought at the end of the season to occupy a not unenviable position in the newly-established Inter-hospital League; and if we cannot give the Hospital Cup a place of honour on our library table, we shall give a *quantum* of trouble to those who do ultimately carry off the trophy to form one of the sights of their scholastic establishment.

### ST. BART'S v. ST. MARY'S.

This match was played on October 10th at Winchmore Hill, under the auspices of the newly-formed Inter-hospital League, and ended in an easy victory for Bart's by 5 to 0.

In the first half, playing towards the Pavilion end, Ward scored. This was all the scoring done, and the teams crossed over with the score—Bart's, 1; Mary's, 0.

In the second half Bart's had all the best of the play, and Ward added three more goals, and Kilby added the fifth, and the whistle finally sounded, leaving the Bart's men winners, as above stated. For St. Mary's B. W. Goin played a fine game, and had it not been for him, Bart's men would have scored a great deal heavier. Team: H. Butcher (goal); L. Orton, W. S. Nealor (backs); G. W. Miller, V. C. Upton, A. N. Other (half-backs); J. A. Kilby, R. C. Berryman, C. O'Brien, V. G. Ward, and Bott (forwards).

### ST. BART'S v. TUNBRIDGE WELLS.

These teams met at Tunbridge Wells on Saturday, October 20th. St. Bart's won the toss, and elected to play with the wind. The first half was very evenly contested, both goals being hotly attacked; but the defence prevailed, and the whistle sounded for half-time with the score-sheet blank.

The second half opened with some very fast play by both sides, and Tunbridge Wells had hard luck in not scoring. Butcher, in

goal for Bart's, made some very fine saves. After about ten minutes' play some good combination between the visitors' outside forwards enabled them through O'Brien to score. Two more goals quickly followed by Ward, and just before the call of time Berryman added a fifth, and the whistle sounded, leaving Bart's winners by 4 to 0. For Tunbridge Wells Wace and B. Murdoch played well. Team:

H. H. Butcher (goal); L. Orton, W. S. Nealor (backs); V. C. Upton, J. W. Goddell, N. E. Waterfield (half-backs); F. W. Jackson, R. C. Berryman, C. O'Brien, V. G. Ward, and G. W. Miller (forwards).

### HOCKEY.

*President.*—Dr. H. Morley Fletcher.  
*Captain.*—F. H. M. A. Becket.  
*Secretary.*—A. Hallowes.  
*Committee.*—I. H. Furber, H. B. Hill, E. T. Glenn, J. A. Nixon, A. H. Pollock.

### ST. BART'S v. ENFIELD.

Played at Enfield on October 6th, the Hospital winning by 4 to nil. This being our first match of the season, the game was somewhat of a scrambling nature. At half-time the score was 1 goal (Nixon) to nil. Afterwards the Hospital did better, goals being scored by Beckett, Bell, and Hallowes. Team:

L. E. Dickson (goal); L. G. Furber, L. Gray (backs); A. K. H. Pollock, A. H. Muirhead, W. E. Fowler (half-backs); A. Hallowes, J. A. Nixon, F. M. Beckett, K. D. Bell, and H. Gray (forwards).

### ST. BART'S v. CRYSTAL PALACE 1ST.

This match was played at Winchmore Hill on October 13th, and resulted in a win for the Palace by 5 to 1. The early stages of the game went in favour of the home side, but the Palace soon began to press, and at half-time were leading by 3 to nil.

Soon after play was resumed Nixon, unfortunately, had to leave the field. The play was very fast throughout, but the Palace put on 2 more goals to 1 (Hallowes). Team:

L. E. Dickson (goal); L. G. Furber, W. E. Fowler (backs); A. K. Pollock, T. A. Mayo, H. B. Hill (half-backs); A. Hallowes, J. A. Nixon, F. M. Beckett, R. M. in Thurn, and H. Gray (forwards).

### ST. BART'S v. ROYAL ARTILLERY.

Played at Woolwich on Wednesday, October 17th, and after a close and exciting game the Hospital were able to claim a victory by 2 to 1. The game was of a very even character for the first ten minutes, in which time the R.A. had scored a goal; but Beckett soon equalised by a good shot, and before half-time Hallowes had also added another goal.

After half-time, although having a slight advantage, due to the sloping ground, Bart's could not score again, and each goal was attacked in turn; but nothing being scored, the game ended in our favour by 2 to 1. Team:

L. E. Dickson, W. E. Fowler, L. G. Furber, H. B. Hill, L. Murphy, A. K. Pollock, N. Holbrooke, A. Hallowes, F. M. Beckett, R. M. in Thurn, and H. Gray.

### ST. BART'S v. KENSINGTON.

This match was played on October 20th at Wormwood Scrubs, and after a fast game the Hospital won by 3 to 1. Soon after the start Beckett scored for the Hospital, and the visitors, keeping the ball in the Kensington "25," soon added another goal (Beckett).

On changing ends the Hospital did nearly all the pressing, but only 1 goal was scored (by Bull). Owing to the unevenness of the ground the shooting was erratic. Team:

L. E. Dickson, L. G. Furber, W. E. Fowler, L. Murphy, A. K. Pollock, H. B. Hill, A. Hallowes, J. A. Nixon, G. N. Bull, and H. Gray.

### UNITED HOSPITALS SWIMMING CLUB.

#### WATER POLO.

The last match of the season was played at St. George's Baths, Buckingham Palace Road, on July 10th, and resulted in a win for Oxford University. The Hospitals were weakened by the absence of H. Graham Marshall (Capt. England and Surrey County) and W. H. G. Thorne.

The following players have represented their hospitals this year.

V. B. Nesfield (Capt.) St. Mary's (U.H.S.C.)	... 6 matches.
S. B. Scott, St. Bart's	... 1 match.
A. H. Blossome, St. Bart's	... 6 matches.
Graham Marshall, Guy's	... 1 match.
R. Newby-Smith, London	... 1 "
G. Teddon, St. George's	... 2 matches.
W. H. G. Thorne, St. Bart's	... 5 "
C. Dix, St. Bart's	... 5 "
F. Gorge, Guy's	... 1 match.
H. Bacon, Guy's	... 1 "
M. B. Scott, St. Bart's	... 2 matches.
O. Levers, St. Mary's	... 4 "
D. M. Stone, St. Bart's	... 1 match.
F. Child, St. Thomas's	... 1 "
W. H. G. Thorne was elected the United Hospital colours this season.	

### INTER-HOSPITAL CUP.—FINAL TIE.

#### ST. BART'S v. ST. MARY'S.

On Monday, October 8th, the Final Cup Tie was played off at Ealing, before a very large attendance. At times the play was somewhat rough, and the whistle was largely in evidence, especially in the first half. O. Levers, for St. Mary's, scored the first point with a neatly placed corner shot. On return of the ball to water, play was again carried into the Bart's half, C. Dix clearing several shots successfully. Sides were now changed with St. Mary's leading by one goal to nil.

In the second half play was for a time even. By a short pass from Lees, A. H. Blossome got in, and dribbling up, passed to Stone, who failed to score. The Bart's forwards continued to press, and the game became exceedingly fast; several shots were sent in, but all were cleared. From a foul given against Webster, who had left goal to tackle Douglas, the latter was able to pass to Stone, who notched a goal for Bart's.

No more scoring was effected by either side, and the match resulted in a draw of one goal each. The teams were: *St. Bart's* (holders)—C. Dix (goal); M. B. Scott, L. B. Scott (Capt.) (backs) U.H.S.C.; A. H. Blossome (half-back) U.H.S.C.; D. M. Stone, K. J. Watkins, and R. I. Douglas (forwards). W. H. G. Thorne, U.H.S.C., was unable to play.

*St. Mary's.*—A. Webster (goal); H. Clarke and H. E. Wellington (backs); V. B. Nesfield (Capt.) (half-back) U.H.S.C.; G. H. Richard, H. C. Lees, and O. Levers (forwards).

## Idle Year.

That Sir Thomas Lauder Brunton intends shortly to resign his Lectureship in Materia Medica and Therapeutics.

That in future all our Assistant Demonstrators, with the exception of those who fill posts open to unqualified men, will take the title of Junior Demonstrators. This seems a step in the right direction.

That the School Committee has acceded to the request of the Amalgamated Clubs, and has placed the Smoking Room at the disposal of the Boxing Club. We welcome anything which tends to keep our club meetings near home.



## The Rahere Lodge, No. 2546.



Ordinary meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, October 9th last, W. Bro. Walter Gripper, M.B., being in the chair. Bro. W. E. Bennett, F.R.C.S., was raised to the degree of Master Mason, and Mr. Richard Henslow Wellington, M.R.C.S., L.R.C.P., was initiated into Freemasonry. Subsequently some thirty of the brethren dined together.

## New Productions.

MESSRS. EDWARD COOK AND CO. have sent us several samples of their soaps. After using them, both for ordinary purposes and in some cases of septic skin affections, we can confidently recommend them. The special antiseptic soap preparation should command a considerable popularity. Messrs. Cook also supply a very pleasant tooth soap, which we find on good authority well fulfils the essentials required of such a preparation.

## Examinations.

## CONJOINT BOARD.

*First Examination.—Chemistry.*—H. W. W. Bund, W. R. Collingridge, C. A. Fernie, W. de M. Hill, G. P. Jones, F. M. P. Rice. *Practical Pharmacy.*—E. W. Alment, J. A. Bell. *Biology.*—W. S. Nealon.

*Second Examination.—Anatomy and Physiology.*—A. J. L. Speechly, W. R. Square, H. E. Scoones, E. Leverton-Spry, L. V. Thurston, N. M. Wilson, A. C. Brown, C. F. Nicholas, L. A. Arnould, R. I. Douglas, J. G. Ingonville, A. C. A. Van Buren.

## Appointments.

BAISS, LI. A., M.R.C.S., L.R.C.P., Surgeon R.N., appointed to H.M.S. "Woodcock," China Station.

BIGG, R., M.R.C.S., L.R.C.P., appointed Ship's Surgeon to the telegraph ship "Dacia."

CLARKE, HUNTLEY, M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Shrewsbury Infirmary.

DOUGLAS, W. C., M.R.C.S., L.R.C.P., appointed Surgeon to the ss. "Titan."

FRASER, J. E. S., F.R.C.S.Eng., appointed Demonstrator of Anatomy at St. George's Hospital Medical School.

HARRIS, H. G., M.B., B.S. Durham, M.R.C.S., L.R.C.P., appointed House Surgeon to the Paddington Green Children's Hospital.

HEY, S., M.R.C.S., L.R.C.P., appointed Resident Medical Officer to the City Road Chest Hospital.

HOBBS, G. C., L.R.C.S., L.R.C.P. Edin., L.F.P.S. Glas., appointed House Surgeon to the Hampstead Hospital.

PARKER, H. F., M.B., B.C., appointed House Physician to the Wolverhampton General Hospital.

PENNEFATHER, C. M., M.B., B.S. Durham, M.R.C.S., L.R.C.P., appointed Junior House Surgeon at the Metropolitan Hospital.

FOLLARD, S., M.B., B.C., appointed Senior House Physician at the Metropolitan Hospital.

RICHARDS, W. J., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the Middlesex County Asylum, Tooting.

ROSS, P. H., M.R.C.S., L.R.C.P., appointed Surgeon to the ss. "Wordsworth."

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

SODEN, Arnold E., M.R.C.S., L.R.C.P., appointed Surgeon to P. & O. S. N. Company's ss. "Chusan."

THORNLEY, L., M.B. Lond., M.R.C.S., L.R.C.P., appointed Junior House Physician at the Metropolitan Hospital.

## New Addresses.

MIDDELTON, W. J., King's Villa, Talbot Road, Winton, Bournemouth.

WELBURN, C. M., Aylsham, Norfolk.

WHAKY, ROBERT, 7, Cambridge Gate, Regent's Park, W.

## Births.

DRURY.—On October 21st, at Grahamstown, South Africa, the wife of Edward Guy Dru Drury, M.D., B.S. Lond., of a son. (*By cable*.)

MASTERMAN.—On Sept. 12th, at Jerusalem, the wife of E. W. G. Masterman, F.R.C.S., F.R.G.S., D.P.H. Cantab., of a daughter.

SEGUNDO.—On October 15th, at 6, Brook Street, Hanover Square, the wife of C. S. de Segundo, M.D., B.S. Lond., of a son.

## Marriages.

COLEMAN—STEPHENS.—On October 24th, at the Church of the Ascension, Balham Hill, S.W., by the Rev. W. Douglas Morrison, LL.D., uncle of the bridegroom, assisted by the Rev. H. Curtis, M.A. (Vicar), and the Rev. A. W. Hooper, M.A., Maurice Were Coleman, M.B., of Reading, eldest son of Alfred Coleman, F.R.C.S., of Tooting Common, to Edith Annie Bowring, only daughter of Edward Bowring Stephens, of Upper Tooting, S.W.

CURRIE—CAVENDISH.—On October 13th, at St. John the Baptist Church, Holland Road, Kensington, by the Rev. L. B. Currie, M.A. (brother of the bridegroom), assisted by the Rev. W. C. Cluff, M.A., and the Rev. W. M. Spencer (Vicar of the parish), John Currie, M.D., of Coleford, Gloucestershire, eldest son of the late Dr. Currie, of Taunton, to Annie, eldest daughter of Harry Cavendish, of 58, Addison Gardens, W.

## Death.

ECCLES.—On October 22nd, suddenly, at 23, Hertford Street, Mayfair, W., Arthur Symons Eccles, M.B., C.M., in his forty-sixth year.

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



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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.

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

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## St. Bartholomew's Hospital Journal,

NOVEMBER, 1900.

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

## Clinical Lecture on Two Typical Cases of Progressive Muscular Atrophy.

By DR. ORMEROD.



WASTING of muscle may occur under very many conditions, such as disuse of a limb, disease of a joint (apart from disuse), injury or disease of a nerve-trunk or nerve-root, local disease of the spinal cord, or even in hemiplegia or hysteria.

But of some cases wasting and weakness of muscle are the dominant, if not the only clinical symptoms, getting worse as the disease progresses, and spreading by degrees from one muscle, or group of muscles, to another. These cases have long been known as "progressive muscular

atrophy," and they have a definite morbid anatomy as well as a definite clinical aspect.

They fall into two main types: the first is known as primary, or idiopathic, or myopathic muscular atrophy, because the disease is seated in the muscle itself, the nerve-centres being intact; the second is called secondary, or myelopathic, or spinal muscular atrophy, because the disease is seated in the anterior cornual cells of the spinal cord. And since these are the nutrient centres for the muscles their destruction entails atrophy of the muscles they support.

I will show you a well-marked example of each type. You must not forget that there are intermediary cases and sub types, but I pass them over, partly for simplicity and partly because I have not specimens to hand.

It is worth while first to mention the points to which we chiefly look for a clinical distinction between the myopathic and the spinal types. They are these:

1. *The point of attack.*—Atrophy of the myopathic type commonly begins in the large muscles of the shoulder girdle, or (less frequently) of the pelvic girdle; \* that of the spinal type in the small muscles of the hand.

2. *The grouping of the muscles affected.*—The nuclei of certain muscles are thought to be in close proximity to each other in the cord; if these muscles waste simultaneously it suggests that the disease is spinal, and the reverse if they do not.

3. *The condition of the muscles themselves.*—In myopathic cases we occasionally find enlargement of some muscles, or congenital absence of some. This brings the disease into close relation with pseudo-hypertrophic paralysis, in which complaint, as you are aware, the leading symptom, enlargement of muscle, may be followed by wasting, or accompanied by absence of some muscles. There is at present a good example of this in Matthew Ward. Indeed, the two diseases are often classed under

\* Excepting the class of cases known as "infantile," which begin in early childhood, and where the facial muscles are affected first, the shoulder muscles later.

the general title of "muscular dystrophy." In the spinal form there is never muscular enlargement, but here, especially in a rapidly progressing case, we may often see the curious spontaneous twitching of muscular fibres and fasciculi which is called "fibrillary tremor;" this is not seen in myopathy. Lastly, the electrical reactions may differ. In myopathic cases the contractility to the coil and to the cells diminishes, but there is no reaction of degeneration; in spinal cases, particularly in those that are advancing rapidly, reaction of degeneration may sometimes be made out.

4. Certain general considerations, such as—

(a) The age of the patient at the time of onset. Myopathy attacks adolescents, or sometimes young children; spinal atrophy attacks adults.

(β) Heredity. The first of these types often runs in families; the second rarely.

(γ) Course. That of the first is very chronic; that of the second (at least for the variety which I shall show you) is more rapid, ending within some six or seven years, and often with symptoms of bulbar paralysis, which do not occur in the first.

I now show you, as an example of primary or myopathic muscular atrophy, a young woman aged 19. She is healthy in every respect save the muscular weakness and wasting. For this there exists no assignable cause; no similar disease is known in her ancestry, but the question of family proclivity cannot be fully followed out, because she is an only child. The duration of the affection is a little uncertain. She herself avers that she never could walk properly, but that no notice was taken of this. However this may be, at the age of ten she had to leave school, because she could not walk the mile distance; and about the same time she used to fall about, had difficulty in getting up from the floor, and was unable to lift heavy weights. These symptoms, which seem to point to a somewhat wide-spread initial muscular weakness, have got steadily worse.

As she sits before you in this chair (she can now neither walk nor stand) you may notice that her face is unaffected, that her body is bent forward from weakness of the erectors spine, that her hands are not wasted, and their power of movement is normal.

The shoulder muscles are widely affected. You can see the deficiency in the lower part of the pectorals, and in the latissimi, when she tries to depress the arms against resistance; the same manœuvre brings out the absence of the rhomboids; for the latissimus dorsi being absent, the teres major seeks to effect depression of the arm, but this muscle takes its origin from the outer and lower part of the scapula, and since there are no rhomboids to hold this bone in position, the effect is to tilt the lower angle of the scapula outwards, as you see. When she lifts her arm (the deltoid being still intact) and stretches it forward, a deep groove appears between the vertebral border of the

scapula and the trunk; this is called "winging" of the scapula, and shows that the serratus magnus is too weak to keep the border of the scapula in apposition to the body. It is probable also that the levator anguli scapulae and the lower part of the trapezius are deficient in this case.

In the lower limbs the glutei are practically powerless; the extensors of the knee and flexors of the hip are very weak; and there appears to be some feebleness of the leg muscles. The knee-jerks are absent, but you must not take this to be a sign of spinal disease; it is simply because the extensors of the knee are too crippled to respond to the blow upon their tendons.

The second case is an example of the spinal type of muscular atrophy. And since in the particular variety to which this case belongs the spinal disease is widely spread, and the symptoms therefore somewhat complex, I will briefly remind you of those parts of the nervous system which we believe to be here diseased. The motor or efferent apparatus of the central nervous system consists of two parts, formerly called "projection systems," now called the upper and lower efferent "neurons." The upper group of neurons comprise the large pyramidal cells of the cortex cerebri in the Rolandic area, and their axis-cylinder processes, which (as you know) pass down in the form of white nerve-fibres, to terminate somewhere near the large cells of the medulla and of the anterior cornua of the cord. They are grouped into the bundles known as the pyramidal tracts, bundles which form a considerable portion of the lateral columns of the cord. The lower neurons comprise the large cells of the medullary nuclei and of the anterior cornua of the cord, with their axis-cylinder processes, which form the motor nerve-roots and nerve-trunks, and which terminate in the muscles. Degeneration of either neuron entails paralysis; but in disease of the lower neuron the paralysis is of the flaccid or atrophic type,—that is to say, the muscle loses its tone, the tendon reactions disappear, the electrical reactions undergo peculiar changes, and wasting sets in; whereas in disease of the upper neuron the muscular tone is increased, the tendon reactions are exaggerated, the electrical reactions are maintained, and muscular rigidity may appear; or briefly, the paralysis is of the spastic type.

Now in this case, which is of the kind known as "amyotrophic lateral sclerosis," the disease affects both the upper and lower neuron,—that is to say, the whole motor tract, and we witness in consequence a curious combination of two things which are in a sense opposed to each other, namely, of spastic with flaccid paralysis.

The patient is a man aged thirty-eight, a commercial traveller. There had been no nervous diseases in his family; he has not had syphilis. He formerly drank somewhat freely, and was a good deal exposed to weather. He himself connects his illness with a shock that he experienced six months before the onset; he was on a scaffolding

at the launch of the "Albion," and was thrown into the water and much frightened, though apparently not physically injured. Two years ago the present affection began with weakness, at first in the right leg, then (four or five months later) in the left. He had some difficulty in holding his urine; this is not a usual symptom. A month later the left hand was affected; some four months later the right hand; there was pain, some feeling of deadness though no actual anaesthesia, and weakness and wasting of the left hand.

When I first saw him, in October, 1899, he dragged his feet in walking, his knee-jerks were exaggerated, and there was a somewhat indefinite ankle-clonus; in other words, his legs showed a commencing spastic paralysis. The muscles of the left hand were small, but not definitely wasted; the muscles of the upper limbs generally showed fibrillary tremors. The probability therefore seemed to be that the spinal nuclei of the upper limbs were degenerating, and the pyramidal tracts as well. The symptoms became more definite, though the paralysis did not spread, during the two months that he stayed in the hospital. During the present year he has become materially worse. He can barely walk; in his legs there is well-marked spastic paralysis—increased knee-jerks, ready ankle-clonus, and the modification of plantar reflex which consists in extension of the great toe. There is rigidity too, but not so extreme as might be expected; perhaps this means that the lower neurons for the legs are beginning to degenerate as well as the pyramidal tracts. Both hands are wasted, as you see; the muscles of the forearms are small, in the left limb particularly. The deltoids are weak and wasted. You can see some fibrillary tremors. In such a case we might expect the electrical reaction of degeneration, but nothing beyond diminution of electro-contractility has been demonstrated. With all this there is no affection of sensation nor paralysis of the sphincters, showing that the motor tracts are affected, and they alone. Indications of coming bulbar paralysis are present, for the tongue is thinned and slightly tremulous, and the patient is becoming emotional.

The diagnosis of amyotrophic lateral sclerosis, except in the earliest stages, is tolerably easy. There are, it is true, one or two other conditions in which the combination of atrophic paralysis of the hands and arms with spastic paraplegia may be found. One of these is chronic meningitis of the cervical region (from whatever causes) involving the nerve-roots at that level, and at the same time pressing on the cord. But here there will be more distinct sensory symptoms in the upper limbs, first pains, then anaesthesia; and the paraplegia, as the pressure on the cord advances, extends to its sensory functions, and to the functions of micturition and defecation. Syringomyelia is another such condition; but here again the peculiar sensory paralysis, and possibly other symptoms, should prevent a mistake.

Both these patients are incurable; but while the woman's

disease will probably proceed very slowly, not endangering life till she becomes absolutely bedridden, or until the atrophy attacks the muscles of respiration, the man's disease is progressing, and will progress far more rapidly. Such cases rarely live more than five or six years. The next set of paralytic symptoms will probably be bulbar, in themselves a source of danger; and meanwhile the paralysis of the limbs will spread and become intensified; he will become helpless and bedridden, and exposed to all the risks which that condition entails.

### Smallpox Epidemic in Jerusalem.

By E. W. G. MASTERMAN, D.P.H. Cantab., F.R.C.S.

Those who, amidst the luxuries of sanitary regulations and more or less compulsory vaccination, practise in the British Isles and other such centres of civilisation, a real unchecked old-fashioned epidemic of smallpox must be an almost unknown experience. Till this year, in spite of six years spent in the Turkish Empire, the real horrors of smallpox were only known to me in medical history. As I write now, however, we are in the city of Jerusalem—a city supplied with as large a proportion of medical men, and a larger proportion by head of population of hospital beds, than most European cities, in the midst of an utterly unchecked epidemic of an extent and severity unknown to any of the residents I have met. Those familiar with all that modern sanitary science has done to meet such a visitation in Britain may imagine our position when I state that we have no law regarding vaccination, neither compulsory nor free vaccination from Government sources; not a single bed for infectious cases for the poor; neither home inspection of infected houses, nor certificates of cases of illness or death. The disease stalks from house to house, visiting in many cases every house in street after street. Fortunately a considerable number of the population are protected by previous attacks of smallpox, as is witnessed by the large proportion of pitted faces one sees on all hands. Another proportion—a small one to the great mass—have been vaccinated and revaccinated, either because they have themselves sufficient knowledge to have made them seek it for themselves, as, of course, has been the case with most of the better-class Europeans, or because they are now, or have recently been, pupils in schools managed by Europeans. For the great mass, however, of the younger inhabitants—Moslems and Jewish—the wave of smallpox has been passing over their devoted heads unchecked. It is impossible in a city where neither illnesses nor deaths are officially registered, to know how many thousands have been attacked, or how many hundreds have succumbed; but the numbers must have been large, and are still being considerably augmented.

The conditions for the spread of the disease are ideal—for the smallpox germs. Most of the poorer Jews and Moslems live in "houses" consisting of one, or sometimes two, rooms opening into a square open courtyard, common to some dozen or more "houses." Many are half underground, and almost all are ill-ventilated. When an individual of any household falls ill, members of all the other households, and neighbours from other parts, crowd into the "house" (often a very low, ill-ventilated room), and if the patient seems acutely ill the crowd becomes enormous.

About a week ago I paid a visit to a young Jewess, who was lying in a small room the ceiling of which was scarcely more than six feet above the floor. On entering the room I found certainly not less than a dozen women grouped round the bed, while the unfortunate patient was every few minutes violently vomiting. Within a few hours a profuse eruption of confluent smallpox appeared. But not only before the smallpox is recognised, but even when every one knows such cases are in the room, people of all sorts—little children, women carrying unweaned babies, anxious relatives, and officious suggesters of any conceivable quack remedy—are constantly in and out. In every case the medical man's first difficulty is to clear the room. But even then the household remain, and, as things are, to clear them out is impossible.

Three nights ago I was called to a small "house"—*i. e.* room about 10 ft. by 12 ft. On a bed at one side lay the mother of the family with malignant (hæmorrhagic) smallpox, evidently dying. Not 5 ft. off, the other side of the room, lay three little children, none, I believe, efficiently—certainly not recently—vaccinated. The husband and the mother of the patient were also sleeping in the same room. The only window—about 2 ft. by 3 ft. opened into the common courtyard, and nothing could persuade the inhabitants to open it. I suppose a doctor's grievance in all climes is the fear by the sick of fresh air. Every window and door is usually closed, except for the few minutes of the medical man's visit, when, of course, he insists on some air for his own lungs; for, to add to the closeness and smell, the favourite and only disinfectant is the burning of dried camels' dung in the sick-room, and also at the door. The fumes are often very irritating.

So much for the surroundings. I have mentioned the houses, but what shall I say of the streets? Here children and adults, covered with half-healed sores, freely pass to and fro among the healthy. Even the healthy do not seem to mind it.

But with vaccination surely an epidemic of smallpox can be kept within bounds? But here we feel our helplessness. There is no possibility of enforcing vaccination, and we see children die from day to day who certainly might have been saved. The great majority of the poorest and most ignorant are "conscientious objectors." Not those fortunate mortals who are sheltered in England from the results of their

foolishness by the hundred guards put round them—the vaccination of such a large proportion of their neighbours, the isolation of the sick, etc.—but poor folks who reap the reward of their folly, and see their children die before their eyes.

To give one instance out of many. A month or so ago I responded to a professional call to the house of some exceedingly poor Jews. The eldest son, one of four, was ill—very seriously ill—with smallpox; and, seeing the other—all unvaccinated—children living, eating, and sleeping within six or eight feet of this boy, I begged the parents to bring the remaining children for vaccination the next morning. If I remember right, they said they would, but they never came. A second visit a few days later found the same condition, and this time I begged and entreated the parents, telling them their children's deaths would be at their doors if they did not comply; but *all in vain*. The father said "he was afraid;" the mother sheltered herself behind her husband, but evidently had no wish to comply. The natural result followed. Three weeks later the three younger ones sickened, and now two I know are dead, and I have reason to believe the remaining one is on the same road. And yet there are people who cavil at "compulsory vaccination"!

It is interesting to try and find out the source of these people's strong objections to vaccination. It is, of course, as is usual, founded on ignorance. They have a deep-rooted idea that to be vaccinated *during* an epidemic of smallpox is a very dangerous thing. I think it arises from two special sources. Firstly, there is a not unnatural confusion between vaccination and inoculation. This latter is still practised out here, and is now a fruitful source of the spread of the disease in the villages around. Government officials, even, have been doing it quite near Jerusalem.

Secondly, I have recently learned from a German physician that some ten years ago, when there was little or no vaccine obtainable, a native "quack" took some of the purulent contents of a smallpox pustule and inoculated the udders of a goat. From the sores that resulted he inoculated a number of babies' arms, with the effect that a most septic inflammation followed, leading to extensive sloughing over the arm and the axilla, and a large number of deaths. It was not vaccination at all, but inoculation of virulent *streptococci*. This has done untold harm, and now it needs hundreds of successful vaccinations to counteract the bad impression. With those who have consented to be re-vaccinated, including, of course, the vast majority of the better-class foreign residents, there has been, so far as I know, an entire immunity. Our school children, many of them living in the very midst of infection, have been quite free since re-vaccination for all has been insisted upon. We have all been using calf lymph from "*Institut Vaccinal Suisse*," in Geneva, and many cases of re-vaccination which have failed to "take" after several trials under the old system of

arm-to-arm vaccination have now had the typical eruption. We receive supplies by post constantly. The tubes are labelled as sufficient for "one or two vaccinations," but I seldom do less than six persons, and often ten or a dozen from one tube, with perfectly satisfactory results. In hundreds of cases I have done in the past few weeks, I have never seen a single troublesome arm.

Now what have anti-vaccinators to say to this state of things? It is anti-vaccinators of Europe who are mostly to blame for its continuance. But for this apparent state of doubt as to the real value of vaccination, you may be sure the Turkish Government would have long ago brought in a law—and seen too that it was carried out—insisting on vaccination, and also on re-vaccination. But how can it be expected that Turkey should do more than such centres of enlightenment as our own home land? Perhaps the anti-vaccinators who raise the outcry that improved sanitary reform makes compulsory vaccination now unnecessary, little dream that they, by hindering legislation on the subject in such lands as this, through their outcries are more or less directly injuring thousands, indeed, one may well suppose millions. Meanwhile, I would urge all "conscientious objectors" to avoid the East, in fact to give smallpox a wide berth; for the only English "conscientious objector" I have known of, a poor girl brought up by a father of that persuasion, died of malignant smallpox here only a few years ago.

And here a native doctor, who alone in the profession was running down vaccination for some time to all his poor patients, hastily, two weeks ago, came to a German colleague to be vaccinated with all his family, after losing his sister-in-law with malignant smallpox. Not by any means a unique occurrence, for at Gloucester one of the first to come with his family to vaccination, when a well-known clergyman there opened his schoolroom for the purpose, was one who was known in the whole district as a prominent agitator against vaccination.

In conclusion, should any of the readers of this have friends going East this season, I would strongly advise them to insist on re-vaccination for all.

### Some Features of Blood Pathology.

A paper read before the Abernethian Society, February 1st, 1900.

By J. H. CHURCHILL, M.B. Lond.

**I**N the examination of the blood the points to which attention is directed are:

1. The colour of the blood—hæmoglobin estimation.
2. The absolute numbers and the characters of the red blood-corpuscles.
3. The absolute numbers of the white blood-corpuscles.
4. The relative proportion of the different kinds of white blood-corpuscles.

5. The presence and relative proportion of abnormal corpuscles.  
6. The presence of alien structures.

Besides these, the chemical and physical characters of the blood as a whole, or of its corpuscular and fluid parts separately, may be investigated. Of this, however, I know nothing, and the difficulties in the way of such examination are considerable, generally necessitating more blood than we in England dare to take from our patients.

I do not, therefore, intend to do more than call your attention to the commoner features of pathological blood, and illustrate them as I go.

You are all aware that in a state of perfect health we are supposed to have 5,000,000 r. b. c. in every cubic millimetre of our blood, and that the ladies do not attain our high standard by half a million. A few examinations of one's own blood, and of that of one or two hospital friends, led one to think that this is too high an estimate, but in my own case, on returning after a holiday, or in the case of people devoted to outdoor rather than indoor labour, I have, on the few occasions tested, found the r. b. c. well up to, or even over the "normal" 5,000,000. A similar result obtained in the estimation of Hb. though I have only once obtained a reading of more than 90 per cent. in healthy persons, instead of the "normal" 100 per cent. allowed us.

At first it would seem absurd that the highest count of r. b. c. I ever made was in a patient who looked as ill as could be, and was suffering from rheumatic fever and congenital heart disease. He was a boy of fourteen, with the most purple of faces, and the most clubbed fingers and toes I ever saw; his lips were nearly black with cyanosis; the veins of his neck were very much distended. Six days after admission his Hb. = + 120 per cent., his r. b. c. = 10,080,000, and his w. b. c. 28,000 per c.mm., and two weeks later, when his oft-recurring arthritis at length subsided, he was left anæmic with 8,440,000 r. b. c. per c.mm.

We will turn to the consideration of this phenomenon (as a possible source of discussion after the paper).

Let us remember first that an increase in the number of r. b. c. could be produced by

1. Increased production.
2. Diminished destruction.
3. Diminution in the amount of the plasma.
4. Unequal distribution.

1. Production and destruction of corpuscles are processes that are always going on in the normal state. Is it possible that in cases of cyanosis such as ours, owing to the defective pulmonary circulation and consequent deficient oxygenation of the body, we go down, or rather come down, on our marrow bones for more oxygen carriers, and those noble and hard-worked factories respond by an increased output? ("work overtime"); or is it that the ill-nourished r. b. c. are small and weak, and that therefore their numbers have to be supplemented? For this there was no evidence in our case.

2. Or, on the other hand, perhaps the lack of oxygen results in a slower combustion of Hb., and a further lease of life to the corpuscles; that is to say, the rate of destruction is diminished.

In connection with this it is interesting to note that within two weeks of the time of taking up residence at great altitudes above sea-level, where oxygen and all other pressures are diminished, there is a marked increase in the number of r. b. c., and that their size is proportionately diminished.

3. As regards the amount of the plasma, we shall not add much to our knowledge until some evil-minded person invents a new method of clinical examination whereby we can gauge the volume of a man's blood without killing him; but it is easy to see that such causes as profuse sweating and diarrhoea may so rapidly deplete the blood of water, as well as of other things, that the blood count may show an increase in the number of the corpuscles owing to the greater concentration of the blood.

Nurses will tell you that after the removal of much æcetic fluid patients get very thirsty, especially where re-accumulation of fluid is rapid; and it is on record in Cabot's book—from whose pages so many of my remarks will be supplemented—that within twenty-four hours of tapping the r. b. c. count rose from 3,280,000 per c.mm. to 5,160,000, and adds that "a careless observation might have inferred a great gain in the corpuscular richness of the whole blood, when, in fact, not a corpuscle has been gained, and those present have probably grown poorer in albumen."

But in our case of congenital heart disease there was no such cause; he had not even been sweating very profusely, certainly not with sufficient rapidity to cause a diminution of the whole of his blood-plasma by one half.

4. An unequal distribution of corpuscles implies a certain degree of stasis, and perhaps some surgical members may be able to instance cases where the pressure of a tumour on a part had led to great slowing of the circulation and an increased blood-count in the congested part. But can we say in the case under consideration that there is any slowing of the circulation in the periphery? And if there is we must argue that the corpuscles tend to linger—and in venous blood they are supposed to be more lazy than in arterial,—while the plasma passes on. It is difficult to imagine what useful purpose such a procedure would serve; and since an occurrence without a purpose is inimical to the best feelings of a would-be pathologist, I leave it to you either to suggest the purpose, if you can, or to deny the occurrence, as I do.

It is impossible for me to profitably discuss the opposite condition—oligothemia, or deficiency of red corpuscles in number—without considering the concomitant changes in the Hb. As you know, anæmias are divided into two classes—*primary*, in which the cause is unknown, and *secondary*, in which the anæmia depends upon some more or less obvious cause.

Let me dismiss the *secondary anæmias*, such as those due to lead poisoning, malaria, nephritis, hæmorrhage, fevers, sepsis, and many other conditions, by saying that the chief changes they show resemble those of chlorosis (presently to be described), though as a rule the hæmoglobin does not sink so low, and that, so far as I can see, their special study would lead to more light being thrown on the shape, size, and abnormalities of the r. b. c. than the profession yet has at its command; and I will come at once to the *primary anæmias*—chlorosis and pernicious anæmia.

Even these have not escaped the expert's suspicion of being in all probability really *secondary anæmias*. Dr. Gee always looks askance at them as diseases occupying proud positions which they have no right to hold, and I shall have occasion later on to point to one example where the diagnosis was exceedingly difficult. Indeed, as soon as physicians can place their fingers on any condition or conditions as being the cause of chlorosis or of pernicious anæmia, all anæmias will be secondary, and it will remain for pathologists to discuss the differences between the various kinds.

For the benefit of the more recent students let me repeat the essential differences between chlorosis and pernicious anæmia.

*Chlorosis* is chiefly met with in young girls, and is almost never fatal. The r. b. c. are distinctly but not excessively diminished in number—rarely as low as 2,000,000,—whereas the Hb is enormously diminished. The average size of the r. b. c. is certainly below normal, their shape is good except in extreme cases, and very few of them are nucleated.

*Pernicious anæmia* is nearly always met with in men aged thirty to fifty, and is probably always fatal. The r. b. c. are much diminished in number, and the Hb, though diminished, is not diminished in proportion to the r. b. c.—*i. e.* each "average" corpuscle contains more Hb. than is normal. The average size of the r. b. c. is certainly above normal; several of them are nucleated, the presence of large nucleated corpuscles being an especially important feature.

It is convenient to express the variation of relations between the Hb. and r. b. c. by what is called the *Colum Index* in this way. The Hb. percentage is made the numerator of a fraction whose denominator is the percentage of r. b. c., 5,000,000 being called 100 per cent.; the fraction is then reduced to decimals. In this way the normal C. I. = 1.0, the 5,000,000, or 100 per cent. of r. b. c. corresponding to the 100 per cent. of Hb.

*Chlorosis*.—I have never yet had the pleasure of examining the blood of a case of real undoubted chlorosis in a man. Those cases of anæmia where a blood-examination gave a result at all nearly approaching the condition found in ordinary feminine chlorosis were undoubtedly cases of secondary anæmia—one of malarial and another of cancerous origin. There is a member of this learned Society whose face, when first I saw it, made me long to have his blood (for scientific purposes, I mean). He was, and still is, thought to a less degree, the picture of a chlorotic maiden; but for this he is apparently in good health, and I feel convinced that, could I have had a fair chance, I should have had some figures and a specimen to lay before you of an undoubted case of chlorosis in a young man.

By the kindness of Dr. Hayward I was allowed to examine the blood of several girls in the surgery, who were obviously chlorotic. The results I obtained have led me to believe that the C. I. is of much more importance in estimating the severity of a case than is the r. b. c. count. I mean that you may find several girls with, say, 2,000,000 r. b. c., and with 20 per cent. Hb (C. I. = 5), while other girls with a count of 3,000,000 will have only 20 per cent. Hb.,

giving a C. I. of '3, and these latter will often feel worse and be less fit for work than the former. I have not observed enough cases, however, to enable me to do more than offer it as a suggestion. Now cases of chlorosis have been watched without treatment, and it is believed that the first change in the blood is a diminution of corpuscle substance, and later only do their numbers become less—*i. e.* the corpuscles which die or are destroyed in the ordinary course of life are replaced by small ill-shaped corpuscles, with, perhaps, even less Hb. than their size could sustain. Why, then, do the girls in an apparently later stage of chlorosis sometimes feel less ill than those in an earlier stage? Is it that the 2,000,000 corpuscles are better equipped with Hb., and hence more efficient, than their less fortunate friends in the 3,000,000 lady? or is the rapidity with which the Hb. is lost a more important factor than the actual amount?

*Pernicious anæmia*.—Let me call your attention to these two charts, representing the typical gross changes in the blood in chlorosis and in pernicious anæmia.

See how much higher the r. b. c. curve is in chlorosis than in pernicious anæmia, and how, in consequence, the Hb. curve is much closer to the r. b. c. curve in the latter than in the former; indeed, the vertical distance between the two, and their position relative to each other, represent the changes in the C. I. (the absolute value of the vertical distance varying according to the height in the chart).

You will notice in the chart of pernicious anæmia that while improvement is going on the Hb. line lies gradually nearer to the r. b. c. line, and finally below it, and when the relapse occurs the r. b. c. line sinks below the Hb. line; the C. I. is thus again raised to more than 1. So that in this pernicious anæmia, as in chlorosis, the C. I. is of value, in this case being an indication of improvement or otherwise, according as it becomes less or greater.

I wish to say a few words about the look of the corpuscles under the microscope. In pernicious anæmia the corpuscles are more varied in shape and size than in any other disease; there are some very small ones, generally much misshapen, but the noticeable feature is the presence of many large corpuscles, some well-shaped, some deformed, and they are obviously paler than normal.

There was a case of pernicious anæmia in Luke nearly three years ago who had blood transfused from another to him on three occasions. It was curious to notice in a drop taken from his finger after the transfusion the difference between the healthy corpuscles and his own irregular corpuscles.

In stained specimens the same features are seen, though not so well, and it is also found that a small number of these red cells, both large and small, are nucleated. Moreover their protoplasm is in patches of a dirty brown or purplish colour instead of the usual eosin pink (if eosin is the dye used); this is notably the case in some of the nucleated reds.

Now in the blood-films of chlorosis you never see such large corpuscles as in pernicious anæmia, where some of them may be 10 or 12  $\mu$  across, half as broad again as normal; the variety in shape, too, is not so constant nor nearly so marked when present, and the brownish staining effect noticed above is much more rare.

No one has satisfactorily settled yet the meaning of any of the appearances I have mentioned; thus the deformity is considered by some to be due to a lack of elasticity of the corpuscle, so that it has no time to regain its shape, lost in the passage through the capillaries; but against this is the undoubted fact that the smallest corpuscles are those that are most deformed. Others have suggested that the appearances are produced in the making of the film; certainly somewhat similar appearances can be artificially produced, but even if they always were, it does not explain why they are more easily produced in pernicious anæmia than in any other disease, care in making the films being equal in all cases. Again, the peculiar staining effects described primarily by Maragliano, and by Hayem, have been variously looked upon as degenerative and as regenerative effects. Most think the former, and yet they often appear in nucleated cells, whose presence is almost universally believed to indicate regeneration. (Truly pathology should spell patience.)

I ought to separate the large type of nucleated red cell from the others when I say that they are almost universally believed to indicate regeneration. It differs from the others in that it is not found in normal adult bone-marrow, while the others are; it is found in fetal marrow. It is called a megaloblast, and Ehrlich considers it the sign of a fetal type of blood formation, where the nucleus is absorbed, not extruded to grow again, so that new cells are not formed from it. Therefore its presence in pernicious anæmia is always looked upon as a marked characteristic of the disease, and its abundance as a bad prognostic sign.

Nucleated red cells, mostly of the normal and small varieties, are also frequently present in severe secondary anæmias, especially, it is said, when due to malignant disease.

A woman was admitted to this hospital nearly three years ago for severe anæmia and wasting. Some time previously she had had her breast removed for what was diagnosed as cancer; she had no recurrence, but under the skin of her arm and forearm there were several small hard lumps whose nature was not settled by removal. No glands were found to be enlarged. I will not now discuss the clinical reasons for considering her a case of pernicious anæmia on the one hand, or of secondary anæmia due to malignant disease on the other.

The condition of her blood was as follows:

Hb.	29 per cent.	} C. I. = 1.03.
R. b. c.	1,395,000	
W. b. c.	32,000	

There were more than 1 per cent. of nucleated red corpuscles of very varying size. Many r. b. c., both with and without nuclei, showed purplish staining effects.

Her blood-stain was investigated frequently, with practically always the result stated above; her anæmia did not progress. No profuse hæmorrhage nor suppuration accounted for the large number of leucocytes, a phenomenon which is exceedingly rare, and of very grave import in pernicious anæmia, and yet a C. I. as high as hers (1.03) is very uncommon in anything but pernicious anæmia. Imagine how tantalising it was to see those lumps under her skin, and feel that the diagnosis of her complaint rested there—beyond reach.

I have mentioned the magic word leucocytes. It is around these interesting little bodies that pathological study has raged incessantly. I wish to remind my future research clerks that in making blood-films the essential thing is to have an absolutely clean cover-slip; I clean mine now with soap and water, and keep them in alcohol and ether. It is necessary, too, to take a very small drop of blood to avoid squeezing the two cover-slips together, and to slide them apart rapidly. The poverty of some of the specimens I have put up for your inspection is due to want of care in one or other of these points. Fixatives, such as the vapour of osmic acid, or of formalin, are of use in preserving the shape of the corpuscles until the film is dry. Before staining it is necessary to heat the films: passing three times through the flame is enough for staining with eosin and methylene blue; when using Ehrlich's triple dye more regular and prolonged heating is necessary.

Owing to the work first of Ehrlich, and later of Kanthack and Hardy and others, the various kinds of leucocytes have been fully described, and have received names accordingly.

	Normal adult blood
Lymphocyte	... 20-30 per cent.
Large mononuclear	... 4-8 "
Polymorphonuclear (neutrophil)	... 60-70 "
Eosinophil	... 1-4 "
Myelocyte	... "
Basophil	... "

Now that seems very straightforward and simple, but as a matter of fact it is complicated by the following conditions:

1. The presence of intermediate forms.
  2. The age of the person examined.
- Frequently in the blood of an apparently healthy person one finds various forms of leucocytes which do not quite conform to these types.

One is therefore not surprised to find that on examining the blood, not of a healthy person, but of a case of any disease whatever, it is sometimes exceedingly difficult to arbitrarily decide to which of two classes some leucocyte or other belongs. Eventually some preponderating characteristic leads to their being placed in one group or the other, or they are impatiently noted as "intermediate forms" at the bottom of one's list. The question has naturally been raised, "Are these intermediate forms transitional?" and there seems to be a good deal of evidence in favour of the idea; indeed, though admitting the matter unproved, Cabot, for convenience' sake, calls the lymphocytes and large mononuclear "young," the polymuclear "adult," and the eosinophil "old" leucocytes.

A specimen shows what I take to be a lymphocyte dividing. Do not please infer that the peripheral circulation is the normal multiplying ground of these structures; though similar phenomena have occasionally been reported, the occasions are very few.

Then one must be prepared, when examining the blood of infants or young children, to find a larger percentage of lymphocytes and smaller of polymuclears than in the adult. In infancy 60 per cent. of lymphocytes is quite a normal thing; as the child gets older, so does his blood gradually assume the older state; but should sickness

of any kind retard his progress in health, the "aging" of his blood is also retarded, so that in a rickety child of a year old we may find but little improvement on the blood he might have possessed at six weeks. So, too, the nucleated reds, which are commonly present in the first few hours of life, are called up again with ease by a slight illness in a child, whereas the grade of anæmia in an adult must be severe to account for their presence in anything but the very smallest numbers.

We will return to this when we have considered the phenomenon of leucocytosis.

This raises the question, "What is the normal leucocyte count?" It varies slightly in all probability with each individual, just as temperature does, and as leucocytosis is proportional to the normal number, where are we to start?

Kanthack used to teach that for clinical purposes, anything above 10,000 in an adult, or 30,000 in a child, was to be considered as a leucocytosis. But there are several physiological causes for a small increase in the number of leucocytes, in some cases the rise not being above the limits set by Professor Kanthack. Suppose a man's blood contains 13,000 leucocytes per c.mm., and the relation between the various kinds is practically undisturbed; is this a leucocytosis? Yes; and to explain it we find that two hours ago he had a large proteid meal, or he has just been engaged in some severe exercise, or has had a cold bath. In these conditions the leucocytosis is physiological. Such leucocytoses are generally slight in degree, and the relative proportion of the various kinds is very little disturbed.

Fasting diminishes the leucocyte count. Succi, the fasting man, had only 861 per c.mm. during the first week's fast, and never more than 1530 during the other three weeks. Similarly any disease of the digestive tract putting digestion out of gear will do away with the digestive leucocytosis. It is interesting in this connection to note that during digestion the eosinophils are diminished in number, and you will remember that Heidenhain demonstrated the abundance of eosinophil corpuscles in the intestinal tract just beneath the mucous membrane (not in increased numbers, though during digestion). It is said that vegetarians, like other herbivorous animals, show no leucocytosis. A small leucocytosis is the rule in the later stages of pregnancy, and at all events for a good part of the period of lactation. It is important to recollect these possible causes of moderate leucocytosis when investigating cases of disease.

In pathological leucocytoses the rise in the number of leucocytes is often very great, and nearly always entails—indeed, is almost entirely due, except in some cases of malignant disease, to a relative increase in the number of the polymuclear cells. I think I include all causes of pathological leucocytosis when I mention large hæmorrhages, toxic influences, microbial or chemical malignant disease. Of hæmorrhage I have no more to say, and of malignant disease I only wish to remind you of the case of the woman with 1 per cent. of nucleated r. b. c., and that the large number of leucocytes (32,000), constantly found in her blood constituted an important argument against P. A., and in favour of malignant disease. In favour, so far as it goes, of P. A. is the further fact that it was the young cells, lymphocytes, and large mononuclear which were chiefly increased. The only thing certain about her is that the abundance of nucleated reds and of lymphocytes both recall more the condition found in the blood of an anæmic child than of an adult.

As an example of leucocytosis due to toxic influences, I cannot do better than bring forward pneumonia. Here are the charts of two cases, showing the daily changes in Hb., red corpuscles, and leucocytes, until one or two days after the crisis. You will see that there is a moderate leucocytosis during the course of the fever, terminating a day or two before the crisis with an enormous rise in the leucocyte count, in the case of the adult to 31,000 per c.mm., and in that of the boy to 56,000. With the fall in temperature occurred the fall in leucocytes, so that the blue leucocyte line marked the crisis in each case even more sharply than the temperature curve. (Dr. Garrod, working at leucocytosis in rheumatic fever, came to the conclusion that the leucocyte curve was even a more delicate indication of the rheumatic state than the temperature chart.) I would, in the case of the boy, call your attention to the second rise in the leucocyte count up to 42,000; a day or two after this count it became evident that the boy had developed an empyema. In the man's case there was no complication, and the leucocytes remained normal in number.

The leucocytosis in pneumonia is not always so marked as in these two cases. In some the count will only rise to 12,000 or 13,000; in a few there is no rise at all. Have these facts any meaning? Apparently they have, and it is this: that the sharper

the fight between the patient and his disease, the greater the leucocytosis. If a febrile being receives a large dose of "pneumonia germ," there will be practically no leucocytosis, and he will probably die. If a healthy and abstemious young man is infected slightly, he will give an enormous leucocytosis, and may or may not recover, the leucocytosis giving no promise one way or the other. As regards prognosis in this disease, then, the only thing to pray for is that a leucocytosis of some sort; that assures us of, at all events, a certain amount of effective resistance to the disease. It is not on clinical evidence alone that this assumption rests. Animals have been injected with varying doses of septic cultures, with the result that only in those cases in which the dose was very rapidly fatal did the leucocytosis fail to appear, and that weakened animals gave less leucocytosis than strong ones to a moderate dose. So, too, it has been noticed that patients whose strength has been very seriously diminished by some disease, whether by one that gave a leucocytosis or not, have not shown any increase or additional increase when that disease has become complicated with another like pneumonia.

Leucocytosis, then, like the temperature, is to some extent a measure of a patient's reaction to disease, but the comparison is not always commensurate. Look at this card (Alfred Langley), and contrast the very high temperature shown on the back with the poor leucocytosis of 18,000 mentioned in his notes, the blood-count having been made just before his crisis.

Von Jaksch, hoping to induce a favourable issue in those usually very fatal cases of pneumonia which give no leucocytosis, suggested by the causation of an abscess, and therefore of a leucocytosis, by injecting turpentine. Leucocytosis has been caused in this way, and also without abscess, by injecting pilocarpine or nuclein, but with no more benefit to the patient than Dr. Gee avers can be given to a case of bronchitis by purging him, even though a natural diarrhoea sometimes favourably ends the case.

To conclude the general consideration of this phenomenon, I must mention that the diseases which give no leucocytosis are typhoid fever, malaria, influenza (some cases), measles, Räteln (German measles), and tuberculosis; always remembering that complication of these diseases, such as by copious hæmorrhage, pneumonia, or sepsis, will in all probability produce their usual leucocytosis unless the patient is already much weakened by the disease.

I have in another place instanced a few examples of the use of this knowledge in the diagnosis of disease, and will, with your permission, repeat them here ('St. Bart.'s Hosp. Reports, 1898, p. 211).

Partly as a curiosity, and partly because of its clinical interest, I will quote to you some extracts from the notes of that case of pernicious anemia, who, I told you, was transfused three times.

He was a man of 35, admitted on July 16th, 1897, for anemia, pyrexia, and vomiting. On August 11th there is this note:—"Became delirious. Delirium at first quiet, then noisy; strange objects seen;" and the next note is "male attendant; temp. about 100°—101°."

"August 13th.—Oxygen inhaled 10 min. every hour; after a few inhalations patient became drowsy and less delirious."

"August 14th.—Still light-headed; at 5 p.m., is sensible, comments properly. 3.30 p.m., transfusion 3viii; 5 p.m., is sensible, comments on his improvement; temp. 102° at night."

"August 15th.—Enjoys solid food, sits up in bed. "Ten days later he has produced no benefit worth noting. On September 10th, "2.30 p.m., third transfusion 3x; bad fit of coughing during the operation. 4 p.m., began to shiver; typical rigor for half an hour, temp. 101.7°; pulse 150, full and soft. 7 and 8 p.m., temp. 103.7°. A.B. distinct (1 inch outside L.N.L. and C.D. to right of sternum), not felt on admission."

"September 11th.—Temp. normal. Urine—a marked urobilin band (once in the twenty-four hours before transfusion)."

The improvement after this seems to have lasted longer, for on the 21st (eleven days after transfusion) he fed himself. But in little more than a week he was dead. Post-mortem examination found nothing to account for his anemia.

I will pass round a list of the blood examinations made on this patient, with notes on the important points, only remarking on the absence of leucocytosis, indeed, upon the very small number of leucocytes present in spite of the high temperature, except on the occasion of his rigor after the third transfusion—diminution in the number of leucocytes, as I said before, being a feature of pernicious anemia, and also on the apparent glee with which the new healthy corpuscles are seized upon and destroyed, the evidence being not only the transitory nature of the rise in the r.b.c. count, but also in the presence of urobilin in the urine after transfusion.

So much for absolute leucocytosis; I come now to changes in the relative proportion of the various kinds of leucocytes to one another, a consideration which includes the vast study of leukæmia.

This chart (on the wall) shows you the course of the leucocytes in pernicious anemia. I have made it represent on the average a low count of about 2000 while the patient is very ill, and a rise to 10,000 or 12,000 while improvement is going on. I have done this in order to call your attention to the blood-chart of a fairly typical case of pernicious anemia, which I now pass round (J. H. R.). You will see that during the first few weeks of his stay in hospital the only steady rise in his blood-improvement was in the leucocyte count, and that this rise in his blood-improvement was in the leucocyte count, and that this feature was conspicuously absent during his second stay in hospital, during which there was no improvement at all. In the other respects during which there was no improvement at all. In the other respects the chart is not quite as typical as my big one on the wall, but it shows the high Colour Index of October 26th, which was of serious import, and although at the time his face and hands were browned by the sun and looked very well indeed. (I have called attention among the spectators to one of this patient's taken at this time, and still showing many deformed corpuscles.) But though the number of leucocytes is so small in pernicious anemia, there is, especially in severe cases, a relative increase of the lymphocytes over the other varieties, making the proportion resemble that found in infants and young children. Thus in this patient's blood the

Lymphocytes	were 34 per cent.	} 45 per cent.
Large mononuclear	" 11 per cent.	
Polynuclear	" 51 per cent.	
Eosinophil	" 2 per cent.	
Myelocytes	" 2 per cent.	

A similar lymphocytosis, as it is called, is also found in chlorosis and in many secondary anemias, e.g. those due to syphilis or malaria.

I have put up some specimens to illustrate the condition known as eosinophilia—relative increase of eosinophil corpuscles. The phenomenon has been noticed in various conditions, notable among which are certain affections of bones and of the skin. Trichinosis is one of the conditions in which it is found, and I have put up a specimen of blood in this disease, which was stained by Prof. Thayer, and given to me by Prof. Kauffack. Account of this case showed a leucocytosis of 33,000, and 44 per cent. of the leucocytes were eosinophils. Next to it you will see a film made from a gentle scraping of the floor of a bleb from a case of pemphigus, and you will see that the leucocytes are nearly all eosinophils.

I should leave my already long paper incomplete if I failed to say something about leukæmia, but all I intend to do is to call your attention to two cases of disease in children, in which the blood count was such as to cause much discussion as to whether they were cases of leukæmia or not, and I do so because leukæmia itself is too big for me to attempt to discuss in a short space of time, and because these two cases in my estimation form a powerful link between leukæmia and other blood conditions.

A boy (J. H.), æt. 7 was admitted with dyspnoea, bleeding from the nose and mouth, and marked anemia. He had huge tonsils and adenoids. Some dullness under the upper part of the sternum, and towards its right just suggested mediastinal tumour; his spleen was enlarged. Later some glands were felt in the neck, and these grew rapidly. A month after admission he had enlarged and enlarging glands in axilla, groins, and abdomen; his spleen grew enlarging glands in axilla, groins, and abdomen; his spleen grew wofully. At this time his Hb. was 24 per cent., r. b. c. 2,500,000, and w. b. c. 50,000, of which many were lymphocytes. Now 50,000 is not a high enough count to suggest leukæmia at first sight, though it is quite possible; indeed, in one undoubted case of splenic leukæmia in an adult the leucocyte count was found to gradually vary from 200,000 to 80,000 and then back again, the altered relations between all kinds being maintained throughout, and it is usual in children, as I stated before, to get many lymphocytes when they are very ill; but a fortnight later his blood showed Hb. 20 per cent., r. b. c. 1,848,000, and w. b. c. 146,000  $R = 1\frac{1}{2}$ . There were some nucleated rods; the lymphocytes and large mononucleated together exceeded 90 per cent. of the leucocytes, and some of the latter resembled myelocytes as well as they could for the staining, and a week later an almost exactly similar result was obtained. It is a result that places the condition of this boy's blood in the rank of lymphatic leukæmia whatever the cause of the condition might be. The mediastinal tumour was found after death, and many of the glands were filled with secondary growths.

So with the second case, that of a slightly rickety baby of eighteen months, who was so blanched, and fair, and waxy that she received the name of "the Botticelli baby."

In her illness, as in the boy's, hæmorrhage from the nose or mouth was prominent among her earlier symptoms. Her spleen was the only organ enlarged, and that was huge. "The cervical glands were felt, but were not unduly large."

On admission her r. b. c. = 2,450,000, and her w. b. c. 160,000; six weeks later they had reached 1,900,000 and 27,000 respectively, and in another six weeks were 2,152,000 and 108,000. On this last occasion Dr. Kanthack reported finding

51 per cent. lymphocytes.
10 per cent. mononuclear.
35 per cent. polynuclear.

4 per cent. eosinophil, of which a half were atypical, a state of things which would fit in well with normal health, but for the enormous excess in actual numbers.

Whether any of the latter or any of the large mononuclear were myelocytes is not reported, but his opinion is recorded that it was a case of mixed leukæmia—splenic and lymphatic. Nowadays, at all events, the presence of the myelocyte in large quantities is regarded as characteristic of splenic leukæmia; but it must be remembered that they often appear in small numbers in other diseases, especially in anæmic children. This child got quite well, and is alive now, and is nearly six years old. Not the least curious feature is the fact that two children born to her parents since have both been admitted here—one twice—with petechiæ and huge spleens, showing grave blood-changes, including the presence of 7 per cent. of myelocytes on one occasion, but never such enormous numbers of leucocytes. They were not regarded as leukæmias, and yet the size differences seemed to be that the elder sister, whom I have described, was more ill than her brother and sister, and had a very large leucocyte count.

This must conclude, I am afraid, my account of the points one looks for in examining the blood of a patient. You would not wish me to have put something of everything into the space of an hour's reading; as it is, I have done little more than hint at some of the more interesting problems that have arisen constantly in the course of a few years dabbling in the science of blood pathology.

### Common Fetal Presentations accompanied by Complications.

By PERCY SHELLEY, M.R.C.S., L.R.C.P.

THE following cases of labour at full time, which appeared normal on examination, seem of interest on account of the complications occurring in them.

CASE 1.—A young woman, primipara, unmarried, aged 19, was seized with labour pains. On examination the os was found to be dilated to the size of half-a-crown. An ordinary occipito-anterior was diagnosed, and as this was her first baby, and later I again examined her, and to my astonishment found a pear-shaped mass protruding from the vagina. This, I discovered, was a fibroid polypus, and as she seemed in great pain, and was evidently getting very weak, I sent for a local gentleman to give an anæsthetic. The polypus was removed, and then the head could be distinctly felt, firmly wedged in. On either side could be felt something which gave the impression to the finger like nothing more than a blanched mango. In the examination a quantity of white, clear, jelly-like substance came away on the finger. After a consultation it was decided to get away as much as possible and apply forceps. This was done, and it was then discovered that there was some great obstacle to natural labour. The masses on either side of the head were removed, and proved to be polyipi. After this had been done the child was born quite easily. A difficulty then presented: the uterus would not contract down for a long time—i. e. two hours,—and felt more like a bunch of grapes than anything else.

CASE 2.—A woman aged 40 was confined in the due course. I was called in, as the baby's head had been born quite fifteen minutes, and though pains were strong, nothing occurred in the way of advancement. When I arrived the child's face was almost black. I introduced my finger, and found a curious condition. The cord was wound twice round the neck, enclosing the hands. Very great force had to be used in traction on the head to release it, and even then there was great difficulty in getting the cord clear. The hands added

greatly to the difficulty, as they overlapped the lower jaw on either side. The infant (a female) weighed quite 10 lbs.

CASE 3.—A multipara, aged 40, was confined of her fourth child. Labour was normal up to the head being born. A difficulty then arose, as no progress was made. After traction had been made the child (a healthy female) was born. In this case the feet were alongside the lower jaw bones. The child was perfectly formed, and of large size as far down as the hips. Here a curious state presented itself. There were no hip-joints; the glutei muscles were to the front; the left knee was posterior; there was no right knee at all, and both patellæ were absent. There was also double talipes equinovarus. The mother had a fall at three months, and a fright on seeing a child of a friend of hers which was born in a somewhat similar state.

I strongly and most emphatically pray that the medical faculty will one day pass a law in Parliament regarding these old women, who, knowing nothing, but because they are mothers, fancy they can manage labours, go out, and in nine cases out of ten cannot express the placenta, but have to send for a doctor to do it for them. Many and many a time have I been called up at all hours of the morning to go to a confinement, only to find the placenta lying idle, so to speak, in the vagina.

In some cases I have found distinct evidences of traction on the cord. One case in particular I remember, in which the so-called midwife had tried all she knew to remove the placenta. When I arrived I found the patient almost pulseless, and the bed soaked in blood. It took me three hours before that uterus contracted down and I had reduced the subinvolution caused by the unregistered woman—I cannot call her a midwife in honesty.

### Notes.

THE Bradshaw Lecture before the College of Surgeons will be delivered on Wednesday, December 12th, at 5 o'clock, by Mr. Langton. Subject, "The Association of Inguinal Hernia with the Descent of the Testis."

\* \* \*

DR. J. MORRISON has resigned the post of Midwifery Tutor.

\* \* \*

WE very much regret to record the death of William Phillips Price, one of our second year's men, who died on October 18th from an attack of perityphilitis. Price was twenty-four years of age. After matriculating at London University he joined the Preliminary Scientific Class in 1896, and after passing the examination he joined the Hospital in October, 1897. Price was a popular member of the Transport Section of the V.M.S.C. for five years, going four years to camp at Aldershot. His loss is deeply felt by all his associates at the Hospital.

\* \* \*

WE congratulate Mr. Louis F. Dods upon the favourable result of his application for judgment of a new trial of the case heard in June last. Our readers may remember that an action was brought by Miss Dowling, a professional nurse, against Mr. Dods for damages for libel said to be contained in a certificate of lunacy addressed to the relieving officer for Paddington. Before Mr. Justice Darling and a common jury the trial ended with a judgment for the plaintiff, and damages assessed at £100. On November 6th, before the Court of Appeal, this judgment was reversed, and costs were allowed.

THERE is a scheme afloat for starting a University of London Athletic Club—or Clubs. At present there seems to be considerable difficulty in deciding whether the name shall have anything to do with the actual constitution of the clubs or not; in other words, whether the clubs shall be restricted for their membership to matriculated students, or thrown open in a truly cosmopolitan fashion. But we are postponing criticism until next month, by which time some definite proposals will doubtless be before us.

\* \* \*

We have received an indirect suggestion from a subscriber that we should publish a "Calendar of Old Bart.'s Men" in the JOURNAL. We should welcome any practical suggestions heartily, for news of old Bart.'s men is always of interest, and finds a ready entry in our columns whenever it arrives. A mere list of old Bart.'s men and their addresses would be a superfluity in face of the small book allotted to these, and issued periodically by the School, whereas for actual items of news connected with our older *confrères* we are dependent largely upon their own communications. For their knowledge of each other's doings we are ever ready to provide a medium, but our personal editorial reminiscences are unfortunately limited to a decade or so, and many names we see in print, or hear in conversation, do not therefore always stir our souls as they might do those of their contemporaries. Once more, then, we cordially invite any items of news concerning old Bart.'s men, either from themselves or those who recognise their names as old friends.

\* \* \*

WE would remind our readers that we do not print contributions unaccompanied by the names of the authors, though these latter are not necessarily required for publication. The poems we have printed in recent issues seem to have awakened a spirit of emulation previously dormant. Unfortunately the Muse has not been wooed with great success. Like so many other wooings where the object is worth the winning, new endeavours would seem necessary before the aspiring poet is smiled upon, and shows it in his rhyme. As it is, we feel sure that the greatest disappointment amongst those who read the poems if we printed them would be felt by the authors themselves. Perhaps the best unpublished thing is by C. R. A., called "The Medical Student from a Feminine Point of View." But the following is surely too gruesomely impossible, either in actuality or in print:

"It's a little disconcerting, when your arm on his is resting,

As you flit among the dancers to the music's sportive sound,  
When he tells you that the member which last week he was dissecting

Though not perhaps so white, was most decidedly more round."

So we refrain, hoping to receive something rather more likely from C. R. A. next time.

WE welcome two new contemporaries this month:—*The New Zealand Medical Journal*, and *The Durham University College of Medicine Gazette*. The former promises to occupy a prominent place amongst purely medical periodicals. The latter makes a good start as a students' journal.

\* \* \*

THE Annual Dinner of the Medical Officers and Teachers is announced for Thursday, December 20th, at the Albion Tavern, at 7 for 7.30 o'clock. Dr. Ormerod is the Chairman. The Dinner was not held last year, owing to the news of the rather sudden death of Sir Richard Thorne Thorne.

### The Amalgamated Clubs Dinner, 1900.

(By our SPECIAL REPRESENTATIVE.)



WAS a few minutes late in arriving at the Café Monico, and the company were just settling into their seats as I entered the room. I therefore lost no time in finding a vacant place, and occupying it just a few minutes before silence was called for grace. This having been said, I had leisure to look about me and review the situation, whilst the first item on the menu card, viz. relishes, were coming round.

Seated at the end of the hall, with the band behind me, I had a good view of the company. My eyes wandered first to the figure away on my left who occupied the "chair." It was Dr. Calvert, looking as genial as ever. Seated on his right was Dr. Tooth, next to whom sat Dr. Hensley, chatting genially to his next door neighbour, whose name I did not then know, but learnt subsequently was Dr. Murray. To his right was Dr. Calverley, looking very fit and just the man for a dinner. On the chairman's left was a line of familiar faces, first of all being Mr. Bowlby, and following on from him Mr. Laming Evans, Mr. Rowe, Mr. D'Arcy Power, Dr. Herringham, Dr. Garrod, Dr. Drysdale, and Dr. Orton. The relishes had arrived at me by this time, so for a space I was otherwise occupied; but between the courses I made out Dr. Griffith and C. Meade, the latter of whom quaffed champagne like a connoisseur, and gave evidence that South Africa had not destroyed an appetite which I well knew in days gone by to be very robust.

The first part of the dinner was quiet, but by-and-by tongues were loosed and a general hum of conversation was heard.

During the dinner an excellent band performed several well-known and popular favourites, so altogether circumstances were very favourable to the enjoyment of the occasion.

Just as the dinner was concluding a very impressive ceremony was performed, of which I got a good view. I had noticed a man at the far end of the room busily engaged in erecting a species of watch-tower, on the top of which he at last placed a camera; this gave me a clue to what was going to happen. Eventually his preparations were complete, and having attracted general attention by this time, he made a little speech, advising all assembled to keep quite still. At this those who had their backs towards him screwed their heads right round and became quite immovable, which gave the little man great apparent satisfaction. There was a click, and then two brilliant flames of light burst forth and waved about in two different parts of the hall, reminding me of a scene in "Faust." They vanished as quickly as they had come; then the little man made another little speech, which was cheered with vigour by the company, in which he gave us great thanks for our kindness.

Hardly was this over when Dr. Calvert rose to his feet, and without any preamble proposed the health of the Queen—general rising of company; National Anthem from band; raising of glasses; "The Queen, God bless her!" empty glasses set down; company reseated. Now cigarettes and cigars appeared from everywhere, a general blaze of striking matches, and a fragrant cloud of smoke floated lazily up to the richly ornamented roof of the dining hall. A gentleman, tall and broad-shouldered, was observed to rise and make his way to the platform occupied by the piano; he sang a song in a good rich baritone, which was so loudly applauded that he consented to give an encore, and sang a quaint west country song descriptive of the death and ghostly reappearance of somebody's mare drawing a ghostly cart filled with an equally ghostly number of passengers whom he mentioned by name. His actions were very comic, and his imitation of the yokel accent was perfect, added to which the song had a short catch of a chorus, which was joined in by every one present.

A few moments were allowed for the thunders of applause to subside, and again Dr. Calvert rose in his seat to propose a most popular toast, viz. "The Amalgamated Clubs." His remarks were few but characteristic of the man—very much to the point. He said the Amalgamated Clubs were an essential part of Bart.'s; that they gave opportunity for the physical development of their members just as the school and hospital gave opportunity for their mental development; that a proper combination of sport and work was acknowledged the best training for a student, both during his student's days and for his battle with the world in practice afterwards. The Clubs were in a flourishing and rapidly growing condition; he could give evidence of that in the frequent demands made upon their treasurers by the different units for "more money." He was extremely pleased to see such a large number there to-night, and thought it augured well for the future. He then proposed the health of the Clubs, which was enthusiastically drunk.

Mr. Tosswill's speech, in reply, was like Dr. Calvert's, short and sweet. He congratulated the members of the Clubs on their good fortune in having Dr. Calvert in the chair, and made a splendid hit by referring to the aptitude which Dr. Calvert had for making the dull subject on which he lectured at the hospital the most interesting, and referred to a description of a drug which has become almost historical amongst Bart.'s men, namely, that drug which is made from "the expressed juice of the squirting cucumber." There had been applause before, there was applause after, but none equalled the delighted shout which greeted this remark. In the remainder of his speech Mr. Tosswill said that they were always glad to see any of the staff present at the matches and athletic contests in which the Clubs engaged.

The next toast on the list was "The Guests," and here Mr. Turner made an admirable speech, his sentences well chosen and well delivered.

Mr. Bowlby replied, and as he rose to his feet it was evident that the popularity which he has always enjoyed had in no way diminished. The leading figure in the Portland Hospital was cheered again and again as he stood calmly waiting till such time as his voice could be heard.

His speech was most interesting, and in places exciting. Seated on my right at a little distance was a group of men who had evidently decided earlier in the day to sit together at the dinner. They were cronies, and were very great admirers of the speaker; they encouraged him to "start right away" and "not be bashful"—a most unnecessary bit of advice. They also formed a little "chorus," and made appropriate remarks as the speech proceeded.

Mr. Bowlby started off by saying that the influence of Bart.'s was wide-spread. (The chorus agreed.) He was always meeting Bart.'s men in out-of-the-way places; this led up to a short description of the African campaign from Mr. Bowlby's point of view, and the work of the Portland Hospital. He spoke very highly of the British Tommy Atkins, his obstinacy and perseverance, his eagerness to fight, and above all, his uncomplaining cheerfulness under adverse circumstances. He also made special mention of the Commander-in-Chief, much to the delight of the chorus. There was one characteristic of Lord Roberts he must specially mention, and that was his consideration for the sick and wounded (chorus, 'Good old Bobs!'); he never ceased to think of their welfare (chorus, 'Dear old Bobs!'). Directly after reaching Capetown he rode over to the camp to inspect the work (chorus, 'Smart old Bobs!'), after which he went straight on to somewhere else to inspect more work (chorus, 'Brave old Bobs!'); after which he rode 33 miles to inspect again (chorus, *crescendo*, 'Energetic old Bobs!'); then he went to an hotel to lunch (chorus, still louder, 'Greedy old Bobs!'). Nothing seemed to escape his eye (chorus, admiringly, 'Cunning old Bobs!'). On one occasion he rode a long distance, got ambulance waggons, and started

off a batch of wounded, having presented them with unlimited champagne (chorus, longingly, "Generous old Bobs!"). Mr. Dowly mentioned many Bart.'s men by name whom he had met in South Africa, some going in pursuit of De Wet, some who went down with enteric, one who had gone to Ceylon, and one who was then present whom he first met at Bloemfontein, driving in tent-pegs, viz. C. Meade (chorus, unanimously, "Good old Charles!"). The last part of Mr. Bowlby's speech was a yarn which he told of his own personal observation of Tommy Atkins; it was excellently told, and had a breeziness about it that Rudyard Kipling might well envy, and brought the house down.

Closely following Mr. Bowlby came Dr. Tooth, whose speech was eminently humorous. He said he felt horribly embarrassed, but the chorus didn't believe him; he described several incidents and persons of the Portland Hospital, and laid great stress on the unanimity of the little community; all selfishness seems to have been abolished, and a spirit of "help your neighbour" reigned supreme; the motto of "Every man for himself, and God for us all," did not apparently exist. In conclusion he prevailed on C. Meade to say a few words.

These were spoken chiefly in praise of the war orderly, both regular and volunteer, of the army in South Africa (chorus, "Still going strong").

Mr. Calverley followed with a neat and funny speech also on the subject of the Portland Hospital, with a brief mention of buck-shooting. The next toast was that of "The staff," proposed in a short speech by Mr. Nicholas.

Dr. Hensley made a speech witty and well-spoken in reply, and remarked on Mr. Bowlby's yarn which savoured of Kipling (chorus in a fever of delight). Dr. Hensley then proposed the health of the Chairman.

Dr. Calvert responded (chorus again rampant). He said the dinner was a special occasion, and had become a khaki dinner; and he felt, as Dr. Norman Moore had said at the recent Cambridge Graduates Dinner, that we ought to respect Lord Roberts's request about *not treating* returned soldiers, and his conscience rather pricked him about Mr. Bowlby and his colleagues, but he hoped that they would not get into a row (chorus furious at the idea).

Dr. Murray, who was House Surgeon and House Physician in 1885-6, and who since then has been in practice at Johannesburg, and was in the town throughout the war until Lord Roberts entered it, gave a very interesting speech, descriptive of the Boers, the way they live, and the way they accepted the success which attended their first efforts in the war (chorus would like to express disapproval, but are compelled by the interesting nature of the speech to refrain).

Dr. Griffith, in a few well-chosen words, spoke of the medical missionary work in China, and the nature of the men engaged in it (chorus look rather sheepish).

The evening was drawing to a close, and Dr. Calvert

suggested as a fitting wind-up that Mr. Crompton, the tall, broad-shouldered gentleman before mentioned, would oblige with another song, preferably with a chorus. (The chorus are again unanimous.)

The song described again a yokel scene in a church when the organ it went toot, toot, toot, and the organ it went toot. The yokel accent was again perfectly imitated.

"Auld Lang Syne" and a rush to the cloak room finish a perfect evening. As the company trooped down the stairs, adjusting coat collars and neckerchiefs, they one and all agreed that for an enjoyable dinner that of the Amalgamated Clubs in the year 1900 was second to none.

### "Amalgamated."

**T**HE Clubs Amalgamated,  
By Bartholomew they swore,  
Their friends Perpopulum and Dens  
Returned from the war  
Should be welcomed at a dinner

At Café Monico,  
And bade the secretaries go forth  
East and west and south and north  
To bid the members go.

East and west and south and north  
The secretaries sped,  
And fast as woman's gossip  
The festal news is spread,  
Shame on the faltering member!  
The laggard slacker slow,  
When Clubs Amalgamated  
Meet at the Monico.

And now they all are gathered,  
The host of members keen;  
Here's Rugby, Soccer, Hockey,  
And others, too, I ween,  
Around the well-spread table  
Is met the great array;  
Proud was Amalgamated  
Upon the feasting day.

For the host of St. Bartholomew  
Assembled 'neath his view,  
And many a doughty dresser,  
And many a "roomsman," too,  
The qualified, the fresher,  
And men beyond their year  
Are gathered here to meet again  
Their friends returned from fields of stain  
With many a ringing cheer.

And from the Chieftain's table,  
Who held the chairman's seat,  
Arose 'mid cheers and plaudits,  
And the stamping fierce of feet,  
And the stamping fierce of feet,  
Calvertius Jacobulus—  
Our cheery warden he—  
Presiding o'er the tens and tens  
Who greet Perpopulum and Dens  
From far across the sea.

And then rose massive Toeswill,  
The secretary he,  
Who gave the evening's toast—Our Guests  
That all had come to see.  
And then spoke out Perpopulum  
Of bloody war's abode,  
What time one called Corbinus,  
With humour pat and luminous,  
Appreciation showed.

Then Dens the plainly spoken  
(The nurses were not there!),  
With interest and humour,  
And tale and story rare,  
Did keep the host assembled  
In humour good and gay,  
And called on stout Calverlius,  
With many a sally humorous,  
To say some little say.

Nor yet amongst the speakers  
Must these then be forgot:  
The elegant Turnerius,  
And Nicholas the hot,  
And Medius few-worded,  
And soft-voiced Hensleius too,  
And clamoured—for Marthurian Knight,  
Who would not here those things recite  
He was accustomed to!

And then to end the banquet  
The deep-mouthed Mammoth sang  
A song of Western Devonshire,  
And out the chorus rang  
From lusty lungs of members,  
That all the world might hear,  
Who then dispersed in great content,  
Their steps to various quarters bent,  
To meet another year.

J. R. R. T.

### The Cambridge Graduates Club of St. Bartholomew's Hospital.

**T**HE Twenty-fifth Annual Dinner of this Club was held on Thursday, November 8th, at Frascati's Restaurant, Dr. Lewis Jones (Caius) being in the chair. The members, we believe, reached a higher total than in any previous year, about eighty members and their friends responding to the Secretaries' invitations. The evening passed off very successfully, but some regret was expressed when it was found that Mr. Dowly had been permitted to dictate certain conditions concerning his attendance, and those present who had looked forward to, and proceeded so far as to suggest a speech from him, were disappointed.

After the Queen's health had been honoured, the Chairman proposed in a short but eloquent speech the toast of "The Club;" he drew attention to the fact that this was the twenty-fifth occasion on which the members had met together to renew their allegiance to their Alma Mater; he also expressed his gratification at having been asked to preside at this, his twenty-first appearance at the annual dinner, and welcomed, in the name of the Club, those who were there for the first time. Dr. Lewis Jones concluded by mentioning the circumstances which led him to select St. Bartholomew's as his hospital, a happy choice, for which he was partly indebted to an old friend present at the dinner.

Dr. Shelley shortly afterwards delighted the company with an entertaining tale of a bereaved widower and his family burial plot. Dr. Drysdale proposed the health of the guests, amongst whom he noticed Mr. Bowlby, Dr. Calvert, Dr. Garrod, and Mr. Waring; touching delicately on their merits, and dwelling upon the various parts they played in the daily life of the hospital.

Dr. Calvert, Dr. Garrod, and Mr. Waring responded in turn, with becoming but ever-increasing modesty, and the last named spoke of the trials which beset the path of the first guest of the club when a sterner spirit prompted its actions.

Dr. Norman Moore in an appropriate speech, proposed the health of the Chairman; passing in review some of his noble predecessors, he told of the traditional origin of the Club, when William Harvey was entertained by Dr. Wilkinson of Trinity; and of Dr. Caius, who on a similar occasion, after it had been found that there was no vacancy for him on the hospital staff, sent for the surgeons and warned them of the penalties they would incur if they ventured to order physic for the patients without the authority of a physician: this seems to have been adequate recompense to the worthy doctor for his want of success at the elections. Then, from some historical storehouse in his memory, Dr. Moore related the tale of the Chairman's forerunner in the Electrical Department, Dr. Freke, who was wont to while away the evening hours with Fielding and Hogarth, and has been immortalised in the former's book, *Tom Jones*, concluding his speech by welcoming the Chairman as a worthy successor to the genial Dr. Freke.

Dr. Lewis Jones briefly responded, and subsequently gave the toast of the Secretaries, to which Dr. Morley Fletcher and Dr. Horton Smith replied.

During the evening Dr. Moore told a thrilling fairy tale, and Messrs. Wood, Jennings, Pollard, and Nixon provided some musical entertainment.

### Ibernetian Society.

**T**HE Third Ordinary Meeting of the Society was held on October 25th, the President (Mr. Gask) being in the chair. The result of the poll for second president was announced, Mr. Nixon being elected.

Mr. Shrubbsall showed an interesting case of hyaline degeneration of the skin. Mr. C. J. Thomas showed two cases of Friedrich's ataxia, as well as a cretin. Mr. Bainbridge showed a case of achondroplasia. A case of congenital heart disease was shown by Mr. Hay, and one of transposition of viscera, as well as one in which there were patent branchial clefts, were shown by Mr. Wethered. Mr. Bull showed a case of epispadias, and Mr. Forbes a series of microscopical specimens from a case of icterus gravis in a boy *et c.*

There was a good attendance of members, and an interesting discussion of the various cases.

The Fourth Ordinary Meeting was held on November 1st, the President (Mr. Nixon) being in the chair.

Mr. F. A. Bainbridge read a paper on "The Relation of the Tissues to Lymph Formation." This paper was the outcome of his recent research, and was extremely interesting.

The following is a brief abstract of the paper, which will appear shortly in full in the *Journal of Physiology*:

"In the course of his paper Mr. Bainbridge pointed out that the question of lymph formation might be approached from two points of view, namely, the relation of the blood to the lymph, and the relation of the tissues to lymph formation. After showing that the latter aspect of the subject had been much neglected, he briefly summarised the existing views as to lymph formation. He then proceeded to give an account of his own experiments on the lymph flow from the submaxillary gland. These experiments showed that an increased flow of lymph is invariably produced by glandular activity, whether due to stimulation of the chorda tympani, the cervical sympathetic nerve, or to pilocarpine. When the irritability of the gland is diminished by obstructing Wharton's duct, less lymph and less saliva are produced by chorda stimulation than under normal conditions. Finally, after giving atropine, chorda stimulation no longer causes any increased flow of lymph from the gland, although by clamping the submaxillary vein or injecting large quantities of dilute salt solution an increased flow of lymph is still produced. Mr. Bainbridge considered that the increased lymph flow produced by chorda stimulation was independent of vaso-motor changes, was dependent on activity of the gland-cells, and was probably due to the casting off of metabolites by the gland-cells into the lymph-spaces, followed by a rise of osmotic pressure, and

the passage of water from the capillaries to the lymph to restore the balance. In conclusion, he threw out the suggestion that tissue metabolism was probably a much more important factor in lymph formation than had hitherto been supposed, and that it might possibly have some bearing on renal dropsy."

The Fifth Ordinary Meeting was held on November 8th, Mr. Gask being in the chair.

Mr. Robbs showed a case of myositis ossificans in a boy æt. 11, and then Mr. Paterson read his paper, entitled "Treatment of Septic Wounds." He briefly recounted the nature and treatment of wounds, dismissing incised and contused wounds in a few words. He thought that suppuration often occurred in lacerated wounds owing to the violent measures being taken to render them aseptic, measures which in his experience rendered the tissues more prone to the action of septic organisms, by impairing their vitality. He suggested that it was advisable to cut away all undermined skin in cases of spreading cellulitis, and then treat the resulting ulcer by skin grafting. He concluded his paper with an account of Tiersch's method of skin grafting.

There was a lengthy discussion at the conclusion of his paper. The Sixth Ordinary Meeting was held on November 15th, Mr. Nixon being in the chair. Owing to the illness of Mr. Everington, who was to have read a paper on "Some Points in the Management of Strick Children," a clinical evening was held. Mr. Eddison showed a case of hermaphroditism in a patient æt. 25. Mr. C. J. Thomas showed a case of paralysis of the 5th, 6th, and 7th nerves, due to a tumour in the floor of the 4th ventricle. Two cases of osteitis deformans were shown by Messrs. Vaughan Pryce and Willett. Mr. Hay showed a case of purpura which had resisted lengthy treatment. Two eye cases were shown by Mr. Danks. In one there was a tumour of the iris containing fluid and bulging through an operation wound in the cornea. The other showed a papillomatous condition of the upper and lower eyelids with some destruction of the lower lid consequent on wearing an artificial eye too long. Dr. Garratt showed some improved tracheotomy tubes, and explained the method of using them. There were a number of pathological specimens as well, but owing to the lateness of the hour no discussion was possible.

The Seventh Ordinary Meeting was held in the Anatomical Theatre on November 22nd, Mr. Gask being in the chair. Dr. Tooth gave an account of his experiences in South Africa, and showed a collection of lantern slides prepared from photographs taken by him while out there.

His account of the doings of the staff of the Portland Hospital, and of others he met there, was most interesting and amusing. The lantern slides were excellent, those in which familiar faces figured being particularly interesting.

Perhaps the funniest was that showing the state of mind Dr. Tooth was reduced to, on being present at the firing of a 47 gun for the first time.

At the conclusion of his remarks, Sir Thomas Lauder Brunton proposed, and Mr. Edgar Willett seconded, a vote of thanks, which was heartily supported.

There was a good attendance of the nursing staff and members. Refreshments were served in the library afterwards.

## Amalgamated Clubs.

(Accounts of the Hockey matches will appear next month.)

### RUGBY FOOTBALL CLUB.

The Rugby team have played eight matches, and have won three and lost five, the victories over Cooper's Hill and Catford Bridge being very creditable, as both these clubs have been going rather strong this season, and from their results with other hospitals it looks as though we have a good opportunity of obtaining the Cup. But very poor form also has been shown by the Hospital in some matches, this being chiefly due to men scratching off and not playing; in fact, in one match only four of the regular first team turned out. With this state of affairs the team will never be able to get together, and it is to be hoped that some members will make a little bit more of an effort to turn out for the Hospital, as it seems a pity to let this chance for the Cup slip. A. O'Neill has been chosen to play for rest of the South v. London and Universities, and ought, before the end of the season, to obtain further honours.

### ST. BART'S v. UPPER CLAPTON.

A very weak team from the Hospital went down to Upper Clapton, O'Neill and Toeswill being away playing for Devonshire, while a number of men scratched off to go and see the C.I.V.s.

Upper Clapton kicked off, and play was chiefly confined to the forwards until Clapton opened the scoring by crossing our line, the try being converted. After the kick-off the Hospital took the ball by a series of rushes down to the Clapton "25," and W. H. Scott, picking up smartly with tricky run, got over, and converted the try himself. Clapton's turn now came for scoring, which they did after a long run by their three-quarters, a goal resulting.

After half-time the Hospital were penalised for off-side, and Clapton obtained a penalty goal. The Hospital then made strenuous efforts to get on level terms, but were kept out by the good tackling of the Clapton backs; at last Plews struggled over for a try, which was unconverted, and the game ended in a victory for Upper Clapton by 13 points to 8 points. Team:

K. McDonagh (back); A. C. Wroughton, N. M. Wilson, G. Martin, T. Bates (three-quarters); W. H. Hamilton, W. H. Scott (halves); H. T. Wilson, J. M. Plews, H. Wroughton, A. R. Neligan, E. C. Hodgson, E. C. Wise, H. S. Stanger-Leathes, G. H. Adam (forwards).

### ST. BART'S v. ROSSLYN PARK.

Played at the Old Deer Park, Richmond. Rossllyn Park kicked off, and very nearly got in at the start owing to some fumbling amongst the backs, in which Bates got his collar-bone dislocated and had to leave the field. With one man short the Hospital played up hard, Plews coming out of the scrum to the three-quarter line, and soon after Drury scored for the Hospital, the kick failing. After the kick-off play remained in neutral territory for some time, and then a rush by the Park forwards ended in King Stephens scoring, then a rush by the Park forwards ended in King Stephens scoring, then a rush by the Park forwards ended in King Stephens scoring. Shortly before time the Park scored again, and Pooley converting. They won a hard game by 10 points to 8 points. For the Hospital O'Neill, Drury, and Stanger-Leathes played well. Team:

E. S. Marshall (back); A. Aitken, G. Drury, J. B. Gillies, D. M. Stone, (three-quarters); W. H. Hamilton, B. N. Ash (halves); A. O'Neill, L. R. Toeswill, H. T. Wilson, J. M. Plews, H. E. Stanger-Leathes, A. R. Neligan, F. Harvey, R. Miller (forwards).

### ST. BART'S v. COOPER'S HILL R.I.E.C.

Played at the College ground at Egham. The Hospital were fairly well represented, Cooper's Hill having their captain away. From the start the play was very fast and scrambling, the Hospital being better in the open; play settled down in the R.I.E.C. twenty-five. T. M. Body receiving the ball essayed a drop at goal which hit the crossbar, H. T. Wilson following up secured the ball and just got over, D. M. Stone converting. After the kick-out play settled down again in the R.I.E.C. quarters till Allan getting clean away beat Body for pace and scored after dribbling run; the kick failed. The Hospital were now playing well together and outlasted the College men put on another try; after some passing between D. Stone, M. B. Scott, and A. O'Neill, the latter scored, Stone could not score again, and so won by 13 points to 3. Stone made a promising debut in the three-quarter line in this match, while O'Neill, Neligan, and Hamilton were also in good form. Team: E. S. Marshall, T. M. Body, G. Drury, J. B. Gillies, D. M. Stone, W. H. Hamilton, T. O'Neill, A. O'Neill, H. T. Wilson, A. R. Neligan, R. Miller, H. E. Stanger-Leathes, J. M. Plews, F. Harvey, M. B. Scott.

### ASSOCIATION FOOTBALL CLUB.

#### ST. BART'S v. OLD CRANLEIGHANS.

This match was played at Winchmore Hill, on November 3rd, in fine weather. The visitors kicked off from the Pavilion end; from the kick-off Bart's got possession, and after a nice bit of combination between the three insides, Marrett scored a good goal. After this success Bart's took it easy for some time. The visitors then scored through the inside right, and shortly after we got ahead through Fernie, who scored from a corner.

This was all the scoring done in the first half, the whistle sounding shortly after half-time with the score two to one in our favour.

The second half opened very fast, and after about ten minutes' play the visitors equalised. Bart's then made great efforts to get ahead again, but each time were driven back. Before long the Old Cranleighans added two more goals through the centre and outside left, and the game ended in the visitors' favour with the score—Old Cranleighans 4, St. Bart's 2.

For Bart's, Orton at back and Godsall at centre half played very sound games. The following represented Bart's:

H. H. Butcher (goal); L. Orton, F. Gröne (backs); G. W. Miller, T. W. Godsall, V. C. Upton (half-backs); T. A. Kilby, H. N. Marrett, C. O'Brien, V. G. Ward, and C. H. Fernie (forwards).

#### WELLINGBOROUGH MASTERS v. ST. BART'S.

A weak side journeyed to Wellingborough, on Tuesday, November 6th, to play the annual match against the masters of Wellingborough Grammar School.

The match was played in most disagreeable weather, and in the end Bart's had to acknowledge defeat by six goals to two. The home side were superior to the visitors at every point, and very good displays were given by Fries in the centre, who got four out of the six goals scored for Wellingborough; the inside right, who got the other two, and Williams at back.

For Bart's Ward and O'Brien scored the goals, Ward playing a very good game all through, and had he had any help from the other forwards might have put a very different complexion on the result. A. Goodman (sub.) in goal also played well, and Godsall and Tourman, centre half and left half respectively, worked well. The following represented Bart's:

A. Goodman (goal); F. Gröne, N. E. Waterfield (backs); V. C. Upton, T. W. Godsall, N. O. Tourman (half-backs); T. A. Kilby, F. W. Jackson, C. O'Brien, C. H. Fernie (forwards).

After the match Bart's were entertained by the masters. We sat down to a very excellent dinner. After dinner we spent a short time in the usual way, and left in time to catch the 7.40 back to town, having spent a very enjoyable day, if the match itself is left out of consideration. Every praise and thanks is due to our opponents, who so hospitably entertained us, and we shall look forward to next year, when we hope to remove the only blemish on the day's enjoyment by reversing the result of the match.

#### ST. BART'S v. OLD CHOLMLEIANS.

Played at Walthamstow on November 10th, and ended in a win for the Hospital by 2 goals to none.

In the first half play was very even, and just before the end Marrett scored for the Hospital. This was the extent of the scoring in the first moiety, and we crossed over with a lead of a goal to nil.

In the second half play was of the give and take order, both sides attacking in turn, but neither was able to gain any advantage. Towards the end, however, Bart's got together a little better, and Marrett added a second point for the Hospital, and the whistle sounded, leaving us winners as above stated.

For the losers P. W. Osocroft played well at centre half.

Bart's were represented as follows:  
H. H. Butcher (goal); L. Orton, F. Gröne (backs); V. C. Upton, T. W. Godsall, N. S. Waterfield (halves); G. W. Miller, R. C. Berryman, C. O'Brien, V. G. Ward, H. N. Marrett (forwards).

### RIFLE CLUB.

Two lessons learnt from the war in South Africa are the value of accurate rifle-fire and the advantage of great mobility; for comparatively undisciplined forces, well posted, kept at bay some of our finest regiments, and then slipped away, when the tables were being turned on them, almost unnoted.

It is difficult to imagine the consternation that would be caused by the sudden landing of a hostile force on our shores within striking distance of the heart of the Empire. Such a contingency might happen should the fleet be temporarily engaged elsewhere. Such a force, however, would be more of the nature of a raid without heavy baggage. To prevent such a force, once landed, marching on the metropolis, thousands of troops would have to be rapidly thrown between. Experiments with the object of testing this were performed in August, a large body of cyclists being mobilised on the southern roads between London and Brighton. These experiments definitely showed that within a few hours large numbers of men mounted on bicycles could be concentrated on the numerous southern

roads, and proved the value of the extreme mobility of the cycle in a good country. That alone would, however, be insufficient unless the defenders could also hold the enemy in check by rifle-fire.

It is, therefore, every able-bodied man's duty to familiarise himself with the use of a rifle; but, unfortunately, at present this is apparently beyond the hope of immediate fulfilment, the difficulties being those of suitable ranges in the main, and the others the lack of rifle clubs.

We, however, are more fortunate, in that we possess a rifle club as one of our Amalgamated Clubs, and all members, therefore, of the latter can, if they choose, learn how to shoot; for the question of a range is solved, since during the Summer Session we have on certain days of the week targets reserved for the use of the Club at Runnemed, near where formerly the first charter of our liberties was signed.

It therefore behoves us who can to make use of our opportunities. Besides, there are many worse methods of spending a summer afternoon than going to Runnemed to shoot.

A plentiful supply of ammunition can always be obtained at moderate rates, and at the end of the Summer Session there is a match day, in which numerous prizes are offered.

In our last number a short account was given of this year's meeting, which took place on a lovely day with a slight breeze, when one felt it was good to be out of town.

One of the objections raised against rifle clubs was that they would interfere with the numbers of volunteers. This, however, is not certain. A few years' training in a good corps ensures habits of discipline which are invaluable.

Finally let us appeal to the Freshmen amongst us, many of whom, no doubt, were members of a school or 'varsity corps, at least to keep up their practice with the rifle, and so remain useful and valuable members of the community, whilst at the same time they reap the advantages of an accurate eye and a steady hand; for, even with modern weapons, rifle-shooting is not merely a case of "you push the button, and we do the rest."

The Annual General Meeting was held in the Demonstrators' Room on Wednesday, November 21st, at half-past twelve. Mr. Waring (the President of the Club) was in the chair, and there were sixteen members present.

The minutes of the last Annual General Meeting having been read and confirmed, the Secretary presented the Committee's Annual Report and Balance-sheet for the past year, which were adopted, and, on the proposal of Mr. D. Finigan, seconded by Mr. P. A. Dingle, entered on the minutes of the Club.

Mr. Waring then proposed from the chair a vote of thanks to the retiring officers. This was seconded by Mr. C. R. Verling Brown, and carried unanimously.

The following officers were then elected for the ensuing year:  
President.—Mr. H. J. Waring  
Vice-Presidents.—Mr. Howard Marsh, Mr. Edkins, Mr. Phillips, and Mr. H. Mundy.

Captain.—Norman Maclaren.  
Secretary.—P. A. Dingle.  
Committee.—P. A. Brown, D. Finigan, and — Wright.  
A vote of thanks was passed to Mr. Waring for taking the chair, and the meeting terminated.

The Prize Meeting was held on Wednesday, July 14th, 1900.  
List of prize winners:

Competition I.  
Prize 1.—J. Morris. Prize 2.—W. T. D. Mart.

Competition II.  
Prize 1.—A. C. Brown. Prize 2.—J. R. Morris. Prize 3.—C. H. Fielding.

Competition III.  
Prize 1 and Benetfink Challenge Cup.—C. R. Verling Brown.  
Prize 2.—Norman Maclaren.

Competition IV.  
Prize 1 and Waring Challenge Cup.—D. Finigan.

Competition V.  
Prize 1.—J. C. Newman.

Competition VI.  
Prize 1.—Mr. H. Mundy.



## Calendar.

December, 1900.

- Nov. 29.—Abernethian Society at 8 p.m., Mr. Langdon Brown M.B.  
 " 30.—Dr. Hensley's Clinic.  
 " Dr. Gee and Mr. Langton's duty.  
 Dec. 1.—Association F. C. v. Old Cholmleians at Winchmore Hill.  
 " Rugby F. C. v. Old Leysians at Wembley Park.  
 " Hockey Club v. Crystal Palace at Crystal Palace.  
 " 3.—London M.D. and M.S. examinations begin.  
 " 4.—London B.S. examination begins.  
 " Sir Dyce Duckworth and Mr. Marsh's duty.  
 " 5.—Mr. Walsham's Clinic.  
 " Association F. C. v. University College Hospital (League Match) at Winchmore Hill.  
 " 6.—Abernethian Society, 8 p.m., Dr. Morrison "Caesarean Section."  
 " 7.—Sir T. Lauder Brunton's Clinic.  
 " Dr. Hensley and Mr. Butlin's duty.  
 " 8.—Association F. C. v. Tonbridge at Tonbridge.  
 " Rugby F. C. v. O.M.T.s at Richmond.  
 " Hockey Club v. Hitchin at Winchmore Hill.  
 " 10.—Cambridge and M.B. examination begins.  
 " 11.—Cambridge 3rd M.B. examination begins.  
 " Sir T. Lauder Brunton and Mr. Walsham's duty.  
 " 12.—Mr. Walsham's Clinic.  
 " Association F. C. v. St. Thomas's Hospital (League Match) at Chiswick.  
 " 13.—Hockey Club v. Tunbridge Wells at Tunbridge Wells.  
 " Abernethian Society at 8 p.m., Dr. Drysdale, "Leukæmia and Pseudo-leukæmia."  
 " 14.—Dr. Church's Clinic.  
 " Dr. Church and Mr. Willett's duty.  
 " 15.—Association F. C. v. Ilders at Winchmore Hill.  
 " Rugby F. C. v. Streatham at Winchmore Hill.  
 " Hockey Club v. Tulse Hill at Tulse Hill.  
 " 16.—Dr. Gee and Mr. Langton's duty.  
 " Association F. C. v. St. Mary's Hospital (League Match) at Winchmore Hill.  
 " 21.—WINTER SESSION DIVIDES.  
 " 22.—Sir Dyce Duckworth and Mr. Marsh's duty.  
 " 23.—CHRISTMAS DAY. Dr. Hensley and Mr. Butlin's duty.  
 " 28.—Sir T. Lauder Brunton and Mr. Walsham's duty.

## New Addresses.

- DRYSDALE, J. H., 11, Devonshire Place, W.  
 \* \* \* \* \*  
 GARSTANG, Englefield, Delamer Road, Bowdon, Cheshire.  
 \* \* \* \* \*  
 HERRINGHAM, W. P., 40, Wimpole Street, W.  
 \* \* \* \* \*  
 MAXWELL, J. P., E.P. Mission, Tainanfoo, Formosa, *via* Hong-kong.  
 \* \* \* \* \*  
 NUNN, J. H. F., Roose House, 3, Upper Tooting Road, S.W.  
 \* \* \* \* \*  
 WARE, A. M., 18, St. George's Terrace, Gloucester Road, S.W.  
 \* \* \* \* \*  
 WHITE, C. P., 2, Blandford Gardens, Woodhouse Lane, Leeds.

## Appointments.

- ARMITAGE, R., M.R.C.S., L.R.C.P., appointed Senior House Surgeon to the Cheltenham General Hospital.  
 \* \* \* \* \*  
 MAXWELL, J. L., M.D.(London), appointed Surgeon to the Tainanfoo Mission Hospital.  
 \* \* \* \* \*  
 PARAMORE, R. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Infirmary, Windsor.  
 \* \* \* \* \*  
 POWELL, J. C., M.R.C.S., L.R.C.P., appointed Surgeon to the ss. "Buluwayo."  
 \* \* \* \* \*  
 RHODES, J. H., M.B.(London), appointed Senior Resident Medical Officer to the London Temperance Hospital.  
 \* \* \* \* \*  
 ROWLAND, P. W., M.B.(London), appointed Resident Surgeon at the Royal Sea Bathing Hospital, Margate.  
 \* \* \* \* \*  
 TURNER, PERCY, M.B., B.S.(Dunelm), D.P.H.(Oxon.), appointed Superintendent of the Salvation Army Medical Department in India, with headquarters at the Catherine Booth Settlement, Nagercwill.  
 \* \* \* \* \*  
 WINDER, M. G., M.R.C.S., L.R.C.P., appointed House Surgeon at the General Hospital, Colchester.

## Examinations.

UNIVERSITY OF LONDON.

M.B. Examination, Pass List.

Second Division.—T. H. Gandy, A. E. J. Lister, E. M. Niall, T. M. Pearce, W. Smith, R. Waterhouse.

## Conjoint Board.

The following have completed the Examinations for the diplomas of M.R.C.S., L.R.C.P.—E. W. J. Ladell, J. A. Lloyd, L. J. Pictou, H. Scanlon, A. B. Brown, C. E. Hogan, R. T. Worthington, J. C. Marshall, J. C. Newman, C. E. West, F. E. Brunner, P. M. Perkins, E. H. Hunt, C. R. V. Brown, E. M. B. Payne, E. V. Lindsay, D. M. Johnston, H. A. Colwell, A. R. Tweedie, S. Mason, J. S. Gayner.

## Births.

- SCRASE.—On November 20th, at 121, West End Lane, West Hampstead, the wife of F. E. Scrase, F.R.C.S., of a son.  
 WALTER.—On November 24th, at 282, Lytham Road, South Shore, Blackpool, the wife of K. A. Walter, M.R.C.S., L.R.C.P., of a son.

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*, *The New Zealand Medical Journal*, *Durham University Medical Gazette*, *Giornale della Reale Società Italiana d'Igiene*, *L'Echo Médicale du Nord*.

## St. Bartholomew's Hospital



## JOURNAL.

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## St. Bartholomew's Hospital Journal,

DECEMBER, 1900.

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

## The Forms of Coma in Cerebral Hemorrhage.

A Clinical Lecture delivered October 12th, 1900,

By DR. GEE

(reported by DR. HORDER).



PROPOSE to lecture to-day on the different ways in which coma sets in in cerebral hemorrhage.

The grand symptoms of cerebral hemorrhage are coma and paralysis. By coma the Greeks meant deep sleep, and we mean deep unnatural sleep. It is due either to disease—including injuries to the head, which probably act by injury to the brain,—or poisons. It is necessary to get these preliminary matters settled, because then there will be no doubt as to my meaning. Coma signifies the abolition of the cerebral functions, *i.e.* the functions of

sensation and voluntary motion. When coma becomes very deep the floor of the fourth ventricle becomes involved, and then two other functions suffer—respiration and circulation; the condition of the patient being very serious, because these are the vital functions immediately essential to life. The functions of respiration and circulation are called "vital functions;" those of sensation and volition are called "animal functions."

Coma in cerebral hæmorrhage sets in in three ways:—(i) *Apoplexy*, (ii) *Ingravescent Coma*, and (iii) *Recurrent Coma*.

(i) *Apoplexy*.—A much-perverted word, as in the expression "pulmonary apoplexy," a very strange deviation. In the Greek it meant stunned, by a blow from within in this case, not from without. The animal functions cease suddenly; the vital functions continue. Now this is what happens in epilepsy, and the rough distinction between apoplexy and epilepsy is that, although there is sudden deep coma in both, in apoplexy the patient lies still, in epilepsy the limbs are agitated by convulsive movements. Syncope is sudden loss of consciousness with failure of the circulation, and it is assumed that the failure of circulation occurs first, and the coma follows. So much for the meaning of apoplexy,—coma coming on suddenly which is not epilepsy and not syncope. If we use apoplexy in this strict sense it is a very uncommon thing.

CASE 1.—A woman suddenly fell off a doorstep and became comatose. She was seen to fall by her husband. She had had pain in the left side of her head, and numbness of the right arm and leg, some weeks before. She never regained her senses. *Post mortem* there was hæmorrhage into the pons Varolii, there was no hæmorrhage into the ventricles.

CASE 2.—A potman aged 34 years, whilst at work, suddenly cried out that he had lost all power in his limbs, and fell down insensible. He died in two and a half hours. *Post mortem* there was hæmorrhage into the pons Varolii, tearing up the floor of the fourth ventricle, and both fourth and third ventricles were filled with blood.

CASE 3.—A cabman aged 58 years, intemperate, whilst driving his cab was seen to fall suddenly forward and become comatose. The pupils were dilated when he was admitted to the hospital. He died in six hours. *Post mortem* there was hæmorrhage into the pons Varolii but no hæmorrhage into the ventricles. I have mentioned the condition of the pupils here because it is sometimes taught that this is an important point in diagnosing the site of a cerebral hæmorrhage. But it is quite erroneous; the state of the pupils in this disease is not worth attending to. It is my opinion that apoplexy does not occur in hæmorrhages situated higher up in the brain.

(ii) *Ingravescent coma.*—(If you like you may call it *ingravescent apoplexy*, but this would not be using the word *apoplexy* as I have defined it.) This is the most usual manner in which coma in cerebral hæmorrhage sets in. It is similar to the surgical cases where symptoms of "compression" follow those of "concussion"; the patient recovers from the shock and then becomes comatose. I believe in surgical cases of this kind the bleeding is usually from the middle meningeal artery; in medical cases the bleeding is usually from some branch of the middle cerebral artery.\*

In this form, then, something occurs which is not coma; there is recovery from this, and then the patient becomes more and more comatose. As to the primary symptoms, the commonest is (a) *sudden pain*, often violent, in the head. Another common symptom is (b) *vomiting*. A third is (c) *paralysis*, most often hemiplegia. The paralysis may be more local than a hemiplegia: one limb, or the face alone, or the eyes alone (oculo-motor palsy, including conjugate deviation), drooping of the eyelid only, or lateral deviation of the face to one side, or of the tongue. These local forms of palsy are rather uncommon, but any of them may occur. A not very uncommon symptom is (d) *aphasia*. The patient may swoon, that is there may be (e) *syncope*, which is recovered from necessarily. Lastly, there may be (f) *temporary coma*; the patient "feels giddy," or worse. He recovers from this, seems to mend, then the fatal coma sets in and deepens. This fatal coma usually follows within an hour, and is due to the same hæmorrhage which produced the initial symptom still going on. I say this because the interval between the first and fatal coma may be longer, —even up to weeks, and it is inconceivable then that the hæmorrhage is going on all the time; it is due to another hæmorrhage; that is, the coma is not *ingravescent* but:

(iii) *Recurrent coma.*—Just as *ingravescent* coma is quite typical of cerebral hæmorrhage, so is recurrent coma, only this form is much less common.

CASE 4.—A woman, on March 1st, 1900, was seized with "sudden headache" (*vide supra*), lasting two or three minutes, and compelling her to sit down. The

\* See a clinical lecture on Cerebral Hæmorrhage published in the JOURNAL of March, 1899.

pain got better, and she resumed her work of washing clothes. A quarter of an hour afterwards, whilst entering the house, she suddenly fell down, and completely lost consciousness. She was picked up and carried into the house, and remained unconscious for an hour. Her face was drawn to the left. On regaining consciousness she was unable to speak for an hour, and was quite powerless in the legs, but could move her hands and arms. On March 2nd she was seized with intense pain over the brows, and severe pain in the loins and down the back of the legs. The left leg has remained weaker than the right. The headache and lumbar pain have remained ever since. She was kept in bed until March 16th, when she was brought to the Hospital, and was found able to walk, but feebly.

I only mention the "pains in the loins" because it is important to distinguish between symptoms that are of use, and symptoms that are of no use. In the mass of symptoms, put aside as soon as possible those that are of no account in the case. Here, then, the headache continued; the coma passed off.

On March 16th she was admitted, and this was all that we knew. We speculated concerning her, but on March 17th our diagnosis was helped by a fresh attack. The case was interesting because it illustrated recurrent coma, and also *ingravescent* coma; for the second attack, like the first, was *ingravescent* in character. We had, therefore, two reasons for diagnosing cerebral hæmorrhage: the coma recurred, and it was *ingravescent*.

"At six in the afternoon the patient was heard moaning, and almost immediately afterwards the left arm became quite rigid and strongly flexed at the elbow, with the fist clenched." As to this rigidity, it always attracts the attention of beginners. What does it mean? Nothing; it is a fugitive symptom, from which nothing can be safely inferred. "She was unconscious, and there was total absence of the corneal reflex in the left eye. This lasted five or ten minutes, and the rigidity passed off. She remained in a semi-conscious state, rambling in her talk, for an hour. At seven o'clock she was able to swallow, and on inquiry said she had no pain. She then became very drowsy, moaning from time to time." Clearly this was a case of *ingravescent* coma. She was unconscious, then recovered and spoke, then had another attack within the course of an hour,—all undoubtedly due to the same hæmorrhage. "At 9.30 she was quite unconscious. The right arm was rigid and was quite unconscious. The right arm was rigid and was quite unconscious. The right arm was rigid and was quite unconscious. The right arm was rigid and was quite unconscious. There were affected. Both corneal reflexes were absent. There were no convulsive movements, and no foaming at the mouth." There was no reason, therefore, to suspect epilepsy. "At 12.30 she was in much the same condition: lying on her back; respiration regular and sighing; cheeks puffed out; later only the right." That is, at first both buccinators were paralysed; then only the right. "The eyes were

closed, the pupils very small,"—yet, as we shall see, the hæmorrhage was *not* into the pons Varolii,—"but reacted to light. The right arm was held rigid, flexed at the elbow across the body; the fists were clenched." Notice that now it is the *right* arm that was rigid. "At 12.15 (noon of the next day) the condition was unchanged; still much rigidity of both arms."

At noon of the third day the note continues:—"Patient more deeply unconscious; rigidity of arm and leg now completely gone." See what a variable symptom this rigidity is. First it was on one side, then on the other, then on both, then on neither. It means nothing. "The pupils are no longer small,"—pay no attention to the condition of the pupils, therefore;—"she passes urine and fæces under her. Respirations an hour later were one or two every half minute. She became more deeply unconscious, and died shortly after three o'clock."

*Post-mortem.*—"Dura mater natural. Beneath the pia and arachnoid a considerable hæmorrhage, extending over the whole of the left cerebral hemisphere except about three quarters of an inch at its highest point. The blood had run from a large hæmorrhage in the usual position, which had ruptured into the island of Reil,"—as it very often does,—"involving the posterior limb of the internal capsule on the inner side; it had also ruptured into the posterior limb of the lateral ventricle, had tracked through the foramen of Munro into the opposite lateral ventricle, and thence into the third and fourth ventricles. The arteries were thickened; the heart weighed ten ounces, and the muscle was poor and soft. In the aorta and big vessels there was considerable atheroma. The kidneys weighed six ounces each; their capsules were adherent, the cortex thin, and there were some cysts.

Let me repeat wherein the interest of the case lay. The coma was both *ingravescent* and recurrent, and the diagnosis was therefore easy. The patient never completely recovered from the first attack. This is not always so; patients sometimes completely recover.

CASE 5.—A man aged 35. This is an instructive case because it illustrates a common experience; you are called to see a patient whom you find deeply comatose, and you know nothing whatever about him except what you can find out by your own resources. We did not even know this man's age, so we guessed it, and it so happened we were correct to the very year. He was deeply comatose and hemiplegic. The discovery of the hemiplegia helped us immensely as to the cause, for because of it we could put out of court the action of any poison. Was it injury? There were no signs of any. Was it epilepsy? because sometimes after the fit the convulsive movements cease, but the patient remains comatose, it may be for several hours or one or two days. All we could say was that epileptic coma, which is sometimes accompanied by hemiplegia, never lasts more than three days, and that time

would therefore be the only means of distinguishing the difference. But such prolonged coma is not common in epilepsy. Was it uremia? I will speak of this presently. Was it chronic disease of the brain, such as tumour or multiple sclerosis? for these cases are very liable to apoplectic seizures and unconsciousness. Was it acute disease of the brain, such as hæmorrhage or sudden arterial obstruction? There were no signs of injury. If it was epilepsy it would pass off. There were no signs of kidney disease, and only a haze of albumen; the ophthalmoscope showed no albuminuric retinitis. Even if there had been more albumen it would have been no proof of kidney disease, because in apoplexy the urine is usually albuminous quite apart from disease of the kidneys,—it may even be loaded with albumen. There was no reason to suspect chronic disease of the brain; against tumour was the absence of optic neuritis; against sclerosis was the absence of optic atrophy. See how useful was the ophthalmoscope; it helped us to exclude Bright's disease, tumour, and multiple sclerosis, though the last was excluded still more by its being uncommon in men of his age.

We therefore believed it to be acute brain disease; either hæmorrhage or arterial obstruction. Now the coma of arterial obstruction is not usually so deep, and there was no evidence of valvular disease of the heart, which is a common cause of arterial obstruction. We therefore believed it to be cerebral hæmorrhage. The man was thirty-five years old; the usual age for cerebral hæmorrhage is forty to sixty years (this is one of Hippocrates' aphorisms), but cerebral hæmorrhage may occur at any age. I have seen children of ten and eight years old, and one of five weeks, die of hæmorrhage into the substance of the brain. The man's arteries were those of arterio-sclerosis; many a man of seventy-five has better arteries than he had. The slight albuminuria perhaps indicated granular kidney, but there was no evidence of hypertrophy of the left ventricle.

The police had found him lying in the street in the state I have described. Next day a sister came and said that he had been accustomed to drink much ale, but that he had not suffered from epilepsy. Twelve months before he had been found in the street unconscious and suffering from left hemiplegia, after which he was ill in bed for three weeks, and was unable to walk. He quite recovered from this, but eight months before had a second stroke, again affecting the left side, and was ill in bed four weeks before he was able to walk. Ever since then he had suffered from weakness of the left arm and leg, and had limped.

These slight attacks of cerebral hæmorrhage are not at all uncommon before the fatal attack. It is very important to warn the patient of his narrow escape. If he is a wise man and follows your advice, he may live to the usual term of his days; a moderate diet, largely vegetable, and strict abstinence from alcohol will give him his best chance. But many patients "are full,"—this is a quotation, not

from a medical book, and therefore, perhaps, for that reason truer, as having no medical bias about it,—“full of coarse strength, rude exercise, butcher's meat, and sound sleep; and suspect any . . . insinuation or any hint for the conduct of life which reflects on this animal existence, as if somebody were fumbling at the umbilical cord and might stop their supplies.” Patients do resent advice, and moreover, they often find a pleasure in taking the opposite course; if they have drunk freely before, they drink more than ever afterwards, and they soon die from a second attack.

A well-marked scar was found on the prepuce of this patient; therefore syphilis was a factor to be considered in his disease as well as drink. He died on the seventh day. *Post mortem* a large hæmorrhage was found to have taken place into the putamen of the corpus striatum,—no doubt here the vessel which had bled was an anterior branch of the external lenticulo-striate artery. The blood thus effused presses upon the lenticular nucleus internally, the island of Reil externally (compare the last case), and the corona radiata above. Thus by pressure on the internal capsule the hemiplegia is produced. There were two small old hæmorrhages, which were doubtless the causes of the two premonitory attacks.

### A Case of Thyroid Insufficiency.

By C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.

(Read before the Plymouth Medical Society, December 1st, 1900.)

THE patient, *æt.* 12½, was brought to me in October, 1898. His mother said he was always cold, languid, pale, and miserable. As he appeared anæmic I put him on iron for some weeks without the slightest improvement. The failure of iron, taken in conjunction with his constantly feeling cold, his pallor, dryness of skin and small thyroid, which consisted chiefly of isthmus, suggested to me the probability of defective thyroid secretion. With this idea I stopped all other treatment, and ordered him liq. thyroidei  $\eta$ v t.d.s. He soon began to improve, grew rapidly, ceased to feel cold, and sweated on taking exercise, which he had never done previously to taking thyroid. He continued the thyroid treatment through the winter, and left it off when the weather became warm. In the winter of 1899—1900 he came to have the liquor thyroidei renewed, because he was feeling the want of it. He discontinued it during last summer. Up to now, December 1st, the weather having been mild, he has not required any.

These cases are probably more common than is generally recognised, as there is just sufficient thyroid secretion

to prevent marked cretinism or myxœdema. As in my case, they are not infrequently treated by iron without effect. The proof of the diagnosis lies in the marked improvement with thyroid treatment. The average daily secretion of the normal thyroid in the adult corresponds to about 10  $\eta$  of liquor thyroidei. The liquor of the Pharmacopœia certainly appears more potent than the dry extract. It rapidly decomposes if diluted with water, the most convenient way to administer it being to let the mother have the bottle and a minim measure, and measure out each dose as required.

Dr. George Murray has pointed out that the “thyroid gland is developed primarily as an outgrowth of the pharyngeal hypoblast, and in some lower animals this connection with the pharynx is still maintained.”

“The gland, as we now find it in man, is descended from a secretory gland, which originally was provided with a duct, through which the secretion passed into the pharynx, just as the secretion of the salivary glands still flows into the mouth. In this we find an explanation of the fact that the activity of the thyroid secretion is not destroyed by passage through the stomach, but still can produce all its usual physiological effects when swallowed and absorbed from the alimentary canal, as it doubtless was by our remote ancestors.”

To this I may add that disintegration in the alimentary canal probably explains the failure of other glandular extracts when given by the mouth, instead of being placed directly into the blood.

### Cæsarean Section.

A Paper read before the Abernethian Society, December 6th, 1900.

By J. MORRISON, M.D.

IF we were inclined to dip into the mythical ages and trace the operation to its remotest origin, we should learn that Æsculapius himself, as is sung by Ovid, was, with his twin sister, cut out of the womb of his mother, Coronis, by Apollo, after he had destroyed her by an arrow for her infidelity.

Bacchus also was preserved by the same means when his mother, Semele, had been consumed under the embrace of Jupiter, who, according to her desire and his extorted promise, visited her in all the majesty of the skies. So that it would seem that the world is indebted, both for medicine and wine, to this operation.

Ovid's description of the birth of Bacchus and Æsculapius in itself would lead us to infer that before his time the operation had been put in practice on the dead subject.

In the “*Mischna*” of the Jewish *Talmud* (Lightfoot), 200 A.D., there are three passages bearing on this subject, from which it would seem both that the operation had been performed on the living subject in those days, and also that some women had survived.

It is said that (765 A.D.) Numa Pompilius, second King of Rome, in his *Lex Regia*, enacted that the body of no female who died undelivered should be burned or buried until after the fœtus had been removed by incision.

This Roman law was transferred into almost all subsequent legal codes; and the Church especially, which regarded the fœtus as

possessing a soul, directed that for the sake of baptism, if for no other reason, the infant should be strictly adhered to; indeed, as late as the middle of 1700 the King of Sicily condemned to death a medical man who had neglected to carry it out.

The earliest writers on medicine, as contrasted with writers of history, are silent on the subject of the Cæsarean section. Thus no mention of it is found in the works of Hippocrates (400 B.C.), nor of Celsus, Avicenna, or Albucasis.

Pliny tells us that the elder Scipio Africanus—the vanquisher of Hannibal—was introduced into the world by this operation; and that Manlius Torquatus owed his life to the same means.

Rousset, in a book published in Paris, 1580, gives the name “Cæsarean” with an “e,” apparently on the strength of Pliny's statement that the family of the Cæsars had that surname given to them because the first of that family was extricated from the womb of his mother when she was almost dead—“*Sicut Scipio Africanus prior natus, primus que Cæsarem, a caeso matris utero dictus.*”

Pliny also avers that Julius Cæsar was ushered into life in this unnatural manner, and from this sprang the surname. If this were the case, his mother, Aurelia, must have survived the operation, since she dies whilst he was engaged in the conquest of Britain. This would render the statement very doubtful; and, indeed, there is nothing in history to warrant us in adopting this belief. Perhaps these anecdotes may owe their origin to the feeling generally indulged in by the ancients, that it was necessary to invest the birth of their great men with circumstances of an extraordinary character for the purpose of elevating them above the (common herd) *profanum vulgus*.

Shakespeare has taken advantage of this from the incident with which tradition has invested the birth of Macduff. The last hope and frantic desperation of Macbeth, built upon the apparitions' prophecy—

“I bear a charmed life, which must not yield  
To one of woman born.”—

suddenly forsakes him when Macduff declares to him the manner in which he was introduced into the world:

“Despair thy charm,  
And let the angel whom thou still hast served  
Tell thee Macduff was from his mother's womb  
Untimely ripped.”

It has been suggested, however, by some inglorious personage that Macduff was an example of that curious accident, cattle-horn Cæsarean section, since Shakespeare would never refer to the delivery of a child by a skilled abdominal operation as “untimely ripped,” although in the early days of ovariotomy the American surgeons were stigmatised as the “belly-rippers.”

In the *Augur Veda*, or *A Book of Life*, referring to the early history of India, which dates back to the beginning of the Christian Era, and is founded on the writings of Hippocrates, or Brahma himself, there is reference to the operation of Cæsarean section being performed once on a dead woman.

In the Middle Ages from the Church of Rome came a powerful stimulus to the development of the obstetrical art, and the penalty of eternal damnation was threatened for the operation of abortion, and Cæsarean section was advocated to replace this accursed proceeding.

The earliest account of this operation extant in any medical work we find in the *Chirurgia* of the celebrated Guy de Cailliac, written in 1363; but this only refers to its performance after the woman's death.

In the middle of the thirteenth century Bishop Paulus, of Merada, in Spain, performed Cæsarean section upon a living woman. (?) 1540, Christopher Baun performed Cæsarean section. (?) Paré, 1550, mentions it on dead women.

On the living subject the first mention is in Rousset's work (1580, Paris), and translated into Latin by Caspar Bahnhine (1591, Basil). This first successful operation was performed at Siegershausen, North Switzerland, by a cattle-gelder, named Alespachen or Nufcr, on his own wife, about the year 1500. She afterwards bore several children naturally.

Nufcr was a gelder, and probably also a spayer, of cattle, and accustomed to the use of the knife. His wife appears to have been in a critical condition, due probably to the want of skill in her attendants, since the fact that she gave birth to other children shows that her pelvis was not deformed. The case had been considered hopeless by a number of attending midwives and lithotomists. The boy lived to the age of seventy-four; and although the case was not reported until eighty years afterwards, there seems no inherent impro-

bability about the case, seeing that we have records of three successful cases in the hands of midwives, namely: one at Charlemont, Ireland (1738), by Mary Donnelly; woman saved, child dead (Radford, *Edinburgh Essays*); one in Louisiana (1738), by an old negro midwife, with a case-knife, while intoxicated; mother and child saved; and one in France (1881); woman nearly moribund, died third day, child lived; and also when there are reliable accounts of six self-inflicted Cæsareans between 1769 and 1885, with recovery in five cases (Harris, *American Journal*, 1888, N. S. 150).

In Rousset's essay there is also mention made of ten cases performed by barbers, the patients in several instances being confined repeatedly, in one instance in six successive pregnancies.

Owing to Rousset's treatise on the subject, and the national religion, the operation became known and practised extensively throughout France about this period, although the objection of Paré to its performance on the living subject, and its high mortality, soon caused it to disappear for a time from general practice.

M. Simon, in the *Memoirs of the Royal Academy of Surgery*, in Paris, some years later collected seventy-four cases, in which it was declared the operation was performed successfully in as far as regards the mothers. In three of these cases he states the operation was performed twice upon the same woman; in two, three times; in one, five times; in two, six; and in one, seven.

“These accounts seem so improbable,” says Ramsbottom, “that I cannot help thinking that craniotomy, or some other operation, has been confounded with Cæsarean section.”

One of the cases is that of the wife of Sonne, a physician at Bruges, who is reported to have been delivered seven times, her husband being the operator in all the instances. Another, the wife of Olaus Rudbecke, Professor of Physic at Upsala, in Sweden, the founder of the botanical garden there, which became afterwards the scene of Linnaeus' labours, who was a skillful anatomist. In this instance also the husband was the operator, and he is said to have saved both mother and child.

In 1826, 1830, and 1832, in Germany, Cæsarean section was performed three times on the same woman. The children were extracted alive, and the mother was suckling the last one at the date of the report.

According to Spiegelberg and others, who disbelieve the history of the “Rufer” case, the first authentic case of Cæsarean section on the living woman was in 1610, by Jeremias Trautman, of Wittenburg, in the case of a patient with hernia of the pregnant uterus.

Many historical cases are probably fiction, and among these probably that of Jane Seymour; for although Mauriceau and Dionis in France, as well as Hull and some others in this country, gave credence to the rumour, there is little doubt that the story was fabricated.

Some suppose the unfortunate Queen died two days after labour, but evidence proves she survived twelve. Edward VI in his journal states that his unhappy mother died within “a few days after his birth.”

Fuller in his *Church History* on this subject says, “for his birth (referring to Edward VI) there goeth a constant tradition that Cæsarean-like he was cut out of the belly of his mother, Jane Seymour; though a great person of honour (deriving the intelligence directly from those who were present at her labour) assured me to the contrary.” (Cottonian MSS.)

The story runs, that it was supposed that a natural termination could not take place; and the officiating attendant in informing Henry of the circumstance, inquired of him whether he willed the mother's or the child's life should be saved; to which he replied with his accustomed coarseness and brutality, “Save the child by all means, for I shall be able to get mothers enough.” (see Dionis' *Surgical Operations*, dem. 2); or according to others, “for it is easier to get wives than children.”

O'Meara relates that the labour of the Empress Marie Louise also was lingering, and it was feared that either the child must be destroyed or Cæsarean section performed; that Dubois put the same question to Napoleon, who desired him to forget the Empress's station, “and to treat her as he would the wife of a shopkeeper in the Rue St. Denis; but if one life must be sacrificed, to save the mother.” (*A Voice from St. Helena*, 1822.)

Towards the end of 1700 Cæsarean section, on account of its high mortality, gave way to premature delivery for the cases with relative indications, and symphysiotomy for absolute cases.

Symphysiotomy had been suggested by Pineau in 1575, but was first performed in 1665. In 1768 it was again proposed by Signault, and in 1777 performed for ricketty pelvis. It had varying success, and being strongly opposed by Banelocque, who was the greatest

authority in France, the operation disappeared completely for the time being.

In favour of the probable antiquity of Caesarean section, I may mention here the fact, that since 1046 there have been no less than eleven women far advanced in pregnancy, who have been the made subjects of gastro-hysterotomy tips by the horns of the bison, buffalo, bull, cow, and ox, and that no fewer than eight women and five children escaped death. Horned cattle were so inclined to goring in the days of Moses, that a law was enacted with severe penalties attached for punishing an ox goring a woman.

Among uncivilised nations the natives of Uganda appear to be the only people in the habit of performing Caesarean section.

In 1879 Robert Felkin witnessed the performance by a native operator on a young woman, favourable to child and mother. Hare-operators and figure-of-eight sutures were used, and elementary antiseptics carried out.

The French Revolution hindered for a time any advance in Caesarean section in France, which may be called the home of mid-wifery, and a regular sect was formed against it under a Parisian fanatic named Sacombe. This was called Ecole anti-Caesarienne, something very similar to our anti-vaccination friends. Sacombe battled against Caesarean section "with all the weapons of a char-battled against Caesarean section" with all the weapons of a char-battled against Caesarean section "with all the weapons of a char-battled against Caesarean section."

In the beginning of 1800 Denman tried to replace Caesarean section by premature induction.

Sigault and Leroy tried symphysiotomy with bad results. Sigault had five operations, four women and one child saved in thirteen months. Leroy later, five operations, four women and three children saved. Later it has been revived by the Italian School of Musisani and Galbati.

From 1847, on the introduction of anaesthetics, until 1870 Caesarean section was performed many times, but with a high death rate; in 1870 antiseptics came in, increasing the number of operations, but not altering to any extent the death rate.

In 1870 the operation for Caesarean section having been universally fatal at Pavia, led Professor Porro, of that University, to introduce the Porro-Caesarean operation. Having first experimented on rabbits, he successfully performed the operation on his first case in 1876. Coming in on the antiseptic wave, Porro's operation became for a time fashionable, on account of its lessened death rate over Caesarean section; but in 1882, with the publication of Sanger's new method of operating, together with improved antiseptics, the whole scene was changed and at one bound Caesarean section became an operation with a risk equal to ovariectomy; less than craniotomy in extreme cases and much less than Porro.

Porro's operation has been performed more than 232 times, and tested in most countries.

In special clinics, Milan and Vienna, the results have been much below the general average; but taken as a whole the recoveries fall far below the average of the Sanger operation in Germany. The general average is about 46 per cent., or double that of Caesarean section.

Germany lost 10 out of her first 28 Porro's.

Austria saved 25 " 38 Porro's—65 per cent. (Harris)

12 " 17 Sanger—70 per cent.; (Harris)

or roughly Porro twice as high mortality as Sanger, with prospect of further improvement in Sanger operation.

The periods in the history of midwifery have been divided by Engelmann into the following periods:

1. Primitive or intuitive epoch, as existing among primitive peoples from prehistoric times to the present day. Caesarean section probably existed because.

(i) It is seen amongst natives in Uganda.

(ii) Cases of self-inflicted Caesarean section are known, and probably done for similar reasons before.

(iii) Cattle-horn accidents must have always happened frequently, as in India to-day, and would be treated empirically by friends.

2. Religious epoch down to Hippocrates, B.C. 400. Women attend. Priests called in for difficult cases.

Caesarean section as in first period. Induction of abortion in women likely to have difficult labours.

3. Advanced pre-anatomic epoch, 400 B.C.; 1350 podalic version. Women attend. Doctor medically taught for difficult cases.

Post-mortem Caesarean section appears.

4. Period of development.—1550—1800. Surgical period. Anatomy taught.

Caesarean section performed on living women with no stitches in abdominal wound or uterine wound. Later, no stitches in uterus, but abdominal wound stitched, or stitches in uterus, old method.

Caesarean section in distilavour; premature delivery tried.

Caesarean section.—Symphysiotomy tried.

The midwife is searching to overcome the enormous death rate in Caesarean section.

1800—1847.—Physiological midwifery succeeds instrumental of last period. Increased opposition to craniotomy, forceps, premature induction. Caesarean section only in absolute indications.

1847—1870.—Anaesthetics. Caesarean section same position.

1870—1880.—Antiseptics, carbolic. Porro's operation a Caesarean section.

1880—1898.—Antiseptics, corrosive sublimate; perfection of Caesarean section by Sanger. Caesarean section performed for relative as well as absolute indications. Stitches in uterus according to new method.

Before 1880 we may consider that Caesarean section was tantamount to death, and only to be resorted to in extremis. Mechanical interference was always tried in the first place, and so skilled did obstetricians become that craniotomy or embryotomy was successfully performed in cases of contraction down to 1 1/4—1 1/2 in. C. V.

The effect of this preliminary attempt to deliver is still felt at the present day, and forms one of the gravest obstacles to recovery in many cases of Caesarean section.

As regards statistics before 1880 little need be said. Harris collected twenty-two cases in which uterine sutures were used as well as abdominal ones between 1828 and 1880, with the following results:

	Mother.	Child.
	Recovered.	Died.
Silk 11	5	6
Silver 9	5	4
Catgut, etc.	0	2

From 1880 until 1891 in Leipzig, under nine different operators the following statistics are given by Professor Sanger. In thirty-five cases—

Women recovered.	Died.	Children saved.	Died.
33	2	33	2

Taking individual cases, Professor Livetzel has eighteen cases, with one death of woman and one child. This patient had albuminuria and convulsions during operation, and died of uremia on fourth day. Wound was healed.

If death rate in Caesarean section can be reduced to 6 per cent.—and this ought to be reached in women previously operated upon—then the question of sterilizing the woman is one to be very seriously weighed.

In 1891 Rosenbergs (Dresden clinic) was fortunate to see three cases of Caesarean section in seven weeks, done in two cases for the second time, and in a third case for the third time; they all recovered.

He has collected besides, authentic records of repeated operation in thirty-six cases between 1797—1891.

28 with two operations	...	...	56
5 with three "	...	...	15
2 with four "	...	...	4
1 with five "	...	...	5
36	...	...	84

Of these thirty-six cases ten ended fatally, a mortality of 27 2/3 per cent., but if distributed over the eighty-four operations 11 1/2 per cent., a remarkable rate considering that the majority were operated upon without any antiseptic or uterine sutures.

If taken according to periods—

19 without sutures, 6 deaths = 31 1/2 per cent.

15 with sutures, " old style," 4 deaths = 26 2/3 per cent.

20 (in 9 patients) after Sanger Leopold method.

Again, in these 36 cases there were 61 previous confinements prior to the first Caesarean section—

Full time	...	...	24
Premature	...	...	9
Forceps	...	...	5
Version	...	...	2
Perforation and decapitation	...	...	19
Unknown	...	...	2
	...	...	61

—an average of nearly two for each case.

All these statistics go to show that Sanger has discovered a method of performing Caesarean section which at once establishes it as the only justifiable manner of performing the operation, and at once opens up the question whether a living child ought ever to be destroyed on account of the narrowing of the pelvic passages.

The statistics for the last nine years have not yet been collected, but in all probability the death rate will prove to be still lower than those already mentioned; certainly in England the results during the last few years have been extremely good.

Fogelmann states that Caesarean section with a death rate of 17 per cent. promises to replace the artificial induction of abortion and premature labour, and questions whether in all cases of a living child craniotomy should not always give place to this operation. Whilst Credé in 1887, in a paper urging Caesarean section in place of perforation, states that the latest statistics give 8 1/4 per cent. of deaths in perforation, whilst in Dresden and Leipzig together under Sanger, Leopold, and Credé, only 5 per cent. of deaths in Caesarean section.

On the other hand, the opponents of Caesarean section state that such advances have been made in craniotomy of late, that a successful operation is possible in cases of a C. V. of 1 1/2 in., and judgment must still be withheld until this is thoroughly tested by all kinds of obstetric masters.

Also, they say that the above good results are local, and depend upon the surroundings and the enormous skill of the operators. In America, in 160 cases of Caesarean section 100 were fatal, or 62 1/2 per cent. (Harris, 1888).

In connection with the risks of Caesarean section, it is interesting to note that six cases of self-inflicted Caesarean section are recorded with only one death, and this low death rate is attributed to the fact that the women were in good health and not worn out by prolonged labour, or infected by manipulations. As an example of these cases I quote the latest and best known one, as recorded by the *Lancet*.

March 28th, 1886, near Viterbo, Italy.—N. de A.—single, set, 23; peasant, 4 ft 7 1/2 in., delicate constitution; in the last month of pregnancy. On account of being "talked about" she came to the following determination. At 3 a.m. on the 28th of March she opened her abdomen with a kitchen knife; the wound, 4 1/2 in. long, inwards from about the middle of the right iliac region downwards and toward the uterus, and extracted a male fetus (under 4 lbs.). The placenta was healthy. This operation completed, the patient states that she tightly bound a bandage round her body so as to bring the edges of the wound together and prevent the protrusion of the intestines. Then, having dressed herself at five o'clock, two hours after the operation, she went into Viterbo on foot, a distance of about half a mile, and visited a married sister, to whom she said nothing of what had happened, but breakfasted with her on bread and coffee and a cup of broth. She then left the house, and walked about the town for some time in order, as she states, to show herself, and put an end to the current talk about her pregnancy. At 10 a.m. she returned to her home, and was seized with unbearable abdominal pains, followed by violent vomiting and fainting. She quickly rallied, and the bandage having slipped, almost the whole of the small intestine protruded. Drs. Balivo and Serpieri arrived at 4 p.m., found the woman in pain, but conscious and calm, lying dressed on a small bed in a well-ventilated room. They cleaned and replaced the intestines after having emptied the abdominal cavity of a quantity of sero-sanguineous fluid; the wound was closed with twisted sutures, and a drainage tube placed in its most dependent part. No serious change occurred for the first five days, temperature never above 103°. No signs of uterine disturbance; the peritonitis was only local; thirst slight; vomiting at night time. Sufferings not great; catheter used once on third day. The discharge from the wound was at first abundant and bloody. Pus followed, thin at first, but became thick by the tenth day, and then gradually decreased in quantity. Dressings changed four times daily for fifteen days. Tube removed on fifteenth day, sutures on fourteenth day; cicatrization was complete by the fortieth day. On the forty-eighth day, when the report was made, the woman was well and walking about.

(*Lancet*, May 1886, p. 890.)

(To be continued.)

Notes.

ANOTHER New Year's list of Honours finds us distinguished by a Baronetcy conferred on our Senior Physician. We offer our heartiest congratulations to Sir William Selby Church on this recognition of his services to the Profession and the public, not the least important of which took him from England last year, to study the lot of our sick and wounded in South Africa. His election in 1899 to be President of the College of Physicians, gave proof of the honour and esteem in which he is held by the Medical Profession. Last year, when an inquiry was held into the condition of the medical arrangements in South Africa, Sir William Church was invited to be one of the three original Commissioners. His services in this connection, following as they did upon his work, in many and varied capacities, for the welfare of the Hospital and the Medical Profession, have at length been rewarded by this—to us particularly grateful—mark of appreciation.

We have much pleasure in recording a distinction of another kind which has befallen the Hospital, in the selection of A. O'Neill to represent England in the Rugby Union Match against Wales on January 4th. O'Neill has done good work for his cap, having filled the post of Captain of the Bart's XV and the United Hospitals' R.F.C., this year, and played for Devon County during the last two seasons. His game in the North and South match this year, when he opened the score for the South in the first two minutes, following on his previous consistent and sterling performances, ensured for him International honours.

WHILE touching on Rugger topics, it is interesting to note that other Bart's men who have represented their Counties this season are, L. R. Tosswill, for Devon, A. R. Ncligan, for Surrey, and H. T. Wilson, for Middlesex.

HEARTY congratulations to Mr. Waring upon his recent marriage.

In another column we notice an account of Dr. Griffith's "At home" to the Musical Society, and we observe that the reference to instrumental soloists appears only to include violinists. Without reflecting in any way on the value of performers on the violin, there is a sad dearth of other instrumentalists in the Hospital, and any one who would sacrifice his neighbours and learn a wind instrument or two, would be of much use in the Orchestra.

THE fourth Annual Ball, given by the members of the Bart's and Thomas's Company of the Volunteer Medical Corps, will be held at the Empress Rooms, Royal Palace Hotel, Kensington, on Thursday, February 7th. The Ball was not given last year, owing to the absence of so many

members in South Africa. But it is confidently hoped that this year the same success will be experienced as on former occasions. The Ball is under very distinguished patronage; several members of the staff of each hospital have promised to be present. The Hon. Secretary for the Bart's company is S. E. Crawford, from whom tickets (Single 10s., Double 20s., to include supper) may be obtained.

\* \* \*  
We regret to learn of the death of Captain H. W. Masterman, of the 3rd Battalion Welsh Regiment, which took place at Prieska, South Africa, on November 28th, after a short attack of malaria. Masterman entered at Bart's, January, 1899, dressed and clerked until the autumn, when his battalion was embodied and sent to the front. He was educated at Weymouth College and Christ's College, Cambridge, where he graduated in 1898 with second-class honours in Science Tripos. He was President of the University Swimming Club for two years, and captain of the University Rifle Volunteers for three years. At the time of his fatal illness he was acting as Garrison Adjutant.

\* \* \*  
DR. HERRINGHAM has been appointed Inspector for the General Medical Council of the examinations of the Apothecaries' Hall in Dublin.

\* \* \*  
DR. G. D. ROBINSON has been appointed Midwifery Tutor, *vice* Dr. Morrison, resigned.

\* \* \*  
In the University of Cambridge Professor Macalister has been appointed an Examiner in Anatomy, Dr. Habershon an Examiner in Medicine, and Dr. Collingridge an Examiner in Sanitary Science.

\* \* \*  
We had thought the various forms of abuse to which the medical student might be subjected were well-nigh exhausted; but Mr. Clement Scott has succeeded in one grand melodramatic effort that convinces us of our mistake. The *Free Lance* of Dec. 8th contained some very amusing Christmas reading in consequence, for which we have to thank "Helen Jerome." The following selections are indicative of the general trend of the article in question:

He is "often a youth of comparatively no remarkable qualities, save a humorously expansive opinion of himself. He is generally tall. Often he is clean shaven, in order to resemble the successful general practitioner."  
"This altogether undesirable young gentleman has *carte blanche* to walk through the wards. He strolls in, hands in pockets; he would like to whistle the air of some comic opera, oblivious of the fact that the sights around him are anything but comic. He approaches the bed of a patient, who, perhaps, utters little moans of pain, at which our young gentleman smiles indulgently, or looks on with a sort of amused interest."  
"The work in connection with the corpse does not come under the *regimen* (*strictly*) of the students; these young gentlemen have a way of stepping aside, Mephisto-like, when Death has entered, their work having ended."  
"The medical student is the only man in any profession who gains his experience, therefore knowledge, gratis (!!!), at the sacrifice of humanity."

There is plenty more, and it is all so very funny that we almost regretted having laid in a stock of Christmas numbers of the "comics"; it would have done instead. The medical student's education being "gratis" would team with quiet humour to certain parents of our acquaintance. It needs no Sherlock Holmes to arrive at the conclusion that Mr. Clement Scott has never made a son a doctor.

### Ibernetian Society.

THE eleventh ordinary meeting was held on December 13th, 1900. Dr. Drysdale read a paper on "Leukæmia and Pseudo-leukæmia."

The speaker began by a reference to the way in which blood-counts were carried out and used as a means of diagnosis. He referred to the fact that observers often gave merely the proportion of whites to red, the absolute number of either being omitted. He instanced Hodgkin's disease, in which the number of red or white corpuscles not being given, the proportion of whites to red may cause a progressive destruction of reds to simulate an advancing leucocytosis. In spleno medullary leukæmia the absolute number of all forms of white corpuscles is constantly increased, and the relative proportion of the different kinds of whites to each other, is only of use when this is varying greatly and rapidly. He then went on to show that an ordinary count taken from peripheral blood could not be taken as a count from the whole blood. He instanced the rapid leucocytosis following the injection of pyogenic organisms into the body, which could only be explained by the supposition that there were stores of leucocytes, the presence of which could not be demonstrated by an ordinary blood-count.

He did not believe that the various forms of white corpuscles represented different stages in the development of one cell, but that they were definitely different cells, having origin in the various tissues. He instanced the lymphocytosis that follows gastro-intestinal catarrh, and the marked diminution of lymphocytes which occurs in some diseases of the lymphatic glands. He then referred to the various points that had at one time or another been used in the diagnosis of leukæmia.

First, dependence was placed on the leucocytosis. Next, the increase of eosinophile cells was held to be diagnostic, but the presence of this in other diseases, *e.g.* pemphigus, led to its abandonment. Nowadays we trust to the presence of myelocytes. These too have been found in other diseases, *e.g.* the so-called splenic anæmia of infants. He thought the points in the diagnosis of leukæmia were—  
1. No other disease has so high a leucocytosis, 40,000 or thereabouts. (In this there is an absolute increase in every form of white corpuscles, although the relative proportion of some forms may be lessened.)

2. The proportion of myelocytes is almost always above 25 per cent. of the white, although during remissions it may fall. Splenic anæmia of infants be considered as a separate disease, although it had several points of resemblance to leukæmia.

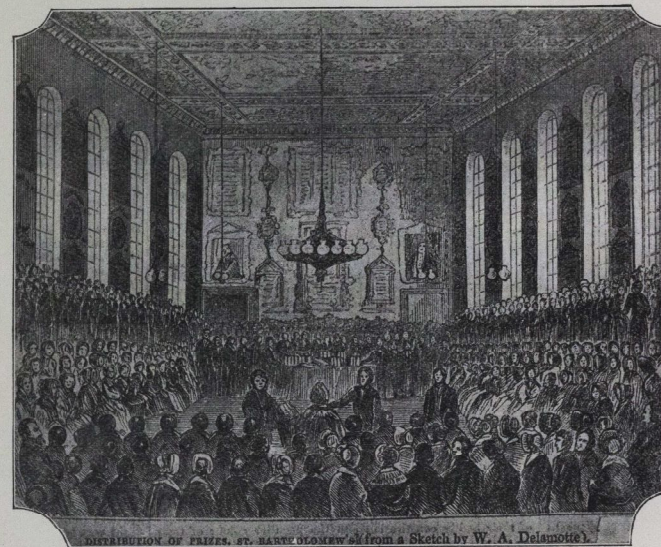
The points of difference were:

1. Total leucocytosis was never so high as in leukæmia.
2. Proportion of myelocytes is very much less, never being more than 8 per cent.
3. There is more anæmia.
4. Age of patient.
5. Recovery is common.

### An Old Custom at St. Bartholomew's.



THE reproduction on this page, illustrating an old function at St. Bartholomew's, we are enabled to publish by the kindness of Dr. Vincent D. Harris. Our picture is from a photograph taken by Dr. Harris from a print belonging to Mr. Sugden of Queensland. It is obvious, so Dr. Harris says, that there had been public distributions of prizes in the forties or fifties, though they were dropped later, to be re-instituted some fifteen years ago in the form of a quiet meeting of scholars and Medical Com-



DISTRIBUTION OF PRIZES, ST. BARTHOLOMEW'S (from a Sketch by W. A. Delamotte).

He considered the blood-changes in both, and, indeed, in every disease, to be probably only symptomatic, but none the less useful.

He said that blood-counts taken by themselves were very unsafe as a means of diagnosis, instancing pernicious anæmia, in which a certain diagnosis could only be made *post mortem* in many cases; and pemphigus, in which the increase of eosinophiles could not be due to the skin lesion, similar vesicles due to burns failing to produce any leucocytosis or increase of eosinophiles.

Dr. Drysdale concluded his paper by urging on every one the necessity of learning to make blood-counts, and of using them systematically and thoroughly as an aid to diagnosis.

mittee in the library. Five years ago history repeated itself, and the distribution returned once more to the place depicted in De la Motte's sketch—the Great Hall. But that scene again has changed, and has become for the second time a thing of the past, a fact we recently regretted. Perhaps when the century is a little older future prize winners at St. Bartholomew's may see a revival of the scene for the second time.

## Musical Society.

**I**N Friday, December 7th, Dr. Griffith (President of the Society) very kindly entertained the members of the Musical Society at an "At Home," at 96, Harley Street. There were about 60 members present, besides other guests. During the course of a most enjoyable evening various members of the Society provided a lengthy programme of music. Nurse March sang "The Sands of Dee," with perfect taste and feeling, which served to enhance the charms of an exceptional voice. Sister Luke delighted the audience with what is perhaps the most melodious of our English songs, "Should he Upbraid." Dr. West was as good as ever, and gave that pleasure that is always expected of him. Two glees and a quartette were sung by the chorus; but perhaps the most striking feature of the evening was the number of really good violinists revealed in the Society; the violin

an astonishing lack of ill results, however! It really seems as if Christmas brought with it an immune digestion to meet the immense demands made upon the hard-worked organs. One patient was heard to say, with a sigh of satisfaction and repletion, after partaking of a Herculean slice of Christmas pudding, "What a lovely pudding!" And when told that in this instance it was not a case of "you can't have your pudding and eat it," but that a similar joy awaited him on New Year's Day, as two large puddings are sent up to each ward, his satisfaction was obvious. This was a poor loco-motive driver, with a badly smashed foot, whose stay in hospital is likely to be a long one, and it is pleasant to think that the hospital has it in its power to create some happiness for such poor sufferers. The pudding, however, was only a preliminary. Christmas festivities are an old song as far as most of the resident and nursing staff are concerned, but the public for whom they cater is an ever-changing one, and they come to most of them as a delightful surprise. A week before Christmas most of the patients who have

solos were of such a quality as to give rise to hopes for great things from the orchestra in the coming year. The thanks of the Society are due to Dr. and Mrs. Griffith for their kindness, and the interest they have shown in its welfare.

## Christmas in the Wards.

**I**F the two great festivities in the Hospital Calendar—Christmas Day and View Day—the 25th of December is peculiarly the patients' red letter day. All other considerations give way to their entertainment and happiness,—we won't add physical welfare, as probably most of them partake of a good deal more than is good for them—with

homes to go to, however poor, are exceedingly anxious to get their discharge in time to spend the day with their friends, and those who by force of circumstances are obliged to stay behind look yearningly at their retreating figures. After Christmas, however, many are heard to say that they would not have missed their hospital Christmas for worlds, and that they had no idea it was as jolly as that! One small boy who came in on the 23rd with a damaged right leg and a broken head, declared that he hoped he would smash his other leg just in time for next Christmas.

The decorations this year, if not presenting any strikingly novel features, were throughout the hospital bright and pretty without any excessive display. Many of the female wards had Christmas trees—always a prominent piece of decoration in themselves, necessitating little else in the way of accessories. Coburn, Lucas, Elizabeth, Mary, and Radcliffe, all had trees. The Lucas tree now is quite a recognised feature, and the "decorating tea," which takes place a few days before the 25th, for all those who assist in loading the branches with pretty things, amounts to an annual custom. Lucas was further embellished by the presence of four charmingly pretty little

girls in cots, two being blondes and two brunettes, in striking contrast, and all four charmingly dressed in blue and white.

The male wards went in for bunting, which is always a popular decoration with the men, and since the walls in all the blocks have taken on a pale green hue in place of the vivid terra cotta of yore, the red, white, and blue stood out in pleasing relief.

Darker was particularly martial, not only in its decorative features, but in the presence of its khaki-clad warriors, who did much to add to the hilarity with which Christmas was observed. In Paget an original entertainment was provided in the form of a huge cracker, out of which at the supreme moment, ushered by an explosive signal, a stalwart and picturesque Father Christmas, represented by Mr. Etherington Smith, emerged and distributed toys and gifts right and left. In Rahere Sir James Sievwright showed South African pictures on a screen, finishing up with a presentation of the sister of the ward, which was greeted with enthusiasm by the audience. A charming trolley work arch, with oranges and lemons growing on it, divided the front and back wards. Conjurers amused the patients in many wards, and in Henry and Charity a ventriloquist with two mechanical dolls caused much merriment. Some very good music, partly home talent, was produced in Luke, and Nurse March sang charmingly in Pitcairn, where Miss Bull also kindly recited. Banjo playing is always popular, and so it proved in Sitwell, Paget, Charity, and Darker, where Mr. Forster, his brother, and a banjo produced songs with a chorus, in which the male patients joined lustily, very much to their own satisfaction. Gramophones, now no longer a thrilling novelty, did duty in some wards as an entertaining element, and bran-pies and tubs proved as popular as ever. It would be a difficult task to enumerate by name all the kind strangers who so cheerfully assisted in entertaining the patients, but we noticed Miss Nettleship, Miss Bué, and Miss Makins, and also Mr. E. W. Roughton, who gave an excellent magic-lantern show in Abernethy.

## The Medical Student:

YET ANOTHER VIEW.

(Vide 'Free Lance,' December 8th.)



HAVE you heard of the Medical Student

Who shaves his face clean, and is tall?

Who swings with a sort of a strut when he walks,

And thinks himself master of all?

Who wishes spectators to fancy

He's in league with some "great psychic force?"

Who is blessed with "opinion expansive,"

And takes it a matter of course

He may walk through the wards of his hospital—

(The monster! he walks through the wards!)—

And the worst of it is that these things are not known

By the hospital governing boards!

And if you've a little clairvoyance,

And a touch of the piercing X-ray,

You can see that he's burning to whistle

Some popular song of the day.

Then, too, all his training is gratis;—

You didn't know that? Oh, go home!

Most costly of any profession?

Go to —; go and ask Helen Jerome!

J. R. R. T.

## The Rahere Lodge, No. 2546.



AN ordinary meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on December 11th, W. Bro. Walter Gripper, M.B., P.P.G.D., (Surrey), the W. M. being in the chair. Bro. R. H. Wellington was passed to the Second Degree, while Mr. Alfred Hepburn, M.R.C.S., L.S.A., Mr. Arthur Maitland Ware, M.A., M.B., B.C. (Cantab.), and Mr. Thomas Jessopp Bokenham, M.R.C.S., L.R.C.P., L.S.A., after being unanimously elected, were initiated into Freemasonry. W. Bro. D'Arcy Sugden, M.R.C.S., L.R.C.P., P.M., the Tyrian Lodge, Queensland, was also unanimously elected a joining member of the Lodge. The sum of Ten Guineaes was voted for the Royal Masonic Benevolent Institution. Subsequently some fifty of the brethren and a considerable number of guests, including the W.M. and S.W. of the Sancta Maria Lodge, dined together.

## Amalgamated Clubs.

## RUGBY FOOTBALL CLUB.

ST. BART'S "A" v. BLACKHEATH "B."

The above match was played on November 3rd at Blackheath, and was won very easily by Hospital by 13 goals 4 tries (77 points) to 1 goal.

ST. BART'S "A" v. PARK HOUSE "A."

Played at Winchmore Hill on October 20th, and won after a good game by Hospital by 3 goals 2 tries (21 points) to nil.

St. Bart's.—R. C. McDonagh (back); H. W. James, Clementi-Smith, N. M. Wilson, D. M. Stone (three-quarters); W. H. Scott and C. H. Cross (halves); T. Bates, E. C. Hodgson, H. M. Huggins, J. H. Wroughton, R. M. Ranking, J. West, — Milson, T. B. Davis (forwards).

Referee.—Cleveland.

ST. BART'S "A" v. MERCHANT TAYLORS' SCHOOL.

This game was played on our ground, and proved a fast and even game. The Hospital scored their first try, which was not improved upon, soon after commencing. After this the Taylors played up well, and from some fine passing by their three-quarters gained a try between the posts, which was converted. On restarting, their captain, from a line out, added a second try far out.

At half-time the School led by 5 points. In the latter half they went to pieces, and the Hospital scored 3 unconverted tries, thus winning by 4 points. Score: Hospital, 4 tries (12 points); Taylors, 1 goal 1 try (8 points).

St. Bart's.—N. M. Wilson (back); T. O'Neill, A. H. Aitken, C. G. Martin, D. M. Stone (three-quarters); A. C. Wroughton, C. H. Cross (halves); Stanger-Leathes, T. Bates, E. C. Hodgson, J. H. Wroughton, H. M. Huggins, R. M. Ranking, J. West, M. B. Scott (forwards).

Referee.—Cleveland.

ST. BART'S "A" v. COOPER'S HILL "A."

The above game was played at Cooper's Hill, and ended in the defeat of Hospital by 29 points to 5.

St. Bart's.—Brewer (back); J. Corbin, A. H. Aitken, Clementi-Smith, W. R. Favell (three-quarters); C. H. Cross, D. M. Stone (halves); E. C. Hodgson, L. Arnold, — Tossill, H. M. Huggins, J. A. West, M. B. Scott, V. Favell, — Watkins (forwards).

The following are the results of the "A" team matches up to November 8th:—Won 8, drawn 1, lost 2; points for 229, points against 88. Goals for 35 (1 penalty, 1 drop), goals against 10 (1 penalty); tries for 19, tries against 13.

## UNITED HOSPITALS' RUGBY UNION FOOTBALL CLUB.

THE annual general meeting of the above Club was held on December 21st at King's College Hospital, R. C. Mallins, Esq., in the chair, when the following officers for the coming year were elected:

President.—S. R. Turner, Esq., F.R.C.S. (St. George's).  
 Captain.—A. O'Neill (St. Bartholomew's).  
 Hon. Secretary.—L. R. Tosswill (St. Bartholomew's).  
 Treasurer.—Munro Scott, Esq. (London).  
 Committee.—C. H. Coltart (Westminster), H. M. Wilson (St. Mary's), H. A. Cutler (Guy's).  
 It was decided to try and arrange a match with United Paris in January; also matches with the Varsitys, Blackheath, and Richmond.

The draw for the cup-ties was—

George's	Jan. 22nd	} Feb. 4th	} London v. Charing Cross	} Mar. 6th.
Thomas's	v.			
Guy's	Jan. 24th	} Feb. 19th	} King's v. University	} Feb. 21st
Mary's	v.			
Middlesex	Jan. 25th	} Feb. 5th	} Bart's	} Feb. 21st
Westminster	v.			

A vote of condolence was passed with the relations and friends of the late Harry Bond, who was for some years secretary of the Club.

ASSOCIATION FOOTBALL CLUB.

ST. BART'S v. HASTINGS AND ST. LEONARDS.

On Wednesday, November 14th, Bart's paid a visit to Hastings to play the annual game against the town club. It was a beautiful day, but owing to recent heavy rain the ground was in a very bad state. Bart's proved victorious for the eighth season in succession by 3 goals to 1. The game was a very hard one, and every man played for all he was worth. In the first half Marrett obtained possession from a free kick, and scored a beautiful goal; a little later Ward added a second with a very nice low, hard shot in the corner of the net, which gave the goaler no chance whatever. Up till half-time there was no further scoring.

After a few minutes' breathe the game started again. If the first half had been hard work, the opening of the second was doubly so, both sides striving for all they knew to score, but for a long time neither could do so. However, after about fifteen minutes' play O'Brien added a third goal with a hard shot from a long range, which, however, might have been saved by the goaler. Shortly after this the Hastings centre forward got possession, and racing down the field beat all opposition, and finished a splendid effort by scoring a splendid goal. The next item of interest was a penalty against the visitors. This, however, Butcher saved in a most masterly fashion. For the remaining few minutes the pace was kept up, and the whistle sounded leaving us the winners as stated above of the hardest game of the season so far.

Of the players themselves suffice it to say they all played for what they were worth, and every man in the Bart's team played as if his life depended on the result. Of Butcher in goal one cannot say too much; he gave a perfect display of goal-keeping. Not only did he save a penalty, but time after time he cleared when a score seemed certain, and only for his excellent play the result would have, no doubt, been different, and his play is generally admitted to be the finest seen in Hospital football for the last few years, and the finest ever seen on the Hastings ground.

The following represented Bart's:  
 H. H. Butcher (goal); L. Orton, F. Gröne (backs); V. C. Upton, J. W. Godsall, N. E. Waterfield (halves); G. W. Miller, R. C. Berryman, C. O'Brien, V. G. Ward, H. N. Marrett (forwards).  
 After the game the old Bart's men in Hastings, with Mr. C. B. Gabb at their head, as is their wont, entertained us to tea, and afterwards a very excellent smoker. The arrangements and everything were perfect, and we take this opportunity of thanking these old Bart's men in general, and Mr. Gabb in particular, for the thoroughly enjoyable day they give us year after year when we go down to Hastings to play the Hastings' and St. Leonards Football Club.

ST. BART'S v. WEST KENT.

Played at Chislehurst on Saturday, November 17th, in very muddy weather. Bart's had the advantage of the wind in the first half, but made little use of it owing to the weakness of the forwards, the Hospital in this department being very badly represented. West Kent scored in the first half, and so led at the interval by 1 goal to nil. For the second half each side scored once, the Hospital goal being scored by Godsall with a very hot shot.  
 In the end West Kent won by 2 goals to 1. The following played for Bart's:  
 H. Butcher (goal); L. Orton, F. Gröne (backs); H. B. Scott, J. W. Godsall, V. C. Upton (half-backs); F. W. Jackson, G. W. Miller, C. O'Brien, C. H. Fernie, and W. H. Orton (forwards).

ST. BART'S v. REIGATE.

Played at Reigate in fine weather, on Saturday, November 24th. Here again Bart's were very poorly represented, and were beaten by five goals to nil.  
 The forwards were again very weak, and only for the sound defence of the centre half, backs, and goal, the score against us would have been much heavier.

The following played for Bart's:  
 H. H. Butcher (goal); L. Orton, F. Gröne (backs); V. C. Upton, T. W. Godsall, G. W. Miller (half backs); F. W. Jackson, W. H. Orton, C. O'Brien, V. G. Ward, and C. H. Fernie (forwards).  
 Up to date we have played 8 matches, of which we have won 4 and lost 4. This is not quite the result one would have expected, as we have had hard luck with our men, and so there were very few soccer playing freshmen, our choice is very limited. Still there are men at the Hospital who, if they would play, would strengthen the team a lot, and it seems a great pity that they don't give the Hospital first choice in preference to playing for outside clubs.  
 It was very refreshing to see so many of the soccer men present at the Amalgamated Clubs dinner.

ST. BART'S v. OLD CHOLMLEANS.

Played at Winchmore Hill on December 1st. The O.C.'s started the game from the Pavilion end, and soon forced their way to the homesteads' territory, but were driven back by the stout defence which met them. Mid-field play followed, but Marrett obtained possession, and after a smart dribble, transferred to O'Brien, who opened the scoring for the home team. The O.C.'s then had a try at goal, and a smart shot from their centre was well saved by Butcher. After this O'Brien again scored from a smart pass by Ward. The O.C.'s then opened their scoring, and shortly after the whistle sounded for half-time with the score—Bart's, 2; O.C.'s, 1.

In the second half Bart's scored again through O'Brien, and the visitors responded with two goals in quick succession, the second one being a very fine goal. The remainder of the game was played almost in the dark. Time arrived with the result a draw of 3 goals all. Team:  
 H. H. Butcher (goal); L. Orton, F. Gröne (backs); G. W. Miller, T. W. Godsall, V. C. Upton (halves); C. H. Fernie, H. N. Marrett, C. O'Brien, F. W. Jackson, H. Honiball (forwards).

ST. BART'S v. IDLERS.

Played at Winchmore Hill on Saturday, December 15th, and ended in a win for the Hospital by 5 to 3. The ground was in a very heavy state, and play was of a very scrambling nature. For the Hospital Ward and Marrett played well. The halves also played very sound games. The goals were scored by O'Brien (3) and Marrett (2). Team:  
 H. H. Butcher (goal); L. Orton, W. S. Naylor (backs); C. H. Fernie, J. W. Godsall, F. W. Jackson (halves); R. H. Bott, H. N. Marrett, C. O'Brien, V. G. Ward, F. Gröne (forwards).

DRAW FOR HOSPITAL CUP.

The draw for the Association Inter-Hospital Cup, which took place at Mr. Jessop's house on December 13th, resulted as follows:

First Round	George's v. Middlesex.	A.
	{ London v. Charing Cross.	B.
	{ Winner of A v. Bart's.	C.
Second Round	Mary's v. University.	D.
	{ Thomas's v. Guy's.	E.
Semi-final	{ Winner of E v. winner of C.	F.
	{ Winner of D v. winner of G.	G.
Final	Winner of F v. winner of G.	

First Round to be played on or before January 19th on ground of first-named.  
 Second Round to be played on or before February 2nd on ground of first-named.  
 Semi-final to be played on or before February 16th on neutral ground.  
 Final to be played on or before March 2nd at Queen's Club.

HOCKEY.

ST. BART'S v. HERTS COUNTY.

This match was decided at St. Albans on October 27th, the Hospital team being defeated by 3 to 2. Shortly after the "bully-off" the visitors scored through Nixon after some good combination by the left wing. The game then continued very evenly, and eventually Boys equalised after Dickson had saved cleverly. At half-time the score was 1 all.  
 On resuming the game became very fast, and it was some time before either side could claim any advantage; then the home team scored from a "corner." Nixon had hard lines in not scoring, and then Herts County, taking the ball into the visitors' circle, again shot a goal. Just before "no side" was called Bull scored with a clever shot. For the Hospital Furber, Flint, and Mayo were best. Team:  
 L. E. Dickson (goal); L. G. Furber and H. E. Flint (backs); T. A. Mayo, L. Murphy, and A. K. Pollock (half-backs); A. Hallowes, J. A. Nixon, F. M. Beckett, G. V. Bull, and H. Gray (forwards).

ST. BART'S v. WEST HERTS.

This match was decided at Watford on Saturday, November 3rd, and resulted in a victory for Bart's by 2 to 1. The ground being very rough, the play was not of a high-class order, and "sticks" were frequently given. The game was evenly contested for the first ten minutes, and, after a good run by the visiting forwards, Bull shot a goal, but was ruled "off side." West Herts then retaliated, and scored their only goal, which should have been disallowed. Bart's then improved, and Hallowes equalised from a good pass. At half-time the score was 1 all.

In the second half the home team had rather the better of the game, but Beckett added a second goal for the Hospital. The game was then interrupted for several minutes, a crowd which had been witnessing a football match swarming on to the ground. The subsequent play was uneventful, and Bart's won as above stated. The score should have been greater, but Bart's were not strongly represented forward, and the referee was not so impartial as he might have been. Dickson in goal saved well. Team:  
 L. E. Dickson (goal); L. G. Furber and H. E. Flint (backs); W. E. Fowler, A. K. Pollock, and L. Murphy (half-backs); A. Hallowes, G. V. Bull, F. M. Beckett, A. B. Pritchard, and H. Gray (forwards).

ST. BART'S v. EASTBOURNE.

The Bart's team travelled down to Eastbourne on Saturday, November 10th, to play the locals, and after a very pleasant game the score was level—2 goals all.  
 Bart's started in very promising fashion, and Nixon soon scored a goal. The home team then attacked and shot a goal, but the referee disallowed it, having previously whistled for "sticks" against Bart's. Then Bart's scored again (Hallowes); and although the visitors attacked for the greater part of the first half, the home backs kept them out, so that at half-time the score was—Bart's, 2; Eastbourne, nil.

During the second half Bart's fell away, and had to act on the defensive. The home team scored a goal from a scrumage in front of goal, and then Gray made several good runs on the left wing, but failed to score on either occasion. Soon after a penalty bully in the visitors' circle the home team obtained their second goal. After that Bart's played a bit better, and took the ball to the other end of the field, and one or two easy chances of scoring were missed. The ground was a bit too rough to make hitting accurate. Dickson again was in brilliant form, and Murphy, Furber, Gray, and Nixon also played well. Team:

ST. BART'S v. R.M.A.

The Hospital team went down to Woolwich for this match on Wednesday, November 14th, the home team winning somewhat easily by 4 to 2. They played a much better game all round than the visitors, and used their sticks very cleverly. The game started very fast, and both sides attacked in turn, and it was some time before the R.M.A. scored their first goal, shortly following this up

with a second, which should have been easily saved. Appeals for "sticks" were frequent, the home team being the chief offenders. After half-time the R.M.A. were still seen to advantage, their forwards combining together splendidly, the left wing being especially noticeable. They shot their third goal, and then Bart's attacked, but nothing came of it, several chances being missed. A few minutes before the call of time the visitors scored a goal by Hallowes from a penalty bully, the result of a foul. The R.M.A. scored again, and Beckett netted the ball for the visitors, the result being 4 to 2 in favour of R.M.A. At one time it looked as though their score would have been bigger, but the Bart's backs were in good form. Team:

Muirhead (goal); Furber and Flint (backs); Fowler, Hill, and Murphy (halves); Hallowes, Nixon, Beckett, Im Thurm, and Gray (forwards).

ST. BART'S v. EALING.

This match was played under miserable conditions at Richmond on Saturday, November 17th, the final score being a draw of 3 goals all. Notwithstanding the rain, the ground was in very fair condition, and a fast game ensued. Bart's pressed at first, but could not score, and Ealing were the first to shoot a goal. Beckett, however, soon put the visitors level again, and shortly afterwards scored again from a "corner." At half-time the score was—St. Bart's, 2; Ealing, 2.  
 After play commenced again for some time each goal was scored in turn, but Ealing were able to add two more goals to their score. Just on the point of time Gray netted the ball from a good pass by Beckett. The halves played well for the Hospital, also Beckett. The light was very bad towards the finish. Team:

Dickson (goal); Furber and Scott (backs); Flint, Fowler, and Hill (half-backs); Hallowes, Nixon, Beckett, Bull, and Gray (forwards).

Calendar.

January, 1901.

- Tues., Jan. 1.—NEW YEAR DAY.
- Fri., " 4.—Sir William Church and Mr. Willett's duty.
- Sat., " 5.—Dr. Gee and Mr. Langton's duty.
- Mon., " 7.—Rugby F. C. v. Bedford. Hockey v. Kew.
- Tues., " 8.—Sir Dyce Duckworth and Mr. Marsh's duty.
- Wed., " 9.—Mr. Willett's Clinical Lecture at 2.45 p.m.
- Thurs., " 10.—Abernethian Society, 8 p.m. Mid-Sessional Address, Mr. Butlin. "The British Medical Association and the Woes of the Medical Profession."
- Fri., " 11.—Dr. Hensley and Mr. Butlin's duty.
- Sat., " 12.—Association F. C. v. Cheshunt. Hockey v. Tunbridge Wells.
- Tues., " 15.—Sir T. Lauder Brunton and Mr. Walsham's duty.
- Wed., " 16.—Mr. Willett's Clinical Lecture at 2.45 p.m.
- Thurs., " 17.—Abernethian Society at 8 p.m., Mr. Shrubbsall, "Prehistoric Medicine, and Savage Medicine of To-day" (illustrated by lantern slides).
- Fri., " 18.—Sir William Church and Mr. Willett's duty.
- Sat., " 19.—Rugby F. C. v. Lennox F. C.
- Tues., " 22.—Dr. Gee and Mr. Langton's duty.
- Wed., " 23.—Mr. Langton's Clinical Lecture at 2.45 p.m.
- Thurs., " 24.—Abernethian Society at 8 p.m., Clinical Evening.
- Fri., " 25.—Sir Dyce Duckworth and Mr. Marsh's duty.
- Sat., " 26.—Association F. C. v. Tunbridge Wells. Hockey v. Uxbridge.
- Tues., " 29.—Dr. Hensley and Mr. Butlin's duty.
- Wed., " 30.—Mr. Langton's Clinical Lecture at 2.45 p.m.
- Thurs., " 31.—Abernethian Society at 8 p.m., Mr. McAdam Eccles, "Irreducible Inguinal Hernia" (illustrated by lantern slides).

## Reviews.

A MANUAL OF SURGICAL TREATMENT, by W. WATSON CHEVRE and F. F. BURGHARD, F.R.C.S. In six parts. Part IV.

In this volume the authors have in great measure upheld the high standard which the previous parts had led us to expect. The part now issued is concerned with the various injuries and diseases of joints, and with the diseases of the spine.

In the earlier chapters the various dislocations are treated at considerable length, and with the descriptions are some very clear illustrations. These chapters we consider the best in the book; the greater part of the space is allotted to the more important injuries, and time is not wasted in discussing rare dislocations.

The chapters on tuberculous disease of joints are not so well done. From the point of view of treatment the various forms of this disease are divided up into groups, of which no less than eight are mentioned, and these groups include some conditions which are excessively common, and others which are quite rare.

It seems to us a far better plan to discuss the common changes in a progressive case of disease with the appropriate treatment of each stage; and we think that such expressions as "empyema tuberculolum" and "hydrops tuberculorum" should find no place in a modern text-book.

In the general account of the treatment of joint tuberculosis the relative advantages of amputation, excision, and erosion are very fairly put.

We must, however, confess that in some respects the great experience of the authors does not tally with our own observations. Thus we had no idea that syphilitic dactylitis in congenital cases was "a not uncommon disease," and we were ignorant of the special liability of Charcot's joints to subsequent septic infection.

Coming now to the diseases of individual joints, the account given of hip disease is good and complete. We cannot agree with the removal of wedge-shaped pieces from the necks of femurs which have become ankylosed during the process of cure. These operations are difficult enough on a bone unchanged by disease, and most surgeons rely entirely in such cases on infra-trochanteric osteotomy.

We are also surprised to find formal excision of the wrist recommended in tuberculous cases. No other joint in the body answers so well to expectant treatment, while the results of excision are too often a rigid and useless hand.

In excision of the elbow-joint the median posterior incision is chosen by most surgeons in preference to the two lateral incisions advised by the authors.

The concluding chapters deal with the various diseases of the spine. They are well written, and the modes of treatment are laid down clearly.

MEDICAL ELECTRICITY: A PRACTICAL HANDBOOK FOR STUDENTS AND PRACTITIONERS. By H. LEWIS JONES, M.D. (H. K. Lewis, pp. 530; price 10s. 6d.)

We congratulate the author upon the appearance of the third edition of this popular book. We have previously had the opportunity of pointing out its merits, and can still recommend it as being the most useful guide to the subject. Its essentially practical details characterise it in its enlarged issue as they did before. The section on the "choice of a medical battery" is an example. Another is the "method of electrical testing of nerves and muscles." A third, "the choice of method of electrical treatment." The routine treatment of that very common disease, infantile palsy, is gone into thoroughly, as indeed it deserves. For the ultimate condition of the affected limbs in this disease varies greatly with the care and perseverance bestowed upon them during the period of wasting. The kind of nevus best suited for electrolytic treatment, and the methods adopted, are fully discussed. We notice a fuller account of electric osmosis and its uses. Space could have perhaps been saved by the omission of paragraphs dealing with the electrical treatment of serous effusions, uterine fibroids, extra-uterine gestation, and a few other conditions where it is admittedly of no service. The added chapter on the Röntgen rays is full and is clearly written.

DISEASES OF THE EYE, AND THEIR TREATMENT. By HENRY R. SWANZY, M.B., F.R.C.S.I. Seventh Edition. (H. K. Lewis, pp. 630. Price 12s. 6d.)

The seventh edition of this justly popular handbook is enlarged by the addition of Dr. Davidson's method of employing Röntgen

rays for the detection and localisation of foreign bodies within the eye, a description of Mules' operation for ptosis, and a fuller account of the actions and relative values of mydriatics, myotics, and local anesthetics.

The admirably-written section dealing with abnormal refraction and accommodation stands almost unchanged, and is the best introduction we know to the study of refractions. The section on progressive myopia is carefully and fully done.

We still await a rational and systematic account of that common disease, corneal ulcer, and Mr. Swanzy leaves us much where we were.

The chapter on the "Motions of the Pupil in Health and Disease" is, so far as we recollect, the only account at all conforming to the importance of the subject. For the beginner it may prove very full and difficult, but that is met by its being printed in small type, and it may be omitted at first reading. Dr. Louis Werner's tables of mydriatics and myotics are very useful for reference.

A brief summary of St. Clair Thomson's collection of cases of optic neuritis associated with chronic rhinorrhoea is given.

An appendix dealing with the tests employed for colour vision is also of value.

TROPICAL DISEASES, A MANUAL OF THE DISEASES OF WARM CLIMATES. By PATRICK MANSON, M.D. (Cassell and Co. Pp. 680; 114 illustrations and plates. Price 10s. 6d.)

The arrival of Dr. Manson's book in its revised and considerably enlarged form is very opportune, coming, as it does, at a time when certain tropical diseases are particularly before the medical world. The sections dealing with malaria and plague are brought carefully up to date, and incorporate all the recent advances in our knowledge of these diseases that are not mere theorising. Especially useful is the account of the malignant forms of malarial fever and the description of the parasites concerned.

As a manual of tropical diseases, we consider Dr. Manson's book easily holds the first place.

## Correspondence.

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

## OUR WIDOWS AND ORPHANS.

SIR,—May I, as President of the Society for Relief of Widows and Orphans of Medical Men, venture to appeal to the younger members of our profession to avail themselves more largely than at present of the benefits of this Society? We all hope, but unfortunately we do not all succeed in providing liberally for those dependent on us; and, if cut off early in life, it must often happen that a medical man leaves his widow and orphans in very straitened circumstances if not absolute want. Anyone who reads the touching appeals for votes for Epsom pensions and scholarships will confirm this.

The widow of a member of this Society, who has no certain income exceeding altogether the yearly value of £80, is eligible to receive a grant not exceeding £50 per annum, and an additional grant for each child under sixteen; but the father must have been a member for three years immediately preceding his decease. Membership is confined to registered practitioners residing within twenty miles of Charing Cross at the time of their election, but there is no restriction as to subsequent residence, and we have lately accepted a widow whose husband died in Australia.

The subscription is Two Guineas annually for twenty-five years only, or Thirty Guineas in one payment, but a member whose age at the time of his election does not exceed thirty years may become a life member on payment of Twenty Guineas, or if under forty years of Twenty-five Guineas. The point I wish to urge upon those recently qualified is that, while still resident in London at their several hospitals, they can, on payment of Twenty Guineas, make a perfectly secure provision for a possible widow and orphans, and will at the same time aid those who may not be so fortunate as themselves.

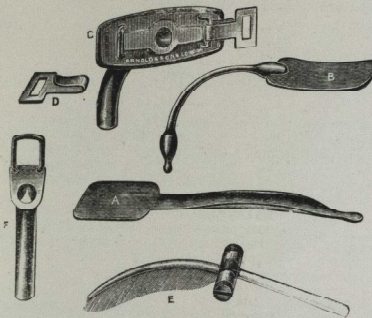
The office of the Society is at 11, Chandos Street, Cavendish Square, W.

Yours obediently,

CHRISTOPHER HEATH.

## New Productions.

We have received from Dr. G. C. GARRATT, Assistant R.M.O. to the London Fever Hospital, the following description of some new rachetomy instruments, the use of which the inventor demonstrated at a meeting of the Abernethian Society recently. "The



dilating director A is introduced by the side of the knife before the latter is withdrawn from the trachea. It is then given half a turn, and the handle is directed towards the chin. In this way the wound is dilated, and a channel is provided for the passage of the pilot and tube. The instrument is made in two sizes, the smaller for use on children under five, the larger for all others. I find it far more convenient than dilators of the usual pattern. The pilot B resembles that of Parker's tube, but has a probe point, which facilitates its introduction. The outer tube, C, is shaped like Parker's, but has longer and wider wings, which are not covered by the bars of the shield, so that the tube can be removed from the shield, and is therefore easily cleaned. When, however, the tape-holders, D, are hooked on to the bars, and this must be done before the operation, they check the wings of the tube, allowing it free movement, but preventing it from being coughed out. The tapes are inserted without any disturbance of the shield, and consequently it is unnecessary to add them until the tube and dressing are in position, and all is clean. The inner tube, E, is self-retaining without key, being held by a split at its upper end, which gives it a light grip on the outer tube. This grip can be regulated by slightly compressing or expanding the split. It should not be at all tight; a good fit is really sufficient. The single handle is placed so as to be in the position of mechanical advantage, and to leave the face of the tube free from dirt trap of any kind. The guarded feather, F, is used for the removal of loose membrane or mucus from the inner tube, and for cleaning the outer tube before the inner is replaced.



The little bars are of aluminium, are secured by rubber rings, and set to the length of the tube. The tube extraction guard, G, is held in the palm of the hand by means of the second finger hooked round the shoulder A. The bent ends are then lightly pressed against the wings of the outer tube so as to fix them against the shield, while the index finger above and the thumb below grasp the handle of the inner tube and withdraw it. There is thus no unnecessary fingering of the shield, no joggling about of the tube in the trachea, and even if the inner tube is somewhat gummed in, a fair pull can be exerted on it without risk, and that by the use of

one hand only, the other being free to hold the child. The arrow in the figure indicates the path traversed by the inner tube." Dr. GARRATT has also introduced a new aseptic hypodermic syringe.



"This is a modification of the pattern designed by Bokenham. The chief objection to the latter is the screw thread cut on the glass barrel. Glass is ill adapted for screw threads, and such barrels are very liable to get chipped or broken. I therefore substitute a sliding metal collar, A, which is prevented from slipping off by a lip on the mouth of the barrel. When the cap B is screwed home the edge of the barrel lies flush with that of the collar, and the cap fixes both. The finger bars on the collar and the cup-shaped handle of the piston are a return to the comfort of the old type of syringe. The plunger is of asbestos and adjustable, and both barrel and piston are graduated, the latter having a guard running on it. There are no washers to curl up or get displaced. The syringe is designed specially for use on infectious cases; it is also well suited for antityphoid inoculation. Messrs Arnold and Son are the makers of all the above instruments."

Mr. HAMILTON WHITEFORD, of Plymouth, has sent us a specimen of camel-hair blanketing covered with butter-cloth, and intended to be used as a flat sponge. We have tested the specimen in various ways, and find it fulfils all that is claimed for it.

- (1) It can be boiled over and over again without deterioration.
- (2) It is very soft and elastic, and has this great advantage over gauze swabs—small pieces of the fibre do not readily separate from it.
- (3) It has also great powers of absorption, will take up blood as readily as a marine sponge, and it can be readily squeezed quite dry.
- (4) It is very cheap, the material for each sponge costing about 2d.

## Shorthand for Medical Students.

THE Society of Medical Phonographers offer for competition among registered Medical Students in the United Kingdom a first and second prize, of the value of £5 and £3 respectively, for proficiency in the groundwork of Phonetic Shorthand (Phonography).

The examination will have for its chief object legibility, accuracy, and neatness of writing rather than speed, and will consist of two simple tests.

- (a) The ability to read at slight a passage of a few hundred words printed in a freely vocalised style of shorthand.
- (b) The ability to write shorthand at a low rate of speed (sixty words per minute), and to produce a correct longhand transcript of the passage so dictated. In this test the quality of the shorthand note as well as the correctness of the transcript will be taken into account.

The passages used in each test will consist of some straightforward medical matter.

The examination will be held early in May, 1901, simultaneously in London, Edinburgh, and Dublin, and at any provincial medical school in the United Kingdom at which not fewer than three candidates shall offer themselves.

Intending candidates are requested to send in their names at as early a date as possible to "The Examination Secretary, care of Messrs. Philman and Sons, Thayer Street, Manchester Square, London," who will inform them in due course as to the precise date and place of examination at each centre. There are no Examination Fees.

The latest date for receiving names will be April 15th.



### New Addresses.

ADAMS, ALFRED, Bridgend, Looe, Cornwall,  
 ALLEN, H., Morchurd Bishop, North Devon.  
 CARSON, H. W., 55A, Welbeck Street, W.  
 DRAKE, D. J., Dibrughur, Assam.  
 GRANT, C. W., 352, Radford Road, Nottingham.  
 HAWKINS, E. J., 56, Upper Kennington Lane, S.E.  
 PARKER, CHARLES ARTHUR, 141, Harley Street W.

### Appointments.

DRAKE, D. J., M.R.C.S., L.R.C.P., appointed Medical Officer to the Assam Frontier Tea Company.

HEPBURN, MALCOLM L., M.D., B.S., F.R.C.S., appointed Surgeon to the Lowestoft Hospital.

HOGARTH, R. G., F.R.C.S. Eng., appointed Honorary Surgeon to the Children's Hospital, Nottingham.

HUTCHESS, HAROLD J., appointed Justice of the Peace within the colony of Queensland; also appointed Medical Officer of Health to the Joint Board for the Prevention of Epidemic Diseases, Brisbane, and to continue to act as Medical Superintendent of the Plague Hospital.

### Examinations.

#### UNIVERSITY OF CAMBRIDGE.

##### Medicine.

W. H. W. Attlee, F. A. Bainbridge, F. E. Brunner, H. St. C. Elliott, N. Maclaren, H. R. Mayo, J. C. Newman, L. B. Scott, F. C. Shrubhall, R. H. Urwick, H. Walker, R. T. Worthington.

##### Surgery and Midwifery.

S. Bousfield, A. J. Fairlie-Clarke, H. Gordon-Smith, G. W. Micklethwaite, F. E. Murray, J. Stirling-Hamilton, F. K. Weaver, H. H. Weir.

##### Anatomy and Physiology.

C. A. Anderson, H. H. Dale, H. Falk, T. J. Faulder, S. L. Hurke.

#### UNIVERSITY OF LONDON.

##### M.D. Examination.

J. S. Chater, F. W. Groves, C. Riviere, W. Wrangham.

##### M.B. Examination, Honours.

E. M. Niall, honours in Obstetric Medicine.

##### B.S. Examination.

W. M. Bergin, A. E. J. Lister, E. M. Niall, J. H. Parsons.

### Births.

DAVIES.—On November 30th, at Home Lodge, Great Amwell, the wife of Arthur Templer Davies, M.D.(Cantab.), F.R.C.P., of a daughter.

HOLDEN.—On December 13th, at Castle Hill, Reading, the wife of George Herbert Rose Holden, M.A., M.D.(Cantab.), of a son.

RUSHWORTH.—On December 18th, at Beechfield, Walton-on-Thames, the wife of Norman Rushworth, M.R.C.S., L.R.C.P., of a daughter.

\*ST. CYR.—On December 21st, 1899, at Aux Cayes, Haiti, West Indies, the wife of D. St. Cyr, M.R.C.S., L.R.C.P., of a son.

TAIT.—On December 15th, at 48, Highbury Park, the wife of Edward Sabine Tait, M.D., of a daughter.

### Marriages.

BENNETT—TANGYE.—On December 18th, at Carr's Lane Chapel, Birmingham, by the Rev. J. H. Jowett, W. E. Bennett, F.R.C.S., of 27, Broad Street, Birmingham, son of William Bennett, Hertford Place, Coventry, to Mary Ethel Tangye, only daughter of George Tangye, J.P., of Heathfield Hall, Handsworth, Birmingham.

O'KINEALY—TREVOR.—On November 10th, at St. Paul's Cathedral, Calcutta, by the Rev. Canon Luckman, Captain F. O'Kinealy, I.M.S., eldest son of J. O'Kinealy, Esq. (late Judge of the High Court of Calcutta), to Helen Mabel, only daughter of the Rev. George A. Trevor, of Queen's Gardens, London.

\*SCORER—NORRIS.—On August 9th, at Holy Trinity, Bournemouth, by the Rev. C. P. Koelle, M.A., assisted by the Rev. Malcolm W. Brown, M.A., Frank Scorer, M.R.C.S.(Eng.), L.R.C.P.(Lond.), of Maplestead, Bournemouth, second son of Alfred Scorer, of Upper Hamilton Terrace, London, to Violet Eleanor, only daughter of Alfred Norris, of Catford, Kent.

WARING—HILL.—On December 10th, at St. George's Church, Campden Hill, W., by the Vicar, Rev. J. W. Robbins, Holburn J. Waring, M.S., B.Sc., F.R.C.S., of 9, Upper Wimpole Street, W., eldest son of J. Waring, of Churchtown, Southport, to Annie Cassandra, daughter of the late Charles Johnston Hill, of 66, Holland Park, W.

### Deaths.

JONES.—On December 1st, 1900, at Llangamarch Wells, Breckonshire, Elizabeth Ada, the dearly beloved wife of William Black Jones, M.D., B.S.Lond., and third daughter of W. K. Burman, of Clapton, N.E.

MASTERMAN.—At Prieska, South Africa, on November 28th, Captain H. W. Masterman (B.A. of Christ's College, Cambridge, and student at St. Bartholomew's Hospital), 3rd Batt. Welsh Regiment, aged 25.

HOWELL.—On December 14th, at his residence, 72, Boundary Road, South Hampstead, Horace Sydney Howell, M.D., F.R.C.S., aged sixty-two years.

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, The New Zealand Medical Journal, Durham University Medical Gazette, Giornale della Reale Società Italiana d'Igiene, L'Echo Médicale du Nord.*

[\* We must apologise for the late appearance of these notices, which had been overlooked.—Ed.]

# St. Bartholomew's Hospital



## JOURNAL.

VOL. VIII.—No. 4.]

JANUARY, 1901.

[PRICE SIXPENCE.]

January 22nd, 1901.

Did ye hear it? a toll . . .  
 A tedious minute of waiting . . . then  
 A mournful message is rung to men—

Our Queen has gone from her earthly throne,  
 Gone from our land to where alone  
 Shall pass her soul;  
 Gone from the land where our Sovereign won  
 The love of all,  
 And ruled, and shone:  
 And whilst that light of guidance burned,  
 To its pure beams all eyes were turned  
 Of great and small.

Her work is done—  
 God bless her Son,  
 God save the King!

## 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.

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## St. Bartholomew's Hospital Journal,

JANUARY, 1901.

"Æquam memento rebus in arduis  
Servare mentem."—Horace, Book II, Ode III.

## The Use of Whey in Uric Acid Gravel.

By Dr. GEE.

**T**HEN the number of this JOURNAL for August, 1899, will be found some notes of a lecture of mine upon uric acid gravel. I was not able to speak very highly in favour of the methods of treatment which are in common use. I believe that since that time I have discovered a much more efficacious remedy; I allude to fresh whey. A large teacupful taken after each meal has not yet failed, so far as my present experience goes, in preventing the appearance of uric acid gravel, even in persons who have been subject to it for a long time.

With regard to the use of whey in the allied disease of gout, I regret that I have as yet no facts to offer.

## Concerning Sickness after Chloroform Anæsthesia.

By R. W. JAMESON, M.R.C.S., L.R.C.P.

**I**HAVE adopted a somewhat cumbersome heading for my remarks, but the term "anæsthesia sickness" I consider misleading, since I regard chloroform as only a predisposing, not an effective, cause of sickness.

The early history of chloroform anæsthesia bears out this contention. Simpson, the discoverer of the anæsthetic properties of chloroform, in 1847 talks of "keeping him

[the patient] perfectly quiet and still, and preventing all noise and talking around him;" and later lays stress on absolute quietude during the induction of, and recovery from, the state of anæsthesia.

In 1848 Miller writes of vomiting at the induction of anæsthesia, but says that "the vomiting of emergence was rare."

In the early days of chloroform, then, great respect was paid to the new agent; the patient was placed under the best possible conditions, and after-sickness was rare. The vomiting of induction, however, showed that Miller had not acquired our later-day skill in administration, seeing that now if a patient be sick after he has lost the power of volition, and before the end of the operation, the anæsthetist may justly be blamed.

In a work dated 1858 I find the first mention of anæsthesia sickness, and the suggestion that in deep anæsthesia there was relaxation of the pylorus and regurgitation of the duodenal contents, causing vomiting. I would account for this first appearance of anæsthesia sickness by supposing that familiarity had bred contempt, the consequent carelessness introducing other factors which caused sickness.

Before one could consider the anæsthetic as a proved effective cause, in contradistinction to being only a predisposing cause, there must be an absence of all other possible effective causes of sickness. And the object of this paper is to lay stress on these other, largely removable, causes, which are frequently to a great extent disregarded. These causes are—

(1) *The moving about of the patient.*—Upon the undesirability of this Simpson laid great stress, but how few do so now! Before an operation with what care the patient is handled! with what anxious care, too, is all movement avoided at the first ward dressing! Compare this with the scene at the end of an operation, when the effect of the anæsthetic is on the wane; first, away goes the surgeon to noisily wash and probably talk; then the house surgeon, sister, and a dresser or two rush at the patient, and throw him about until he is dry, and the bandage satisfies their artistic sense. And this is not all, for usually two even less considerate porters arrive, and each taking an end of the patient, they independently deposit him on a stretcher, on which he is jolted to the ward. Is it to be wondered at that the man is sick? (At a provincial hospital I once saw the substitution of a wheel trolley for a hand stretcher sensibly reduce the cases of after-sickness.)

(2) *Nature of the operation.*—Sickness can be produced in the unanæsthetised by various mechanical means, such as taxis, etc. Surely, then, the surgeon's manipulations, more especially in abdominal work, are often the cause of sickness. That paralysis of the gut may unavoidably be produced by the surgeon at an operation is allowed.

(3) *Pain or other sensory stimuli.*—In that other anæst-

thetisation, by alcohol, which has been more carefully studied, the higher centres are first paralysed, then in regular order to the lowest ones. Pain may produce sickness in the unanæsthetised. Pain, then, may react on the vomiting centre, although the pain felt cannot be manifested by the patient, or even remembered by him. But the stimulus stored up in the vomiting centre may quite possibly cause vomiting at the end of the anæsthesia. If a patient be kept lightly under an anæsthetic, it often happens that every time the surgical procedure is such as would cause severe pain in the unanæsthetised the patient will exhibit the early manifestations of sickness; at the end of such a procedure the patient is always sick. In the same way, beginning an operation a little early produces a pain stimulus, and although the anæsthesia is rapidly deepened, the stimulus having travelled to the centre may subsequently produce sickness.

The tendency now-a-days is to give too little of the anæsthetic,—for one reason because both instructed and uninstructed give it; for another, the deaths being so much more widely recorded, the dread of its lethal effect is increased. It is well known that the early Scotch administrators aimed at anæsthetising deeply; consequently "emergency vomiting" was rare. Cutting the spermatic cord is said to produce collapse. I have once seen it do so; I was then keeping the patient very lightly under the anæsthetic. I have never seen it since, and have at that period of the operation always kept the patients deeply under the anæsthetic. It could be explained on the hypothesis that in one case the stimulus could travel, in the other it could not. So in the case of pain stimuli, I regard a sufficiency of anæsthetic as a preventive of sickness.

Pain or other stimuli antecedent to the anæsthetic being given, also fever, exhaustion, etc., predispose to sickness after an operation.

(4) *Administration of other drugs.*—As, for example, opium before or after the anæsthesia. Impurities in the anæsthetic would also come under this heading.

(5) *Fear.*—An undoubted cause of vomiting. Before the power of volition is lost patients are often sick. That the stimulus caused by fear before the operation may be kept in suspense till the end of the operation is difficult of proof. Still, if you have a terror-struck patient, who is sick before volition is lost, and he be periodically allowed to come round a little, he will each time be sick, or tend to be, and afterwards be very sick. This often occurs when the administrator is nervous, so it can often be seen. Fortunately for the anæsthetist the surgeon usually regards the patient as a bad subject, and no blame attaches to the administrator.

(6) *Emotion.*—Often acting by association of ideas. Patient B observes that patient A returns to the ward vomiting, with chloroform aroma, and evidences of an operation. When her turn arrives she is sick also.

(7) *Feeding.*—This is about the one thing the modern surgeon does attend to, and often overdoes, the patient being, according to his own expression, "sick with hunger." One often sees the patient involuntarily feeding during the operation, his head being placed so high that during the operation saliva, blood, air, and chloroform vapour find their way into the stomach certainly a cause of sickness. It would be interesting to try the dental suction-pump, and see if keeping the mouth dry had any effect on sickness.

(8) *Idiosyncrasy.*—Seemingly unexplainable vomiting—rare when all other causes are eliminated. With most drugs it is the case that occasionally they unaccountably produce abnormal effects, so that some cases of sickness may be left in this category.

Seeing that some or all these causes are usually present, it may be justifiably said that anæsthetic sickness, *i.e.* due entirely to the chloroform, remains non-proven. To further say that chloroform is not a predisposing cause is, of course, incorrect, seeing that many of the above effective causes are non-operative without an anæsthetic. This is particularly well seen in minor operations, where with an anæsthetic the patient is often sick, and not sick without, for here, of course, many of the other causes are much exaggerated in comparison with major operations.

That chloroform is not an effective cause of sickness is to some extent borne out in the medical wards, where the other causes are largely absent; for instance, the treatment of anginal attacks, convulsions, etc. Chloroform in the few cases in which I have used it, or seen it used, has not caused sickness.

In midwifery, too, where the other causes are largely in abeyance—no movement, the patient craving for, rather than fearing, chloroform,—post-anæsthetic sickness is uncommon.

*Administration to children.*—Here, with reasonable care, fear is not present, and the weight of the patient, if it require to be moved, allows that movement to be of a less violent character; one finds sickness is not so frequent as in adults. To definitely prove or disprove the existence of chloroform sickness one might anæsthetise healthy children during sleep.

I may have unduly emphasised some of my points, but let the frequent lack of common sense observed in the treatment of anæsthetised patients be my justification. For if chloroform be a predisposing cause of sickness, an anæsthetised patient should be treated with even greater care than the unanæsthetised; instead of which, the patient being insensible, he has come to be regarded by some as more nearly approaching a corpse than a sentient being.

The curative treatment of sickness after an anæsthetic is a much written-about subject, but the comparative rarity of remarks on the preventive treatment is my excuse for this paper.

## Four Abdominal Emergencies.

By G. V. BULL, M.R.C.S.

**T**HE following four cases were all admitted within sixty hours in a "short duty" in November; all were operated on within seven hours of the onset of symptoms, and all recovered.

**CASE 1.**—Perforated gastric ulcer. M. R.—, a single woman *æt.* 20, was admitted November 27th suffering from abdominal pain.

**History.**—Pain after food for some months; never sick. November 23rd.—She had an attack of severe pain. She went to bed, but got up next day feeling better. November 27th.—She had a meat lunch, and at 6.30, while stooping before the fire, was seized with acute pain in the epigastrium, and was sick. She was brought up and admitted at 11 p.m.

**On admission.**—Patient was anæmic, evidently in pain; her abdomen was immobile but not hard or distended, tender in the epigastrium; liver dulness present. Temp. 98.6°, pulse 105, respiration 28.

**Operation at 12.30.**—Six hours after the onset of symptoms. The abdomen was opened in the middle line above the umbilicus; some gas immediately escaped, but there was no other evidence of escape of stomach contents. After a short search a perforation was found on the anterior wall towards the pyloric end, and near the lesser curvature. In this region were some flakes of lymph and recent adhesions. The stomach was brought out of the wound, and some blood-stained viscid fluid then escaping. The perforation was closed by two layers of Lembert's sutures, and after sponging the stomach, the abdomen was closed by two layers of sutures.

Patient stood the operation well, and on return to the ward was given five minutes' morphia; temp. 100°, pulse 120, respiration 44.

**After-treatment.**—Patient was given nutrient enemata (4½ ounces) every four hours, the rectum being washed out every twenty-four hours. Nothing was given by the mouth for twenty-four hours, but the mouth was frequently sponged out. After twenty-four hours a drachm of hot water every hour, and after forty-eight hours a drachm of Benger's food. This was gradually increased, and on December 10th patient was taking solid food; and enemata were stopped. Pulse only twice over 120, temp. 98.5° to 100°.

On dressing the wound for the second time, on December 11th, some thick pus had oozed out in two places; a small track was found which was plugged for a few days, but the wound was almost healed on January 10th, when a stitch came away, and was quite healed when she went to Swanley on January 16th. Her appetite was then good, and she was free from pain after food.

**CASE 2.**—Perforated gastric ulcer. W. M.—, a man *æt.* 34, was admitted on November 29th suffering from acute abdominal pain and collapse.

**History.**—For two years patient has suffered from pain after taking food, and at times has had to lie up for three or four days. On the evening of November 20th he was walking home when he was seized with sudden pain in his abdomen, but was able to walk about a mile; he then had some milk and soda, but as the pain got worse he asked to be taken to the nearest hospital.

**On admission at 8.30** patient was very cold and collapsed; abdomen hard and retracted, tender in epigastrium; liver dulness absent. Temp. 97.2°, pulse 120; his pulse got weaker in the next hour, and operation was decided upon, and was performed five hours after the onset of acute symptoms.

**Operation.**—The abdomen was opened in the middle line, and a large quantity of liquid stomach contents at once escaped. The ulcer was found on the anterior wall about one inch from the pylorus; the stomach wall was thickened and friable, and on attempting to close the perforation with Lembert's sutures they cut out, so a piece of omentum was sewn over the perforation, and then healthy stomach wall sewn over this with mattress sutures, great difficulty being met with in closing the pyloric end, as this portion could not be pulled up into the wound. The abdomen was then rapidly flushed out with hot saline solution at 110° F., and the wound sewn up with two layers of sutures, and dressings applied, though some of the fluid was oozing from the lower part of the wound. Pulse 140 after the operation, and general condition good, so patient was given five

minims of morphia, and was asleep five minutes after his return to the ward. Pulse 112 to 120 during the night.

The after-treatment was the same as in the previous case, except that nothing was given by the mouth for forty-eight hours. In this case recovery was complicated by bronchitis. Solid food was first given on December 12th, but on the night of the 12th patient had pain in the stomach, and next day at noon suddenly vomited nearly two pints of undigested milk, and broth, etc. He was put back to his original diet with nutrient enemata for six days, but was having solid food again, and since then has put on weight, and has had no further symptoms.

The wound was dressed on December 5th, but it was found to have broken down, and to be discharging some thin pus. It slowly healed, however, and patient was discharged to Swanley on January 11th, the wound being then quite healed.

The statistics of the last five years show eleven operations for perforated gastric ulcer at this Hospital with three recoveries, but most of these cases were operated upon at a later period than the above two, which were exceptionally favourable, being admitted so soon after perforation.

**CASE 3.**—Ruptured liver. L. B.—, *æt.* 10, was run over across lower ribs by an empty four-wheeled van on November 29th, and was brought to Hospital at 7.30 p.m.

Patient was very cold and collapsed. Slight bruising of right hypochondrium; abdomen moving freely; pulse 105, temp. 99.4°. Admitted surgery ward. At 9.30 patient was worse, in much pain, continually crying out; abdomen not moving; pulse 120.

Operation was then decided upon, and performed at 10.30. The abdomen was opened in the middle line, and a small quantity of blood-clot escaped; a rent about two thirds of an inch long was found in the anterior border of the liver, without much laceration, between the median fissure and the gall-bladder. This was packed with iodoform gauze, which was brought out of the wound, and the rest of the wound sewn up. The bleeding had almost ceased at the time, so that recovery might have been possible without operation, but the child got so rapidly worse during the hour she was watched, that further delay seemed impossible. After return to the ward temp. 99.8°, pulse 132, resp. 34. The packing was also taken out two days later, and the rest of the wound closed in hopes of its uniting.

Patient was sick off and on till the removal of the plugging, but then improved. On dressing her on December 7th pus was found oozing from the wound, which was therefore opened up and plugged. Patient also had a sharp attack of pleurisy on one occasion; this gradually subsided. The patient was discharged to Swanley on January 23rd, the wound having quite healed after the escape of a silk suture on January 13th.

**CASE 4.**—Perforating wound of abdomen, with protrusion of omentum. J. P.—, *æt.* 21, was admitted on November 28th with the above injury.

**History.**—Patient was cutting a rope with a knife with its edge towards him; the knife slipped, and entered his abdomen.

**On admission.**—A small wound was found in mid-line half an inch long, midway between the umbilicus and the pubes; from it protruded a small button of omentum equal to a large pea. No constitutional symptoms. Patient was anaesthetised in the ward, and the wound enlarged; the omentum was pulled out a little more, and the wound enlarged; the omentum was the stump returned. The peritoneum was sewn up with silk, and the skin and aponeurosis with gut. Patient recovered without a bad symptom. He was seen again on January 23rd; the scar was sound, and showed no sign of yielding.

I have to thank Mr. Willett and Mr. D'Arcy Power for permission to publish these cases.

An earnest-looking individual presented himself at the Surgery last week, and handed in his card to the house surgeon on duty. He said he had heard that one of the house surgeons was recently "sacked for being drunk." He wished to offer his services; he had "been in Kimberley sixteen years, and was practically a doctor!" He was referred to the Office.

## Cæsaræan Section.

A Paper read before the Abernethian Society, December 6th, 1900.

By J. MORRISON, M.D.

(Concluded from p. 39.)

**I**NDICATIONS for Cæsaræan section.—In giving these we must lay aside all opinions of authors, however great, who wrote before the introduction of the Sænger-Leopold method?

Does Spiegelberg, one of the best of latter-day obstetricians, state the present-day position when he writes, "The preceding statement of the risk that accompanies Cæsaræan section (two thirds women, one third children) makes it easy to settle the indications for operating on a living woman: these are only sufficient where delivery *per vias naturales* is absolutely impossible, the limit for which begins at C. V. 2½ in., in some pelvis (reniform) 1½ in."?

Referring to a *conditional indication*, which exists in the third degree of disproportion when the child is alive and vigorous and the mother gives her consent, he says, "In view of the uncertainty in saving the mother, and the improbability of such an issue, the question in actual practice is, Are we to sacrifice the mother for the sake of the child? No one can advise her to submit to the operation under such circumstances. Indeed, it is incomprehensible how a medical man can dream of asking a parturient woman or her friends such a question as, Shall I perform Cæsaræan section or perforation? The woman is utterly incompetent to give an unbiased judgment, nor, indeed, can she clearly grasp her true condition. To rely on her reply at such a time is to show a lamentable ignorance of what humanity is." Credé has truly said that the majority of parturient women are utterly incapable of deciding, and grow more so the further their labour has advanced, and the honest admission of this teacher on being asked by the husband of the parturient woman whether he would, under similar circumstances, allow the operation to be performed on his own wife,—"As a medical man I would consent, but as a husband I would unhesitatingly refuse" is a stronger condemnation than any words of mine can be of this "conditional" indication.

This statement of Credé's dates back to 1851, and Spiegelberg writes in the days before the new operation, and, indeed, with an experience of having performed five Cæsaræan sections with five deaths. Winckel, again, writing in 1888, makes no mention of any conditional indications, thus following Spiegelberg and the older writers.

He gives us indications for Cæsaræan section:

- (a) On the living woman.
  - (i) If absolute pelvic contraction renders delivery by the natural passages impossible, the woman being at full term, even if the child be dead.
  - (ii) If tumours of the pelvic organs which cannot be pushed out of the way or diminished in size make it impossible to deliver a mutilated child through the genital canal, when child is living or dead.
  - (iii) If extreme cicatrization of vagina exists, so that the natural passage cannot be dilated without lacerating neighbouring organs; child living or dead.
  - (iv) If the child is living, but passages contracted and only possible to deliver after mutilating the child, and mother refuses her consent to this.
  - (v) When child is living or dead and uterus is strangulated in a hernia, and cannot be replaced.
- (b) On the dead woman.
  - (i) If child alive shortly before mother's death, if the latter has occurred rapidly, and not more than twenty-five minutes have elapsed to the beginning of the operation. (Such cases as apoplexy, heart failure, eclampsia, or death from acute injury.)
  - (ii) If woman is moribund, and this is the quickest and least damaging mode of delivery.

Referring to the German cases between 1880 and 1889, however, one finds that out of 35 cases 31 operations were for contracted pelvis; in 26 of these the C. V. is stated, and in all but one the conjugate was above 2½ in., in 15 even 3 in. or more. Also in the other

cases in which the C. V. is not given, in all but one the woman was a multipara, and so C. V. probably above 2½ in.

The other four cases were for—retro-uterine 1, rupture of lower uterine segment and contracted pelvis 1, oostomalacia 1, contracted pelvis and eclampsia 1.

This means, therefore, that those operations have almost all been performed for relative indications only and are quite unjustifiable according to Spiegelberg or Winckel.

Referring to other recent writers, one finds that all American authorities recommend the new operation for relative indications, that is to say, risking the patient in order to secure a live child.

In England, Herman, Playfair, Galabin, and the smaller textbooks of Edinburgh and Dublin Schools, all give relative indications, whilst most of the present-day obstetricians have performed the operation on these conditions; your teachers, Drs. Champney, Griffith, and Gow, have all performed the operation on patients when the passages admit of the delivery of a mutilated child, but not of a living one, at full time.

On the whole, therefore, we must discard Spiegelberg's and Winckel's ruling, and allow that it is justifiable to perform the operation, as at present carried out, in certain cases in the interests of the child, at a certain risk to the mother.

At the present moment, to give you exact rules for this procedure is difficult, owing to the vast difference of opinion in the matter, but I will state them as nearly as possible, according to the general rules of the majority.

Some major operations should be done—

i. In cases where fetal destruction may accomplish delivery but at a greater risk than under Cæsaræan section as now performed. C. V. from 1½ in. to 2½ in.

ii. Where craniotomy can more safely be done, but the woman has had premature induction thoroughly tried at previous confinements without success, and the woman wishes to have a live child. Cæsaræan section under these circumstances is never justifiable, therefore, in a primipara. 2½ in. to 3½ in. in flat pelvis.

iii. In cases of malacosteon pelvis with moderate contraction, where the woman is in hospital.

iv. In very rare cases where C. V. is above 3½ in., and the woman has been repeatedly delivered, by various methods, without obtaining a live child; the woman's consent must be obtained.

In future the vital question will surely range about the pelvis with 3 in. C. V. where four operations may be possible. In a primipara—forceps, symphysiotomy, Cæsaræan section, or craniotomy; in a multipara—premature induction, craniotomy, symphysiotomy, and Cæsaræan section.

Rules for accepting operation.

- i. If the patient is primipara and conjugate above 2½ in. and under 3½ in., try forceps, and if this fails perforce.
- ii. (a) At her next delivery induce at time of election after seventh month.
  - (b) If she has gone to full time and is not in labour—
    - i. Send to hospital or secure skilled operator for Cæsaræan section.
    - ii. If impossible, try turning or thin forceps, *perforate* child yourself.
    - (c) If she has been long in labour—
      - i. Try forceps, then perforce.
  - iii. If patient multipara who has previously had craniotomy and induction—
    - (a) At full time not in labour, Cæsaræan section.
    - (b) At full time, late in labour, Porro.

As regards the preference for kind of operation—Cæsaræan section, symphysiotomy, Porro-Cæsaræan, and craniotomy—the relative values are as follows:

Cæsaræan section has its best results in cases which have not been long in labour, and where no manipulations have been performed. If, therefore, Cæsaræan section is decided upon, do not attempt to deliver by the passages; and conversely, cases where attempts to extract have been made are most unfavourable for Cæsaræan section, Cæsaræan section is not the operation of last resort; in absolute obstruction it is the only operation, and therefore to be done at once; and in minor contractions, falling forceps or turning, perforce is the last resort, not Cæsaræan section. The high death rate from the operation in England up to 1890 has been due almost entirely to this mistake.

Experience shows that pregnant women are good subjects for anaesthesia and operations in general. The technical details of the operation ought to be easily under the control of every doctor.

The incisions are made under the guidance of the eye, and not in

the dark, as in many laparotomies, and the sutures are likewise so placed.

Hæmorrhage can be easily controlled from the wound, and very rarely occurs later from the placental site.

The only real dangers are septic infection of the peritoneum by the surgeon's hands or instruments, and occasionally hæmorrhage due to non-action of the uterus.

The first accident should never happen, and rarely does in good hands; and the second is even more rare, and only in cases where the muscle is exhausted by long hours of labour (Noble).

According to one writer, "the facts in the case justify and fortify the statement that the Cesarean section done by the expert before or later in labour is scarcely more dangerous than the average of confinements as at present conducted in our large cities!"

Operators are agreed on most points concerning the principles governing success in the operation. The points agreed upon are—

1. The diagnosis should be made during pregnancy, the operation determined upon, and the patient should be put in good condition for operation.

2. Operation should be done with the same antiseptic and other care, as in other laparotomies.

3. For the best results it should be done by an expert.

4. After-treatment should be the same as in other laparotomies, modified by the treatment for the puerperal state.

5. The sutures should be put in deep and superficial.

6. Rapidity of operation within certain limits is essential. The points at issue are:

1. Should the operation be done before, or early in, the first stage?

2. Should the uterus be turned out or incised *in situ*?

3. Should the tubes be tied?

4. Should the uterus be constricted by rubber tubing to control hæmorrhage during operation, or should manual compression be employed?

As regards the first, it has been found that you may eloct your time for the operation without danger of hæmorrhage. My own opinion, from cases seen, is to let the patient come well into the first stage of labour before operating, if possible.

Do not turn out uterus unopened, but do so immediately the child is extracted; this avoids a long skin incision, and gives you absolute control of the uterus. The risk from blood and liq. amnii escaping into the abdominal cavity is nil.

Do not use the elastic ligature if possible; it damages the tissues, causes atony of the uterus, and is unnecessary. Absolute control of bleeding is obtained by an assistant holding neck of uterus lightly, and tightening the grasp according to the hæmorrhage.

As regards sutures, it is usual to employ silk abroad, but best salmon fishing gut I have most frequently seen used in England. The method of insertion varies, but cannot be better than in the original Sanger operation.

As regards tying the tubes, in England it is usual, abroad not. I think it should not be done, but it is a difficult question, and still open to statistics.

The Porro operation—Should be done:

i. In cases seen late, where the woman is in a bad condition and rapid operation is requisite.

ii. In cases already septic from manipulation.

iii. In cases complicated with fibroids.

iv. In osteomalacia.

v. In cases of Cesarean section where the bleeding cannot be controlled.

*Symphysiotomy.*—This much-abused operation is gradually coming to the front again, and, I believe, will, within a very few years, find its place as a recognised operation far more resorted to than Cesarean section. It has been condemned by the greatest midwives; its performers have been called every name from scoundrels to murderers, but so have the operators in Cesarean section. Just listen to Mr. Ould, the first Master at the Rotunda, who died 1789. Referring to a Cesarean section case, the mother being alive, he condemns the operation as "detestable, barbarous, and an illegal piece of barbarity."

The statistics published in 1893 give:

*Mortality.*—Fifty-four cases of symphysiotomy, fifty-three women and forty-eight children saved; the operation in England has only in a few cases been performed, and only once or twice by the same operator; it is still on its trial and will probably become the operation for pelves from 2½ in. to 3½ in. The same rule will hold here

as in Cesarean section, namely, do not pull the woman and child to pieces before deciding to do symphysiotomy. With these two operations embryotomy on a living child will practically disappear.

*Embryotomy* should be preferred to Cesarean section:

(1) If the child is dead.

(2) On hydrocephalus and monsters.

(3) In cases seen late by the surgeon, especially when violent efforts with forceps have been used, etc.

(4) In cases remote from assistance (symphysiotomy may in time replace this).

*The operation of Cesarean section:*

i. Preparation of patient.—When possible daily baths for one week or vaginal douche boracic acid night and morning; immediately before the operation the vagina should be washed thoroughly with soap and water. Bowels freely opened by oil night before. Enema four to eight hours before operation. Catheter to be passed at time of operation.

ii. Operate at end of pregnancy, or better, at commencement of pains.

iii. Instruments.—Scalpel, scissors, needle-holder and needles, half a dozen pressure-forceps, the salmon-gut ligature, Chinese twist (fine), sponges, towels, dressings, piece of red-rubber tubing—all absolutely aseptic.

iv. *Cleanliness of operation.*—As in a laparotomy, remembering that the whole success of the operation depends on this; if you are not aseptic the woman will die. I need not give instructions here to Bart's men.

v. Number of assistants.—Chloroformist and two others, if possible; it can be done with only one assistant and a nurse. (Gow.)

vi. Posture of patient.—As for ovariectomy, seeing that the patient is kept warm. Abdomen prepared overnight is washed again with soap and water, ether, and then per chloride lotion; abdomen surrounded with four towels sterilised and wrung out in hot carbolic lotion, 1 in 40.

vii. *Abdominal incision.*—In middle line from 1½ in. below umbilicus to 1½ in. above symphysis pubis. Do not waste time in clamping and tying off bleeding points; enlarge primary incision if necessary with scissors.

viii. Assistant to centre the uterus, correcting obliquity and torsion, and keep abdominal walls pressed in apposition to uterus.

ix. Incise uterus in middle line 6 in. in length, beginning well towards fundus (point just below fundus), taking care not to go too low down towards the lower uterine segment, where there is loose areolar tissue between the muscle and peritoneum. Cut through whole thickness until membranes appear.

x. If placenta is in front do not cut into it, but push the hand to side of it and the ruptured membranes.

xi. The assistant keeps the abdominal walls closely applied to the uterus, and as the child is delivered presses the uterus out of the abdomen into the wound, holding the uterus with a hand on either side of its neck. The operator removes the child quickly by seizing the leg, hump, or head. Do not get the arm if you can help it; but the chief thing is to deliver as quickly as possible.

xii. Rarely the head sticks; then hook finger in the mouth and two fingers of other hand over neck, and pull the head out forced.

xiii. The assistant keeps the uterus firmly squeezed, and controls bleeding, which, as a rule, is slight. The operator cleans out child's mouth and starts resuscitation, clamps cord, and hands over child to a skilled nurse if possible.

xiv. If no bleeding wait a little for the expulsion of membranes and placenta. At this time an assistant gives a hypodermic of ergotin mx. The uterus will be seen to contract in a few minutes; if not, ergotin may be repeated.

xv. Let uterus rest on a hot flat sponge, or pad of gauze wrung out of hot water (120°). This occludes the abdominal wound above and retains the intestines, as well as catching any further bloody discharge from the uterus.

xvi. Uterine sutures.—(a) These are of silk or salmon gut, every half inch, inserted quarter inch from the cut surface, and passing through peritoneum and muscle, but not through the decidua. Begin at the lower end, as this is the hardest to get neatly together; eight to ten are

necessary. Don't tie sutures until all the deep ones are inserted. Tie each suture with just enough firmness so as to bring the cut surfaces snugly together, and to blanch a small area of the uterine tissue in the immediate neighbourhood of the suture. Never tie very tightly, and above all things avoid a slack tie. (8) Superficial sutures:—If the wound between the stitches gapes, then insert a few sutures through peritoneum and a little muscle. (7) Superficial Lembert sutures should now be inserted, so as to bring the peritoneum, with its edges tucked in, over the line of sutures. These are placed alternately to the deeper sutures, and only passed through the peritoneum. Thin Chinese twist may be used, or generally the salmon gut is used throughout the operation.

xvii. (a) Now tie tubes if this is to be done, and remove a portion (Champneys' method).

(b) Cleansing the abdomen previous to closure.—Hook up the lower angle of the abdominal incision with first and second fingers, and carefully sponge out the vesicouterine pouch, the iliac fossa, and lastly, the small intestines and Douglas's cul-de-sac; the uterus is then dropped down into the pelvis. If blood and amniotic fluid have escaped into the abdomen pour in a quart of water (108° F.), and wash the lower abdominal cavity well out.

xviii. Drawing down the omentum.—If septic infection is excluded with certainty, the omentum should be drawn down over the uterus in front, protecting it and the viscera from the abdominal incision. If there is a possibility of septic infection, or after previous instrumental interference and prolonged labour, it is better to draw the omentum down behind the uterus, thus separating it from the small intestines, and leaving the uterus in close relation to the abdominal incision. A septic process may thus be localised and discharged through the abdominal wall, thus saving the patient.

xix. Closing the abdominal incision.—Use salmon-gut sutures half inch apart, embracing all layers, especially the peritoneum, between these. Superficial skin sutures may be placed if there is any pouting, so as to get accurate apposition of the cut surfaces.

*Subsequent care of the Case.*

Immediately after the operation pass catheter, and wash up labia, and dust over with iodoform and boracic (1 in 7). Care in passing catheter by nurse.

A pad of absorbent wool over vulva changed every three hours at first.

Baby may go to breast after first twenty-four hours. Nothing by mouth for twelve hours; ice and morphia if necessary. Remove sutures on tenth day, and put on strapping and firm binder.

*Errors to be Avoided.*

1. Do not use antiseptics for instruments or hands after operation has begun. Use pure boiled water throughout.

2. Do not turn uterus out before incision.

3. Do not cut through the placental tissue. Leopold lays great stress on this.

4. Do not waste time picking off small bits of decidua from uterine cavity, but be sure to remove all placenta and membranes.

5. Do not do a conservative Cesarean section when the uterus is already septic. Prefer Porro.

6. Do not use catgut.

7. Never use a continuous suture in the uterus.

8. Do not attempt to drain the abdominal cavity.

9. Keep vagina aseptic.

10. Make all preparations, if possible, fully and carefully before the operation.

## Notes.

PROFESSOR PERCY FURNIVALL is advertised to lecture before the Royal College of Surgeons upon "The Pathology, Diagnosis, and Treatment of the Various Neoplasms of the Stomach and Intestine," on Monday, March 11th, and on the following Wednesday and Friday.

MESSRS. HARMER and MUNDY have been appointed Surgeons to the Western General Dispensary.

OUR readers have probably already noticed the untimely death of Fredk. George Engelbach, who was killed in the action at Nooitgedacht on December 13th whilst attending to the wounded. Engelbach left Bart's, after qualifying in 1886, to practise at Morctonhampstead, and whilst there organised and became captain of the local volunteer company. In January of last year he left for South Africa as a Civil Surgeon, and was most of the time attached to the 2nd Cavalry Brigade. He was present at the relief of



Kimberley, at the battle of Paardeberg, and entered Bloemfontein with Lord Roberts. Later he accompanied the field hospital of his Brigade on Ian Hamilton's great march, and was present at the battles of Houtnek and Diamond Hill.

At Nooitgedacht, says the *Standard* correspondent, Engelbach's death was "a typically brave one. Tending the wounded under heavy fire, he was shot through the palm of the left hand, and had just made a grim joke about now being handicapped in his work when, in standing up to dress his hand, he was killed by a bullet through the forehead." For the photograph which we publish we are indebted to the kindness of the editor and publisher of *Navy and Army Illustrated*.

WE have also to record the death of Dr. Bernard Leumann, which took place suddenly on January 7th in very painful circumstances. Leumann had been invalided home from South Africa in October on account of dysentery. It was stated that he also suffered from heart disease. Whilst acting in the Indian Medical Service he contracted plague, and our own museum is indebted to Dr. Leumann for several valuable specimens illustrating the pathology of this disease. Our readers may remember that we recently opened a fund in the columns of the JOURNAL at Dr. Leumann's request, to supply certain necessities for the Indian stretcher bearers at the seat of war, in whose welfare he had taken considerable interest.

\* \* \*

ON another page will be found an account of the death of yet a third and younger of our colleagues—Lance-Corporal Mountain, who fell a victim to enteric fever at Pretoria.

\* \* \*

It has been said that the popularity of amateur theatricals exists chiefly in the minds of the players, and that if their efforts result in producing a feeling of toleration among the audience that they may be considered to have done well. The pessimistic author of these remarks evidently has never been present in the Great Hall at one of the Christmas entertainments.

Since the unambitious beginning in January, 1883, till the present time, an unbroken series of performances has been given, some more successful than others, but all equally kindly received by the audiences.

The entertainment which brings so many old friends together, which, too, is held amid such beautiful surroundings, has with the passing of years acquired certain unique features, among which the playing of female characters by

men is not the least curious, though it can hardly be said that plays thus cast can be given as effectively as they could with the help of ladies.

Still time changes all things, and we think that there is a tendency growing up amongst many of the audience to laugh less at the man in petticoats, and find more legitimate enjoyment in the way he plays his part, thus making more allowance for the difficulties that beset him.

\* \* \*

This year's selection proved a happy one, due in part to the comparative modernity of the play, and in part to the exceptionally good all-round cast—the most equal one we remember to have seen in the career of the Club, and the most satisfactory, in as much as the percentage of new members was much larger than usual, the chief characters in the play being on their shoulders.

That attention to details which is so essential, was this year more conspicuous than for some time, and but for the very ineffective thunder, and a long wait between the scenes of the last act, Miss Jedd's words may be taken to apply to the production, that as a whole "it was frightfully jolly—taking it all round."

The laughter during the performance was not as continuous as usual; but this may be accounted for by the greater attention paid to Mr. Pincro's exceedingly brilliant lines, and the verdict from the front was universally favourable.

\* \* \*

The Hospital Musical Society, under the able direction of Mr. J. A. Nixon, who was most heartily congratulated on the result, was better than it has ever been before at the Christmas entertainment.

\* \* \*

One serious drawback, not noticed for the first time, was the overpowering heat of the hall, especially on the second night, when the thermometer stood about 20° higher than the previous evening. The large rose burners are themselves responsible for much discomfort, but the greatest amount of suffering is caused by the enormous fires which are lighted early in the day, and are lavishly replenished just before the arrival of the guests.

Surely it would be possible to let the fires out some time before the company assembled, so that, while the Hall would be pleasantly warm on arrival, there would be no roaring furnace to torture the guests when the place became full. We noticed on entering the hall at 6.30, when there were but three other people present besides ourselves, that the windows were already covered with moisture—and none were open.

We have been asked to afford to the present members of the Dramatic Club this opportunity of thanking past members for their help in the production of this year's play, and for the interest they have always shown in the Club's welfare. We are also desired to state that to old members both the Club and the audience are indebted for the selection of the piece, and many valuable suggestions and criticisms.

### Abnethian Society.

THE Mid-Sessional Address of the Society was given on January 10th, in the Medical Theatre, by Mr. H. T. Butlin, who took for his subject the British Medical Association and the Woes of the Medical Profession.

Unfortunately, owing to the theatricals on the two preceding nights, the nursing staff were unable to be present.

Mr. Butlin began his address by saying that his position there reminded him of a Chinaman he once had in one of his wards. It was Christmas Day, everybody was enjoying himself in the usual way. The Chinaman was asked to sing; for some time he refused, but at last consented. When he had sung some twenty verses of his song his hearers thought it was very nice, but were beginning to get a trifle restless; when he had sung thirty they still thought it was very nice but the restlessness was increasing, and so on until he had finished forty, whereupon, as the Chinaman showed no signs of coming to the end, they could stand it no longer, and hurried him out of the ward into the scullery and locked him up until he had finished, which he did at some early hour the next morning. Mr. Butlin said that he hoped, when his hearers had had enough, they would not bustle him out of the theatre and lock him up in one of the adjacent rooms, but would take him to his carriage and put him in and let him finish his address by himself on his way home. Continuing, Mr. Butlin said he had been led to choose the British Medical Association as the subject of his address on account of his close connection with that body extending over many years, during some of which he had been its Treasurer, and because he had lately been on a committee on the constitution of the Association. Concerning the second part of the subject he said his hearers would all have to meet "woes" on entering private practice, and it was as well for them to know something about them, and how to combat them when they encountered them. He considered the profession of Medicine was just as good as any other profession, and had neither more numerous nor greater drawbacks.

The troubles besetting it he divided into two great classes: (1) those arising from without; (2) those arising from within.

(1) In the first place, medical men hold positions of great responsibility and often of difficulty, and so are especially liable to attacks on their moral status. These charges, which sometimes reached the Law Courts, were very frequently attempts made by unscrupulous persons to levy blackmail,—charges, however unreasonable and undeserved, which often did the medical man subjected to them considerable damage. The abuse of hospitals, dispensing chemists, patent medicines, the competition of quacks of all kinds, were mentioned as other troubles, having their origin from without.

(2) The troubles arising within the profession Mr. Butlin divided into four groups:—first and most serious, *underselling and unfair competition* amongst individual medical men; second, *medical aid associations*; third, evils of *advertising and touting*; fourth, *overcrowding*.

Mr. Butlin next considered the methods of combating these evils. *External evils*.—He first dealt with the attacks on medical men. He advised all his hearers to join one or other of the Medical Defence Associations, with one of which Mr. Bruce Clarke is connected, with the other Mr. Victor Horsley. These Associations, whose members pay an annual subscription of about 10s., take up charges brought against their members, many of which are immediately withdrawn when it is found that the medical man has power and influence behind him to meet them. With regard to the abuse of hospitals, Mr. Butlin said that there were two ways of dealing with this evil:

(a) What is known as the *Bart's method*,—that is where a person, a kind of private detective, is employed to make inquiries about the means of patients applying for relief.

(b) *The fixed wage limit*, where persons whose weekly earnings are over a certain fixed amount are refused treatment.

*Evil of prescribing chemists*.—Mr. Butlin said that he really knew of no remedy for this evil, and that he did not know the extent of injury it inflicted on the profession.

*Patent medicines*.—These could, of course, be suppressed by interference from the Government, but interference is unlikely to arise from this source, as from the sale of patent medicine over a quarter of a million of money annually accrues to the Exchequer.

*Quacks, herbalists*.—Attempts have been made by various medical associations to put down these evils, but such attempts, when brought before the courts, often did not meet with the success they merited. It seemed probable that the Government, if it interfered with quacks, would put a yearly tax on medical men such as it put on lawyers. This, if medical men were taxed at the same rate as lawyers, would bring in, in round figures, £200,000. Mr. Butlin said that he thought quacks of all kinds were principally supported by the highest and lowest classes, and not to any great extent by the middle classes. He thought, without wishing to appear irreverent, that there was an

example of this in the Bible; he referred to the story of Naaman consulting Elisha for his leprosy. He said he felt confident that Naaman must have considered Elisha a sort of quack or irregular practitioner, and he founded this opinion on the fact that he brought him such a handsome fee. Whereas, if Naaman had been going to consult a regular medical man, he would have brought two pieces of gold and two pieces of silver, and having carefully wrapped them in a piece of paper, would have laid the whole surreptitiously on a corner of his table.

*Internal evils.*—Advertising, touting, and such malpractices, he said, are dealt with very severely by the colleges and General Medical Council. That very afternoon, at a Council meeting at which he was present, a medical man was deprived of his diploma for connection with an improper institution. The abolition of the practice of employing unqualified assistants had lessened the evil of overcrowding, and at the present time the supply of qualified men was scarcely equal to the demand, and, indeed, any student from the day of qualification need have no fear of being unable to earn a livelihood. This state of affairs, he said, was partly caused by the present condition of events in South Africa, and partly by the large expenditure necessary in equipping the student for the practice of his profession. Mr. Butlin said that he thought that at no period in the history of medicine had the medical man been better educated and more thoroughly trained for the battle against disease than at the present time. Continuing, he said that on cursory inspection medical aid associations appear to be reasonable institutions, and doubtless had their origin in a desire for the promotion of the benefits of co-operation; but they are open to abuse, and, indeed, are largely abused. Enumerating some of the reasons for their abolition or reform, he stated firstly that often, indeed too often, people who can well afford to pay the ordinary fees for the services of a medical man are admitted to the associations, and by contributing a small sum per week obtain medical advice in time of illness. Secondly, after the salary of the medical officer, who very often has been imported to compete on unfair terms with the practitioners already in the place, has been paid, money is left over which goes to enrich the promoters of the association, thus turning the talents of a medical man into the capital of a limited liability company in which he has very little interest, and over which he exercises no control.

Mr. Butlin said that he believed that the General Medical Council had determined to take steps to stop medical men undertaking work in connection with the Medical Aid Association. He gave an example of the case of a woman who came to him for an operation for which she was well able to afford and paid a large fee, who for years had been obtaining medical advice from the Medical Aid doctor in her town for 1s. per week. In concluding this part of the subject, he said that he thought the external woes are more easily dealt

with than the internal, the greatest of which, he said, was underselling, for which he knew no remedy, save that which can only be applied by the individual members of the profession.

Mr. Butlin next dealt with the British Medical Association, giving an account of its history, aims, and attainments. He said that it is the greatest medical organisation which has ever existed. Seventy years ago Dr. Hastings, of Worcester, conceived the idea of trying to bring medical men together to discuss the best methods of upholding the "dignity of the profession," and for the purposes of scientific discussion and discovery. The first meeting was held in 1832, 140 medical men being present. At this time the title of the Association was "The Provincial Surgical and Medical Association." Twenty-four years later the title was changed to "The British Medical Association," and all medical men were eligible for membership. This was done with a view to setting it on a firmer and surer basis, as at that time the finances and general condition of the Association were at a low ebb. In the year 1867 the services of Mr. Ernest Hart were obtained by the Association, and it is to his care and diligence that the *British Medical Journal* owes its present proud position in the ranks of medical literature. In 1871 Mr. Fowler was appointed general manager, and he has done for the finances what Mr. Hart did for the journal. At the present time the membership numbers over 18,000, scattered over all parts of Great Britain and the colonies. The annual income is between £30,000 and £40,000, and the accumulated fund between £75,000 and £80,000; numerous scholarships have been founded, and grants awarded for scientific research. At present about £1000 is annually distributed in this manner. Various committees dealt with all subjects of interest to medical men, and which concern their welfare; to mention only two—the Parliamentary Bills Committee, which watches the interests of the profession in the Commons, and the Ethical Committee, which deals with points of medical etiquette as they arise. Two other services rendered to the profession were the steps taken by the Association to secure proper recognition for medical men in the army, and the work done in connection with rendering "double qualification" necessary before a diploma allowing to practise was granted. In spite of the good work the Association has done and is doing, Mr. Butlin said there is constant grumbling heard from a section of its members; very often no definite complaints were made, so that it is impossible to remedy any evils which may exist unless it is known exactly what is wanted. It has been said that the constitution is not representative; at present attempts are being made to remedy this evil, but it is doubtful whether these attempts will be successful.

Mr. Butlin desired to impress on the members of the Abernethian Society that half the woes of the profession are due to the apathy of medical men, and to the want of *esprit de corps*. Instead of determining to do something

for themselves, the majority of members of the profession were always looking to some body or association to do something for them; and the vast majority of them made no movement to help themselves. The want of *esprit de corps* was still more lamentable. Instead of standing together, medical men were far too much in the habit of speaking ill of each other, and of damaging their fellows and rivals in the eyes of the public. The solicitor to the British Medical Association and to the Apothecaries' Hall, who had a great experience both of the medical and of the legal professions, in discussing the troubles of the medical profession, especially the question of underselling and accepting work for Medical Aid Associations, had said to him some years ago that the great difference between the members of the two great professions lay in the much greater *esprit de corps* in the legal profession; and that, if the medical men would stand by each other, there would be far less grumbling at the treatment of medical men by the public than there is at present. Mr. Butlin therefore hoped his audience would do their best in the future to cultivate cordial relations with their fellow medical men, and would understand that when a great reform is necessary, it can only be obtained by individual effort of the men who desire it.

Mr. Butlin was much in favour of maintaining what is called the etiquette of the profession, which is quite as much to the advantage of the patient as of his medical attendant.

He finally hoped that those who were present would remember the three duties of the medical man, as he had heard them laid down by his former colleague, Mr. Luther Holden:

First, his duty to his patient.

Second, his duty to his profession.

And last, his duty to himself.

*January 17th* (Mr. G. E. Gask, President, in the chair).—In the absence of Mr. Shrubbsall, owing to indisposition, a Clinical Evening was held instead of the paper on "Prehistoric Medicine and Savage Medicine of 10-day."

Mr. Nixon showed a case of erythema scarlatiniforme desquamatum. The rash and subsequent peeling were first noticed whilst patient was in the Hospital seven years ago, being treated for extensive sulphuric acid burns. It was then thought that he was suffering from scarlet fever; but, as he showed no other symptoms, this view was abandoned. The rash and peeling had been noticed several times since its appearance for the first time. It was suggested that it was caused by some impairment in function of the trophic nerves from injury inflicted by the sulphuric acid burn.

Mr. Thomas showed a case of atrophy of some of the shoulder and arm muscles in a boy, both sides being almost identically affected. Only quantitative, not qualitative, electrical changes were observable. During the last six weeks, whilst under observation, no further changes had become manifest. It was put forth as a possible cause of the atrophy and paralysis that a pachymeningitis, affecting the fifth and sixth cervical segments, would explain the motor symptoms; but against this view was the lack of sensory symptoms.

Mr. Ridout showed a case of a boy with a swelling in connection with the right knee. He had been under treatment in the Hospital for genu valgum. The swelling was regarded as an exostosis rather than a hyperostosis in connection with the internal condyle.

Mr. Wethered showed a case of sclerodema for Mr. Darby. Patient was a boy who has been under treatment for some months, some of the patches having cleared up under treatment, others having broken down and ulcerated. There was some discussion as to the pathology of the disease.

Mr. Scholberg showed a specimen of plague bacilli from a case occurring at Hull a few days previously. The bipolar staining was very clearly seen.

Mr. Gask showed a large hair-ball, successfully removed by operation from the stomach of a young girl. He also showed an excellent series of specimens from the Museum illustrative of the terminations of carcinoma of the oesophagus.

### Junior Staff Appointments.

NOMINATIONS for House Physicianships, etc., April, 1901.

#### HOUSE PHYSICIANS.

Sir William Church.	A. H. Hayes, M.R.C.S., L.R.C.P.
Dr. Gee.	A. T. Pridham, M.B. (Lond.).
Sir Dyce Duckworth.	F. C. Shrubbsall, M.A., M.D., B.C.(Cantab.).
Dr. Hensley.	S. Hey, B.A.(Cantab.), M.R.C.S., L.R.C.P.
Sir Lauder Brunton.	A. H. Bostock, M.R.C.S., L.R.C.P.

#### INTERN MIDWIFERY ASSISTANT.

J. A. Willett, B.A., M.B., B.Ch.(Oxon.).

EXTERN MIDWIFERY ASSISTANT—*April*.

S. R. Scott, M.B.(Lond.).

EXTERN MIDWIFERY ASSISTANT—*July*.

H. Vaughan Pryce, B.A.(Cantab.), M.R.C.S., L.R.C.P.

The College Exams. were on, and a certain trio of diseased humanity—consisting of a G. P. I., a progressive muscular atrophy, and a boy with mitral disease was travelling slowly Embankmentwards in a growler. Passing the Old Bailey the G. P. I. suddenly recognised some pals, and made a dash for the road. He was dragged back by his disease-embarrassed companions, with the loss of the window-strap, and for the rest of the day belied the text-book picture of *bien-être* by indulging in floods of tears. The chance which made muscular atrophy and morbus cordis male attendants on the violence of general paralysis was a grim one.

The question was about "laryngismus stridulus" and its treatment, and the candidate was out of his depth, but not out of his humour; for after steering carefully through the spasm (suggested by ismus) and the croup (suggested by strid-), he said, "As regards treatment, patients at this age stand drugs so badly that I will not venture to give a prescription!"

## Correspondence.

THE LATE LANCE-CORPORAL MOUNTAIN.  
IMPERIAL YEOMANRY BRANCH HOSPITAL,  
EASTWOOD, ARCADIA, PRETORIA.

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

DEAR SIR,—I believe a great many of those who knew Lance Corporal Mountain as a second-year student at Bart.'s would be interested in the enclosed account of Bart.'s world written by a sergeant in his Company who had been with him the whole time he was out here. With regard to his last illness, Mountain came into Pretoria with his Company, most of whom joined the Imperial Light Horse. Mountain himself at that time was unable to ride on account of veldt sores on his legs. Hearing that I was at this hospital, he came up to see me. I treated him for the veldt sores, and got him an appointment in the hospital stores. He had only been at the hospital nine days when he developed enteric fever. He progressed very favourably until the end of the third week, when he developed gangrene of his right leg. At the most favourable opportunity his leg was amputated, but he died the following day. He had extensive valvular disease of the heart, probably malignant, with blocking of both the arteries and veins on the right side as high as the bifurcation of the aorta. He had a military funeral the next morning at 8 o'clock in the Pretoria cemetery. Some of the Sisters and Bart.'s men at the hospital were present. A brass plate was placed on his coffin, and a large wreath and cross of flowers were sent from the Bart.'s men here, and from his friends in the hospital. The morning of the funeral was very wet, but that only made the service more solemn and impressive. I suppose, with the firing party, there were about fifty people present. The question is now being considered of a headstone. Will you make what use you like of this letter and the enclosure?

Yours truly,  
A. R. J. DOUGLAS.

LANCE-CORPORAL MOUNTAIN, who died of enteric fever at the Imperial Yeomanry Hospital, Pretoria, saw a deal of active service in South Africa.

He enlisted in the 72nd Company Rough Riders, Imperial Yeomanry, under the command of Lieut.-Colonel Colvin, and was quartered for a short time at the Aldershot Barracks while the Battalion was being equipped and put through its preliminary drill.

His commanding height of 6 ft. 4 in. made him conspicuous amongst his comrades, and with his kindly disposition he soon became a general favourite, while his careful attention to duty begot him the entire confidence of his commanding officer, so that he (Mountain) was frequently called upon throughout the campaign to take charge of patrols to scour the country in advance of the moving column.

Embarking at Southampton early in April in the s.s. "Canada," he assisted in the hospital on board throughout the voyage.

Arriving in Pretoria in June, his Company was attached to General Mahon's Brigade, and he received his first baptism of fire on the march to Balmoral. The hardships of this march may be judged by the fact that the men were on short rations, and on one cold and bitter night three privates and one officer of the Highland regiment perished from exposure, while over 400 cattle and mules died the same night.

Corporal Mountain then saw continuous hard fighting with his Company up to the end of October, first under General Mahon, then under General Clements, during which time he was always foremost in the fight when fighting had to be done, and, being an excellent shot, he rendered good service to his Queen and country, and by his death he is greatly mourned by his officers and comrades in arms.

AMONG some testimonials we lately read recommending a candidate for a resident hospital appointment, was one which should have proved a decided bar to election. It was from a surgeon, who said the particular candidate "had spared no pain in making thorough use of his opportunities." Mr. Stephen Coleridge and Helen Jerome please take note.

## The Christmas Entertainment.

"DANDY DICK," although written by the author of "The Second Mrs. Tanqueray," "The Notorious Mrs. Ebbsmith," and "The Benefit of the Doubt," is not a problem play, and does not deal with a woman with the tedious and inevitable past. It is a farce; and, regarded as such, it is full of amusing situations, it bristles with brilliant lines, and it will, through the obviousness of its characters, be easily cast by the theatrical manager.

The professional manager has, of course, all the unemployed members (often the majority) of the theatrical persuasion to choose from; yet, even with this fact before him, the wise playwright often limits his risks by writing his principal part around some leading actor. The part plays the actor, not the actor the part. It is obvious that in the character of the Rev. Augustin Jedd Mr. Pinero wrote around the personality of the late Mr. John Clayton, and that the character of Georgiana Tidman was designed and fitted to the personality of the inimitable Mrs. John Wood. The Hospital Dramatic Club, unfortunately, cannot afford to pay playwrights to idealise the idiosyncrasies of its members; it cannot, like the Musical Society, strengthen its ranks on occasions with professional assistance; and in its choice of members it is limited to men whose primary object in life is Science, and not Art.

It is necessary to remember these facts to adequately realise how much the Club is to be congratulated in putting on a three-act play by a popular author, in which almost all the parts are played not only intelligently, but by men of appropriate individuality and temperament.

"Dandy Dick," as Mr. Pinero describes it, is essentially a farce. Its incidents are too impossible, its characterisation too exaggerated, for it to be regarded with patience as a comedy pure and simple. The members of the A.D.C. availed themselves of the author's obvious intentions in this respect with great effect and considerable discrimination. Nothing could have been more quaintly decorous, more humorously dignified, than the admirable delineation of the Dean by Mr. R. J. Waugh. Excellent in every respect, and full of character, was the Noah Topping of Mr. A. H. Pollock. What an amusing couple were Major Tarver (played by Mr. L. M. Morris with a wonderful make-up) and Mr. Darbey by Mr. P. Gosse! Mr. H. S. Ward, as Blore, was very well suited, and acted with his usual spirit and vigour. The smaller the part, the more difficult to play it; but Mr. C. Dix got full change out of the character of Hatcham. Of one and all of the gentlemen named above it may be said that they were admirable, and remarkably free from the usual indications of amateurishness.

In the part of Sir Tristram Marsdon Mr. Jeudwine was not quite well suited. His chief faults were restlessness

and unnecessary movement. Sir Tristram (judging from the text, and from the selection of Mr. Edmund Maurice for the original production) was a stolid, heavy, hearty Englishman. Mr. Jeudwine gave the heartiness, but not the weight and stolidity.

What can be said of the gentlemen playing the ladies' parts? Well, certainly that they should be thanked for undertaking an ungracious task, which at once places them beyond the pale of ordinary criticism. They did everything that could be done in the circumstances,—Mr. Kaw as Hannah, and Mr. Upton and Mr. Elmslie as Salome and Sheba. Imagine a man having to play a part written for Mrs. John Wood! No one could have got nearer the impossible than Mr. R. C. P. Berryman. "Dandy Dick" being confessedly a farce, the unseemly anomaly of men dressed and acting as women is less pronounced. But such an excellent all-round display of talent inevitably recalls the old regret that, by the exclusion of ladies, the Dramatic Club should be so restricted in its choice of plays. The Club, perhaps, is partly to blame for this, for in the one year it was given the woman's franchise it chose the worst possible play for the occasion—"The Heir-at-Law."

This year it has given a first-class performance, and has obtained some excellent recruits, especially in Messrs. Waugh, Gosse, Dix, and Upton, whom we shall all look forward to seeing another Christmas.

Men who are fond of private theatricals should join the Club in their first medical year, so that they may have time to get to know their audiences, and their audiences have time to get to know them.

Whether acting should rank high among the arts, or whether it should be regarded as an art at all, this is not the place to discuss; but there can be no doubt that men who have the dramatic instinct find an unending delight in the expression of it. We recommend such men to join the Hospital Dramatic Club. They will make many lasting friendships with men whom they otherwise might never have met; they will have the satisfaction of knowing that their histrionic efforts give pleasure not only to themselves, but to others; and they will find that the entire change of mental atmosphere will enable them to return to their scientific pursuits with greater zest.

STEPHEN TOWNSEND.

## The Rahere Lodge, No. 2546.

MEETING of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, January 8th, 1901, the W.M. Bro. Walter Gripper in the chair. Messrs. L. E. Whitaker and H. S. Beadles were initiated into Freemasonry, and Bro. R. H. Wellington was raised to the Third Degree by the W.M., whilst Bros. Hepburn and Bokenham were passed to the Second Degree by Bro. Phin. S. Abraham, S.W. W. Bro. Brodie was nominated a steward at the forthcoming festival of the Royal Masonic Benevolent Institution, and a grant of ten guineas was made from the Lodge funds in aid of this charity.

## Amalgamated Clubs.

## ASSOCIATION FOOTBALL CLUB.

ST. BART'S v. CHESHUNT.

Played at Cheshunt on Saturday, January 12th, and resulted in a defeat of the Hospital team by 4 goals to nil. Owing to several of our men not being back from the Christmas vacation St. Bart.'s were very poorly represented. Losing the toss, St. Bart.'s started playing downhill, but it was soon apparent that the opposing forwards were too fast for our backs, and for the first twenty minutes they pressed continually, during which time they scored twice. Then our forwards began to get together better, and a fine shot by Rankin only just failed to score. Ward in the centre was doing a lot of good work, but was not well supported. A third goal was scored before half-time, which arrived with the score 3-0 against us.

In the second half Waterfield played in goal instead of Trist, who went forward. It should be mentioned that neither of them had played in that position before, but it was impossible to raise a regular goaler. Although playing uphill St. Bart.'s did better after the restart, and several times nearly scored, but were unable to put on the finishing touch, while Cheshunt added one more to their score, and thus retired fairly easy victors. Team:

T. R. Trist (goal); L. Orton, W. S. Neale (backs); G. W. Miller, V. C. Upton, N. E. Waterfield (half-backs); F. Grone, H. N. Marrett, V. G. Ward (capt.), F. W. Jackson, and Rankin (forwards).

If we are to uphold the reputation of our Hospital in the approaching Cup Ties, it is very certain that great efforts must be made at once to get our representative team together as soon as possible. Up to the present the Hospital has never been represented this year in any two matches by the same team.

## Reviews.

ORTHOPÆDIC SURGERY. A HANDBOOK. By CHARLES BELL KEETLEY, F.R.C.S. Pp. 540, illustrations 253. (Smith, Elder, and Co. Price 16s.)

"When this work was planned out—nearly twenty years ago—there existed no systematic treatise on orthopædic surgery which recognised properly the revolution which had been made in all surgery by the demonstration of the germ theory of disease, and by the introduction of 'the antiseptic system.' . . . Since those days a number of excellent treatises on orthopædic surgery have appeared, both in English and in foreign languages, both in Europe and America. I do not, therefore, publish my book as one that supplies a great want, but rather as a statement of the views and as an analysis of the observations of a surgeon who has for twenty-two years devoted much time, thought, and labour to studying deformities and practising their treatment." Thus the author in his preface. The apologia is, in the light of the facts he states with regard to the existence of other text-books on the same subject, a right one; but in the light of the book itself—its merits and claims to popularity—we readily forgive Mr. Keetley his apparent intrusion upon a field already crowded.

The work gives evidence on almost every page of ex-

ceptional powers of observation, and, more valuable still in an essentially practical manual like this, exceptional care in description and detailed treatment. We can most heartily recommend it, both to the student and to the practitioner, and shall hope to witness evidences of its success.

A noticeable feature in the work is the accurate account of the various deformities directly due to nervous diseases, and the careful descriptions of their appropriate treatment. Equally useful is the chapter on "Hysteria in Relation to Orthopedics." A brief description of the rarer conditions leading to deformity is included, such as acromegaly, osteitis deformans, and the forms of chondrodystrophia studied fully by Kaufmann.

The details of the various operations are clear and full; the section dealing with osteoclasia has a useful supplement descriptive of the various effects experimentally produced by the operation on the dead body. In the section dealing with "The Direct Treatment of Spinal Caries" we notice that the author considers "the gentler methods of Chipault and of Calot" to be justifiable; but the remark immediately following—that the author has "used them himself *without harm*"—scarcely carries much conviction to the reader's mind!

The literary merits of the work deserve a word of praise in these days, when so much that is poured out from the medical press has no merit at all to speak of. The book before us is not only lucid and concise, it is interesting. The following sentences, descriptive of the kyphosis of old age, are chosen at haphazard in illustration:—"There is, however, a form of kyphosis which is so common in old age that its absence is regarded as more exceptional than its presence. It is the characteristic old man's stoop, the result of muscular weakness, or of habit, or of both. It often commences in middle life. In fact, it is apt to come on *pavi passu* with the disappearance of the elasticity of youth. It is justly considered to be the result of care and loss of gaiety as much as of weakness of the muscular system. The latter, indeed, often does not exist. Care brings thought; thought bends the eyes downward; the head and neck follow, and then come the arching shoulders, on which the load of care is often figuratively said to be borne. And what is to be done?"

"Oh for the foot that bounds forward,  
And ever the wind it awakes  
Lifts no lock from the forehead that's whitened,  
No leaf that is withered yet shakes!"

"It is vain to preach gaiety and cheerfulness to a man every month of whose life for many a year may have brought home to him the fact that life is more of a tragedy than a comedy. But the simple, commonplace truth remains, that habits of erect carriage, such as those of the soldier, will often last far into old age. It is, therefore, in youth and middle age that measures must be taken to ward off the kyphosis of advanced life."

We must not omit to mention the fact that the illustrations are a prominent feature of the book. Many of them are exceedingly good photographs, which amply pay for the unusually good paper upon which they are printed. The illustrations average one in every two pages of printed matter. The double index—subjects and names—is carefully compiled. We congratulate the publishers upon the general get-up of the work.

DISEASES OF THE ANUS AND RECTUM. By D. H. GOODSALL, F.R.C.S., and W. ERNEST MILES, F.R.C.S. In two parts. Illustrated. Part 1. (Longmans, Green, and Co. Price 7s. 6d.)

To a certain extent the authors of this book disarm criticism by the statement made in the Preface that the work is the outcome of their practical experience for twenty and for six years respectively.

This volume treats of the anatomy and general diagnosis of abscesses, fistule, fissures, and piles.

The chapter on anatomy is carefully written, the leading authorities being drawn upon for diagrams and descriptions. Particular attention is drawn to the arrangement of the fibres of the external sphincter into a superficial and a deep layer, some inferior hæmorrhoidal veins intervening, in addition to a tendinous downward continuation of the longitudinal muscular fibres of the gut. This last feature figures in many of the diagrams (*vide fig. 23, p. 61, i*). The authors do not agree with the usual description of the ischio-rectal fossa. Furthermore, for clinical purposes they subdivide the anal region by four straight lines intersecting in the centre of the anus, the most important of which is called by them the "transverse anal line;" points on these lines round the anus are called A. (anterior), R.A. (right anterior, etc.), R., R.P., P., L.P., L., L.A.

Under each section of the chapter the surgical bearing of the anatomical facts is given.

The chapter on general diagnosis takes each symptom in turn, giving a series of questions relating to them, and the probable diagnosis therefrom. The questions are to the point, but are rather too numerous. They strongly advocate the examination of the rectum in the male in the knee-elbow position, and in the female in the right lateral semi-prone position, using in each case the left forefinger instead of the right.

In the chapter on abscesses in the peri-anal region the usual subdivision is followed, but the term "pelvi-rectal" is substituted for "peri-proctal." Good diagrams are given illustrating the anatomical varieties of these abscesses. The authors say that abscesses in front of the "transverse anal line" are more superficial than those behind it. A T-shaped incision is particularly recommended in incising ischio-rectal abscesses. No mention is made of the frequent extreme fetidity of the pus often met with here.

Fistula is treated in great detail, eighty pages being devoted to the ordinary ano-rectal form. The authors lay great stress upon its position in relation to the "transverse anal line," treatment being modified according to its situation fore or aft of that line. They state that care should be exercised not to damage the internal sphincter, lest incontinence of fæces results; should the internal opening of a fistula be through or above it, it should remain intact. They further state that healing will occur, although the internal opening has been so left. Particular attention is drawn to the differential diagnosis between certain urethral and anal fistule. We do not like the advice given on page 156 of plugging the wound with cotton wool soaked in perchloride of iron in the event of recurrent hæmorrhage after operations for fistule. For the treatment of tracts running too high to be safely slit up they inject a saturated solution of silver nitrate. This chapter is copiously illustrated with original photographs of patients before and after treatment, the incisions made for each variety being thus clearly indicated.

A special chapter is devoted to sinuses over the coccyx and sacrum with cases: in none of them was there any evidence of carious or necrosed bone; in all, though mostly of long duration, permanent recovery ensued after simply laying open the tracts and their lateral ramifications.

The authors do not believe in the torn-down anal valve theory of Ball, in connection with the ætiology of fissure, as they only found the so-called "sentinel pile" present in 14 out of 221 cases of fissure.

In treating of external piles we find that the "thrombotic pile" is considered to be of the nature of a hæmatoma rather than a thrombosed vein, and advocate palliative treatment; if however, an operation be performed, they advocate excising the hæmatoma in its capsule. They consider that the term external piles should be confined to a dilated condition of the peri-anal veins, a condition associated with spasm and hypertrophy of the external sphincter, and treat them by dividing that muscle.

Internal piles are named according to the above-mentioned points,—*e.g.* the R.A. pile, the R.P. pile, and so on; and further they endeavour to show that in patients under twenty the R.A. pile is invariably met with; similarly that when several are present, certain definite ones are coalesced. They divide the formation of internal piles into three stages.

Heredity is considered to be a prominent factor in the ætiology of piles in the early decades, but considering the frequency of this affection there is considerable risk in overrating its influence.

Ligature of internal piles is most strongly advocated. The operation is modified by making an incision through the skin, round the redundant tag of skin, instead of through the muco-cutaneous margin, the external sphincter being divided if it will not readily relax.

We disagree with their method of dressing a pile case

after operation, it being simply to insert a plug of cotton wool within the anal canal; we think that plugging round a thick rubber tube is both safer and more comfortable to the patient, this latter method being advocated should recurrent hæmorrhage ensue. We also prefer the use of sterilised lint or gauze to that of cotton wool for plugging wounds.

In most operations the authors place the patient in the lateral position instead of the usual lithotomy position (this position we believe, however, to be usually adopted at St. Mark's Hospital). The after treatment of a patient is most carefully described; a mixture containing opium and catechu is administered every four hours, in addition to the usual dose of opium, soon after recovery from the anæsthetic. For the first twenty-four hours the fluid taken is limited, and the patient is forbidden to micturate; by this means the use of a catheter is said to be avoided, a warm bath or fomentations to the penis being employed if necessary!

The book is well printed and excellently illustrated with numerous original photographs. The subject matter is conveniently arranged, and the index, as far as we have tested it, is complete and accurate.

We congratulate Mr. Goodsall and Mr. Miles on part 1 of their work, and look forward to the early appearance of part 2.

A MANUAL OF SURGERY FOR STUDENTS AND PRACTITIONERS. By WILLIAM ROSE, F.R.C.S., and ALBERT CARLESS, F.R.C.S. Third edition, pp. 1182, 406 illustrations, and 25 plates. (Baillière, Tindall, and Cox. Price 21s. net.)

Twelve months ago we reviewed the second edition of this manual, and predicted an increase of popularity for it. This has been verified. There are but few changes of importance in this edition, the chief one being an increase in the number of skiagraphic plates. The chapter on "Anæsthetics" and that on "Diseases of the Throat" have received some revision to advantage. As we have previously recommended the book very highly, we will here only repeat our recommendation. We know of no more helpful manual written on the same lines.

A MANUAL OF PHYSIOLOGY. By G. N. STEWART, M.D., D.Sc. Fourth edition, pp. 894, 336 illustrations, and 5 coloured plates. (Baillière, Tindall, and Cox. Price 15s. net.)

This manual is in the same series as the above. Considerable revision has been undertaken, and the chapters on "The Central Nervous System" have been thoroughly brought up to date and illustrated by very useful diagrams.

The series of practical exercises appended to each chapter are still a feature of the book, and form a useful guide to the student's class-work. They perhaps do more to give him a sound knowledge of the means by which facts have been arrived at, however, than to serve as detailed instruction for his own experiments.

We still think the book is the best text-book of physiology for students preparing for the examination of the primary Fellowship of the College; but it must be supplemented by a manual of histology, of which subject it does not pretend to give any full account.

LECTURES ON MEDICAL JURISPRUDENCE AND TOXICOLOGY. By FRED J. SMITH, M.D., F.R.C.P. Pp. 396. (J. and A. Churchill. Price 7s. 6d.)

These lectures have been delivered as a course on forensic medicine at the London Hospital. The somewhat colloquial method evidently adopted by Dr. Smith in lecturing seems to be retained in



the published pages before us. The value of the book, however, is not thereby lessened, for the facts seem to be thoroughly sound, and the manner of putting certain subjects before the student distinctly lucid and convincing. A healthy straightforward diction pervades the work; and this is often very much to the point, if seemingly somewhat quaint. Dr. Smith's discussion of the well-known confusions likely to result from the use of psychological terms of varied meaning in the law courts is a good instance:—"Try and avoid the terms, and . . . repeat the facts you have observed. . . . To illustrate the position in plainer language, we may take a case of delirium tremens. The beetles, rats, and mice he sees running over the bed are hallucinations. If his own little dog comes into the room, and he thinks he is the devil come to remove him (the patient), this is an illusion. When the nurse, by sweeping the bed, or calling the dog to be fondled by his master, tries to convince the patient that there is nothing on the quilt, and that "the devil" is his own pet, and he yet persists in his former beliefs, this persistence constitutes a delusion of such nature and degree as proves (at least temporary) insanity. If counsel and disputation disputes your choice of a term, tell him about the beetles and the devil, and give him a choice of expression."

The book will be found very useful for students preparing for examinations which require a knowledge of the chief points in forensic medicine and toxicology, and for which Dixon Mann's larger text-book is too full. We can cordially recommend it.

## Calendar.

February, 1901.

Fri.,	Feb. 1.	—Sir T. Lauder Brunton and Mr. Walsham's duty. Dr. Hensley's Clinical Lecture at 1 p.m.
Sat.,	" 2.	—Rugby F. C. v. Royal Naval College at Greenwich. Hockey v. Tulse Hill at Winchmore.
Tues.,	" 5.	—Sir William Church and Mr. Willett's duty.
Wed.,	" 6.	—Mr. Langton's Clinical Lecture at 2.45 p.m.
Thurs.,	" 7.	—Abernethian Society, 8 p.m. Dr. W. J. Collins, L.C.C., "Public Office and Public Health in London."
Fri.,	" 8.	—Dr. Gee and Mr. Langton's duty. Sir T. Lauder Brunton's Clinical Lecture at 1 p.m.
Sat.,	" 9.	—Rugby F. C. v. Marlborough Nomads at Winchmore. Hockey v. Kensington at Kensington.
Tues.,	" 12.	—Sir Dyce Duckworth and Mr. Marsh's duty.
Wed.,	" 13.	—Mr. Butlin's Clinical Lecture at 2.45 p.m. Rugby F. C. v. Kosslyn Park at Richmond. Hockey v. Enfield at Winchmore.
Thurs.,	" 14.	—Abernethian Society at 8 p.m., Mr. H. Burrows, M.B., "Euthanasia."
Tues.,	" 15.	—Dr. Hensley and Mr. Butlin's duty. Sir William Church's Clinical Lecture at 1 p.m.
Sat.,	" 16.	—Rugby F. C. v. Croydon at Croydon. Hockey v. Epping at Winchmore.
Tues.,	" 19.	—Shrove Tuesday. Sir T. Lauder Brunton and Mr. Walsham's duty. Hockey v. Epsom College at Epsom.
Wed.,	" 20.	—Ash Wednesday. Mr. Butlin's Clinical Lecture at 2.45 p.m.
Thurs.,	" 21.	—Abernethian Society at 8 p.m., Clinical Evening.
Fri.,	" 22.	—Sir William Church and Mr. Willett's duty. Dr. Gee's Clinical Lecture at 1 p.m.
Sat.,	" 23.	—Rugby F. C. v. Upper Clapton at Winchmore. Hockey v. West Herts at Watford.
Tues.,	" 26.	—Dr. Gee and Mr. Langton's duty.
Wed.,	" 27.	—Mr. Marsh's Clinical Lecture at 2.45 p.m.
Thurs.,	" 28.	—Abernethian Society at 8 p.m., Mr. T. P. Legg, F.R.C.S., "Cotic."

## New Addresses.

ARMIT, H. W., Holmer, Elm Road, Wembley, Middlesex.  
PADWICK, J. C., East Castle, Bridgnorth, Salop.

## Appointments.

HARMER, W. D., M.D., B.C.(Cantab.), F.R.C.S., appointed Surgeon to the Western General Dispensary.

HUNT, HENDERSON E., M.A., M.B., B.Ch.(Oxon.), appointed House Physician to the Radcliffe Infirmary.

LISTER, A. E. J., M.B., B.S.(Lond.), appointed Surgeon to ss. "Dahome" (Furness Line).

LLOYD, J. A., M.R.C.S., L.R.C.P., appointed Second Assistant Medical Officer to the Lewisham Infirmary.

MUNDY, H., F.R.C.S., appointed Surgeon to the Western General Dispensary.

TURNBULL, C. C. L., M.A., M.R.C.S., L.R.C.P., appointed Second Resident Medical Officer to the Chester General Infirmary.

WAKE, A. M., M.B., to be Surgeon-Lieutenant to the 14th Middlesex (Inns of Court) (London Gazette, Nov. 27th, 1900).

## Examinations.

UNIVERSITY OF OXFORD.

M.B. Examination.

E. H. Hunt, C. E. West.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Second Professional Examination for the Diploma of Fellow.  
F. P. Maynard, E. G. Carpenter, J. H. Parsons, E. W. Rowverton,  
R. S. E. Hower, T. A. Mayo.

First Professional Examination.

V. T. Greenyer, J. K. Murphy, F. Norman, W. J. Richards.

## Birth.

CORFIELD.—On January 3rd, at Gothic House, Upper Tooting, Helen Beatrice, the wife of Edward Carruthers Corfield, M.R.C.S. (Eng.), L.R.C.P. and L.S.A.(Lond.), of a daughter.

## Marriage.

TAYLER—CLOTHIER.—On January 1st, at St. Michael's, Highgate, by the Rev. Canon Trotter, Vicar of Christ Church, Barnet, assisted by the Rev. T. A. Davies, George Padgett Tayler, M.B. (Lond.), eldest son of G. C. Tayler, M.D., of Trowbridge, to Ethel Mary, second daughter of Henry Clothier, M.D., of Highgate, N.

## 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.

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,  
FEBRUARY, 1901.

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

## Bowater John Vernon.

ANY of our readers will have heard with regret of the death of Mr. Bowater John Vernon, who for thirty years filled the post of one of the two ophthalmic surgeons in the Hospital. He will probably be better known and better remembered by the later generations of students than by those who joined the school soon after the department of ophthalmology was instituted. There was, indeed, never any lack of house surgeons or of dressers; but in those earlier days attendance in the ophthalmic wards was not compulsory, and consequently they were visited by few except by those who could spare an additional year to acquire some knowledge of the eye, ear, and throat. The regulations of the College, as well as the not infrequent introduction of questions on the ana-

tomy, physiology, pathology, and treatment of diseases of the eye, led to great changes in this respect. Of late years most men spent some time in the wards, and the personal appearance of Mr. Vernon was as well known as that of any member of the staff. Of moderate height, with head well set on his shoulders, dark complexion, with deep lines on the face and below the lower lip, a most mobile and expressive mouth, a high well-proportioned forehead, and scanty dark, almost black hair, he gave the impression at first glance of being a feeble and delicate man; but upon closer acquaintance it was seen that he had fair breadth of shoulder and strongly made limbs, and little surprise was felt when it was learnt that as a boy at Marlborough he obtained a well-earned reputation as an athlete, proving victorious in many a short distance and hurdle-jumping race.

Mr. Vernon was the second son, in a family of nine, of the Rev. John Vernon, who was for twenty-seven years Vicar of Westfield, an ancient Sussex parish near Battle. He was born in 1837, and died January 28th, 1901, his life therefore just covering the period of her late Majesty the Queen's reign. After the completion of his education at Marlborough he became a pupil of the late Mr. Jowers, of Brighton, at the Brighton Hospital, under whose tutelage for three years he familiarised himself with the general aspects of medicine and surgery. He then entered at St. Bartholomew's Hospital, and after the usual three years' attendance upon lecturers was appointed house surgeon for a year to Mr. Womald in 1862, and for the following year house surgeon to Mr. Paget. In 1862 he took the Hospital Scholarship, and in the same year passed the Membership Examination of the College of Surgeons, and the Licentiatehip of the Royal College of Physicians. In 1864 he passed the Fellowship Examination of the College of Surgeons. In the meanwhile he had acquired so good a knowledge of anatomy, and was so clean and excellent a dissector, that he was elected Demonstrator of Anatomy, which post he held for several years. His student career may therefore be regarded as one of unusual distinction

and success. About this time his attention was directed to the eye, and he attended the practice of the Royal London Ophthalmic Hospital, where he was soon appointed Clinical Assistant to Mr. Wordsworth. After the retirement of Mr. Baden he became Curator of the Museum, and Pathologist to the Hospital.

These posts brought him into immediate relations with the best and most skilful ophthalmic surgeons of that day—with Sir William Bowman, Mr. Critchett, Mr. Hulke, and others of equal renown, from whom he learned many niceties in the delicate art he practised, and became an excellent judge and critic of the operative abilities of others. Whilst admiring, as all did who witnessed them, the operations of Sir William Bowman, he highly appreciated the manipulative dexterity of Mr. Hulke, whose hand, he would say, "though large was as steady as a rock."

The Ophthalmoscope, which had not long before been devised by Helmholtz, had opened up an entirely new field of ophthalmology, and was attracting great attention on all sides. Mr. Vernon naturally soon became an adept in the use of this instrument. He had then also the opportunity of seeing new operations like iridectomy, the linear operation for the extraction of cataract, and various operations for the relief of lachrymal obstruction performed by masters of the art of surgery. It was not surprising then, when the need for some one skilled in the knowledge of diseases of, and operations on, the eye began to be felt at St. Bartholomew's, in the interests both of the patients and of the students, that Mr. Vernon should be elected as Demonstrator of eye diseases in association with Mr. Callender. The importance of the department was immediately perceived, and the Governors determined to build two eye wards, one for males and one for females, over "Casualty," which were completed in 1870, and opened by the then Prince and Princess of Wales in the summer of that year. Mr. Vernon and myself were appointed respectively junior and senior surgeon, with twenty-six beds and a child's cot to be divided between us. The arrangement proved a fortunate one. The two surgeons worked together in the most amicable way, sometimes one; sometimes the other monopolising the wards, whilst in cases of emergency a bed could still always be found—through the address of Sister Alexandra, to whose kindly offices, untiring assiduity, and admirable management of her wards both were always willing to admit they were deeply indebted.

Mr. Vernon was an original member of the Ophthalmological Society, which was founded in 1888, but he scarcely attended any of the meetings, the late hours being uncongenial to him. He was a member of the staff of the Great Northern Hospital, and was for twenty-seven years ophthalmic surgeon to the West London Hospital, in the affairs of which he took much interest.

As an ophthalmic surgeon and as a clinical teacher he

was in all respects admirable. Constant in attendance, he rarely kept his class waiting for a moment. Considerations of light led, as a rule to the operations which had been decided on previously being at once undertaken. As soon as the patient had been wheeled in, and whilst chloroform was in course of administration, he would give a short history of the case, call the attention of the class to the salient points which it presented, state the different methods of treatment that had or might have been adopted, and gave the reasons for the particular operation he was about to perform; then after a careful examination of his instruments, and satisfying himself of their sharpness and cleanliness, he proceeded to operate. He was then seen at his best. Clearly recognising what had to be done in each case, every cut was accurately limited, every closure of the scissors did what was required and no more. He was really a beautiful operator, and this was the more meritorious in him, that his wrists were often swollen with rheumatism and very tender and painful. For the most part his cases were highly successful. His talents as a teacher were not less conspicuous. As soon as the operations were over he entered the wards which adjoined the operating room, and in each case would find something of importance to dwell upon, some useful bit of knowledge the thoughtful student might carry away with him and garner up for future use. Finally the out-patients had to be seen, which often occupied two hours more, yet at the close he was as calm and deliberate, as willing to answer questions as if he had just entered the hospital. He was an ideal teacher. His energy, however, seemed to be exhausted with teaching and hospital work, for although he wrote a few articles in the *St. Bartholomew's Hospital Reports* in 1870 and 1871, he apparently was unable to make any effort to collect or comment upon the cases that had passed before him, after the latter date. This is to be especially regretted as his style was good; he was well read, and he had large experience.

His talents as a microscopist were scarcely sufficiently appreciated. His knowledge of the technique of the microscope was greatly improved by his practice as curator at the Moorfields Ophthalmic Hospital, but apart from this the instrument was at all times a source of infinite pleasure and gratification to him. He was fond of flowers, knew most of the English plants by name, and throughout the summer and autumn rarely appeared without a fresh flower in his buttonhole, which he cherished with particular care and complacency. His kindly disposition was displayed in his love for animals, and both dogs and birds shared his attention to an almost equal degree. His principal recreation was a day's shooting in September, and the opportunity of enjoying it was always given to him with the warmest of welcomes by his old and attached friend, John Henry Salter, of Tolleshunt d'Arcy.

The end came suddenly. He had seen his patients at the

Hospital on Saturday, the 19th January, but on the following day some kind of cardiac spasm, with dyspnoea, supervened, and he placed himself under the care of Dr. Attlee. But neither skill nor attention—and he had both to aid him—could stay the inevitable hour, and he died on the 28th January. His body was committed to the grave on the 1st February, when the guns of the war-ships in the Solent were proclaiming the passage of the Queen, to whom he was so intensely loyal, to her resting-place at Windsor.

He, too, has gone to his rest; and he may well have thought, in the solemn moments that precede dissolution, that he had worked honestly and truly to the best of his ability for the good of the great Hospital to which he belonged, and that he bequeathed to those who succeed him a shining example of that gentleness, courtesy, and rectitude of purpose in his relations alike with his friends upon the staff and with the patients of the Hospital, which has in the past, as we may well hope it may continue to do in the future, made St. Bartholomew's so useful and so great an institution in the history of this country.

HENRY POWER.

### Medicine and Surgery in Primitive Culture.

By F. C. SHURBULL, B.A., M.B. (Cantab.).

THE early history of the medical profession is a subject of great interest, but unfortunately one for which but few materials are available; a few inscriptions, implements, and osteological remains being all that are left to serve as a link with the past. If, however, these be supplemented by the descriptions of reliable authorities of the methods of medicine and surgery in vogue among savage tribes in various stages of primitive culture, we can build up a skeleton framework which in all probability gives some idea of the genesis of the healing art. In the following columns will be found recorded a few notes compiled from various sources dealing both with prehistoric and contemporary savage medicine. As we all know, our profession is a very ancient one, and its origin is lost in the mists of time, but we may believe it was coeval with man himself, as no tribe is known some members of which have not a special reputation for skill in treating those suffering from the effects of injury or disease. Such individuals, from their powers or supposed powers of alleviating suffering, come to be regarded as possessed of supernatural skill—an idea still prevalent in present-day London; consequently upon this the profession has almost always been looked on with wholesome feelings of dread, if not of respect. Probably the lowest ebb of reputation was reached in this country between the twelfth and seventeenth

centuries, when it appears to have been safer for a patient to treat himself, or to be treated by his female relatives, than to trust himself to the tender mercies of the village leech or barber-surgeon. The corresponding high-water mark, so far as I can discover, was reached among the Hindus about five centuries before our era, when the author of one of their religious books records the following authoritative dictum:—"Whoever rejects a physician shall be punished in hell, but whosoever employs a physician shall enter paradise, even though he see not the sacred Ganges in his dying moments." Lest we should all feel unduly elated, I hasten to add that the same gentleman also records, "The practitioner who knows the use of quicksilver is like a god; one who knows the qualities of roots and herbs is like a man; whereas one who knows the use of the knife resembles a demon." Passing on to describe a physician, our author says, "The physician should possess a healthy body, he should keep his nails and beard cut short, his body pure, and his clothes clean. He should possess a good memory, and be always amiable, cheerful, and collected. His language should be mild, candid, and encouraging, rather like that of a friend than an acquaintance. He should possess a character for strict veracity, calm temper, and the greatest sobriety and chastity. As a person may be afraid of his father, mother, and friends, but not of his physician, so must the physician be more kind and considerate than any of these. A good physician will continue to visit his patients diligently, examine them carefully, and give medicines always when the patient can live; but if a physician attempts to treat an incurable case it will diminish his reputation, friends, and riches." After this high standard set up for the practitioner long before our era, it may be of interest to read his description of the ideal student of that day. "In all cases the student should be the son of a respectable and ancient family, who is either the son of a practitioner, or one who respects the medical profession. He should be inquisitive and observant, not covetous or lazy. He should possess a generous heart, and his disposition should be amiable and happy. The indications of such qualifications are an agreeable voice, small tongue, eyes and nose straight, with thin lips, which do not expose the gums, and thick hair, which retains its vigour." Having thus briefly narrated the ideals of one of the leading medical schools of former civilisations, I will pass further down the cultural scale. What is the earliest evidence we possess of the practice of the healing art?

In point of time we must start from the early neolithic age in Southern France, a skull with a circular hole in it, obviously produced before death, the injury not proving fatal, having been found in the Caverne de l'Homme Mort, in the valley of the Lozère, amidst remains certifying to the date of the deposit. The hole could not have been produced by a single blow from any known weapon in use at

the time, and agrees in form and appearance with those produced by comparatively modern savage operators. So far as we can judge from history and contemporary savage medicine, our profession has passed through somewhat the following stages:

First, a stage of purely empirical and experimental treatment of injury and disease by the patient and his immediate relatives.

Secondly, a stage in which certain individuals acquired special skill, and were consulted by sufferers.

Thirdly, a stage in which these individuals were credited with supernatural powers, and consequently were respected and feared by their neighbours. They were thus enabled to lead a life of, comparatively speaking, luxurious ease. To encourage this they doubtless spread abroad freely the idea that all disease is due to the action of evil spirits, who required propitiation, and that as they were the only people who understood the said spirits, all gifts and offerings must pass through their intermediation. Priestly and medical functions for a time remained merged, and then the latter became more and more dropped. During this period other members of the tribe doubtless continued to treat empirically for themselves with well-known simples and methods all easily yielding ailments, assigning all resistant or incurable affections to the malignant action of evil deities, to be appeased by sacrifice and the like.

During the next period the study of medicine got almost entirely forgotten in a maze of theological wrangles, and such progress as had been made was largely lost sight of. As an example of this we have only to consider the state of the rank and file of the profession in Europe between A.D. 450 and A.D. 1450.

Finally, in Europe, as we know, empirical medicine gradually reasserted itself upon an apparently firmer foundation. In the few other civilisations we can study, it would seem that stage four has lasted to the present time, or that while in this stage of culture the whole civilisation was swept away. The whole subject is so vast that in a short note it is only possible to pick out isolated facts here and there, the first two, and to a less extent the third, of the stages into which I have divided medical culture being of the greatest interest.

It is very doubtful if definite hospitals exist, or ever existed, among primitive man. In savage America the patient was taken to a large adobe hut or shed for the medicine men to hold a consultation, and dance around him. Among many primitive races the women at the time of childbirth are regarded as unclean, and are compelled to resort to certain huts, mounds, or wigwams specially set apart for the purpose, and where they are attended to in labour by those of their own sex. These may be regarded as the precursors of Martha Ward or Queen Charlotte's.

In India, Ceylon, and Assyria, amidst far higher stages of culture, hospitals existed in which the sick were tended,

operations performed, and students educated in quite a modern fashion. Incidentally it may be noticed in passing that in Assyria the profession formed a great State department, as is our Local Government Board at the present day. At that time before a physician would visit any patient an order from the king had to be obtained. In a table case in the Nineveh Gallery of the British Museum is the following letter, written about B.C. 1140.—“To the king, my lord, from thy servant Shamesh-mituballit.—Greeting unto the king, my lord. May Nahi and Marduk be gracious and propitious unto the king, my lord. The lady Baugamillat is grievously sick, and unable to eat. Now let the king, my lord, give the order for a physician to come and see her.” Unfortunately no more is known of this case, although there is in our national collection a letter thanking the king for sending a physician to another citizen, who quaintly expresses himself thus: “For I was dead, and the king, my lord, hath made me to live, and his kindness toward me is exceeding great.”

After the foregoing brief review of the status of the medical man it is interesting to consider his practice, which may conveniently be divided into two parts, real or practical, and mystical, the former only being of any clinical interest. In the first place, dealing with medicine, it is found that with the exception of recent synthetic products almost every individual drug in our pharmacopœia is in use among some savage tribe or other. The great size of the United States Pharmacopœia is due to its inclusion of all known native vegetable remedies in former use in the States. As examples of adoptions of savage drugs, note—

Calumba from the forests of the Zambesi and the east coast of Africa.

Jalap from Mexico, named after the Otomie city of Xalapa.

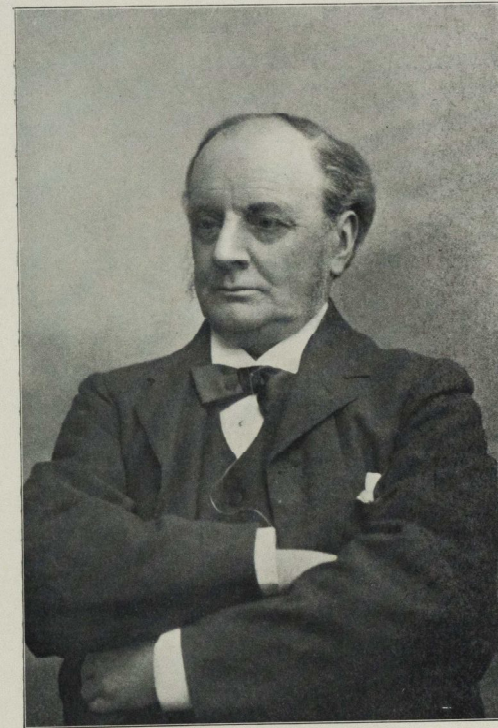
Cinchona from Peru.

Guaiacum and quassia from the West Indies.

Copaiba from the Amazon valley, etc.

Our methods of medication and of preparing drugs differ only in small details from those of savage man. Infusions and decoctions of all kinds are of course in universal use, as also are hot fomentations for wounds and painful swellings, *e.g.* the natives of Central Sumatra find a fomentation of tobacco leaves in warm oil applied to the breast very efficacious in cases of asthma; the aborigines of South Australia apply warm fomentations of the leaves of the blue gum to relieve the tenesmus of severe diarrhoea, while warm fomentations and hot smoke baths are applied to joints affected with chronic rheumatoid arthritis by the Karok Indians of Northern California. Embrocations and massage with fats and oil are largely used by savage man throughout the world, palm oil being the favourite in the tropics, and train oil in northern latitudes.

Purgatives, and even enemata, are very generally employed, the most interesting of the former being live larvæ of bees



Yours with kind regards  
Walter Cannon

fresh from the honeycomb, taken by the Mincopies of the Andaman Islands when constipated.

Emetics, both medicinal and mechanical, are very popular. The Dacotas tickle the fauces with a bird's feather, while the Karyas of Brazil cut a stick obliquely at one end, fire-harden it, push it well down the throat, and twist it round and round until the desired effect is produced.

Inhalations of the smoke of various plants (tobacco, datura, and the like) are in vogue as a treatment of headache, epilepsy, coughs, and colds in Siberia, Dacota, Brazil, Ashanti, and Abyssinia. Venesection is not uncommon, and is performed by very varied methods. The natives of some of the Malayo-Melanesian Islands shoot at the patient with a small bow and arrow until a suitable vessel gets opened; the Navajo and Chippeway Indians make a small incision into a vein, and suck up blood through the hollow bone of an eagle.

Cupping is in use as a treatment of fever, neuralgia, and pulmonary affections throughout Africa, Malaysia, and among the Creek and Dacota Indians of North America. A common method is to apply a cow's horn broad end to the skin over the affected part, and to suck out the air through a small hole in the tip afterwards closed with clay. In Morocco the method employed closely resembles that in present use, grass being burnt inside the horn as it is applied to the skin. Wet-cupping instruments have been found among relics from early Egypt.

Massage is a popular form of treatment throughout Asia, and was commonly employed in Greece before the time of Hippocrates.

Baths of all kinds, particularly hot baths, mud baths, and vapour baths, are considered of high therapeutic value by many savage tribes. The Maori of New Zealand and the prairie Indians of North America alike journeyed to the hot springs of their respective countries to undergo definite courses of hydrotherapy. In New Zealand the treatment continues unbroken to the present day, though now the Briton and not the Polynesian avails himself of the indifferent thermal baths, mud baths, alum baths, sulphur baths, and oil baths provided by nature in generous profusion. The natives highly esteemed the remarkable effects of these in cases of skin disease, rheumatism, and "fits," by which epilepsy was probably meant, although the term may have included various uræmic manifestations. In the hinterland of Venezuela the patient lies in a hammock over a series of red-hot stones, on to which a little water is poured, so that he or she is kept enveloped in steam; among other tribes of the same continent the system is more developed, and special buildings are constructed for the provision of hot air and vapour baths.

Primitive surgery appears to be and to have been conducted on a large scale, and often in a very skilful manner. As regards prehistoric man our records are, of course, scanty,

and limited to operations on the osseous system, the only part of the human frame which resists the action of time and decay to preserve the records of our ancestors for our use. We find that they performed various operations of the nature of trephining and osteotomy, and also set fractures, usually indifferently badly.

Anæsthetics are apparently unknown, but in isolated cases various alcoholic intoxicants are administered to stupefy the patient prior to operating, e.g. in Uganda banana wine is given before performing Cæsarian section; in some of the islands in the Pacific it was given before trephining. Among the Indians of North and Central America the patient smokes dried leaves during an operation to divert his attention, to some extent, from his physical sufferings. There is one reference in Hindu literature to a surgeon who flourished about 500 B.C., and is said, by administering a drug, in a manner not stated, to have caused a patient not to feel during the performance of laparotomy upon him. The accounts given by various writers of certain potent anæsthetics in use in Central America are, as far as I can gather, baseless, and to be relegated solely to the pages of fiction.

Probably antiseptics are quite unknown to savage man. I can find only one instance of their deliberate use, viz.—before performing laparotomy in Uganda it is customary to wash the patient's abdomen, the instruments, and the hands of the operator in banana wine, which contains enough alcohol when well fermented to enable it to burn. After this all are again washed in clean water. Savage man generally is not afraid of washing, and it is usual for wounds to be thoroughly washed with water as a preliminary to treatment.

To arrest hæmorrhage several methods are employed, which can be classified into three heads:

1. The actual cautery, the use of which seems to be universal as the last resource in severe cases.
2. Pressure on the surface of a wound, the lips being as well as possible brought together, and the whole bound up with leaves, bark cloth, and the like.
3. The addition to the wound of fine foreign particles increasing the rate of clotting of the blood, and so naturally leading to pressure on the bleeding area; hot coffee dregs, thistle down, cotton fluff, being employed in the various districts in which they are to be found. Ligature of vessels seems to be unknown to uncivilised races.

Among certain Brazilian tribes the pincers of ants are said to be used as sutures, the edges of a wound being held together, an ant placed against the lips, which it promptly nips, and the body being torn off the pincers maintain their hold. Among the Fans sutures of pineapple fibre are inserted by means of a bamboo needle.

In Uganda after a laparotomy the abdominal wound

was closed by driving seven or eight long polished iron nails through the walls, and binding these in a figure-of-8 fashion with fibre, as is done in the case of acupuncture needles. Schoolcraft said that the Indians of the American prairies sewed up wounds with fibres of lime tree and tendons of deer or bison.

The Winnebago Indians pack wounds so as to make them granulate up from the bottom.

In Australia pressure is applied by means of resin, but if the wound becomes warmer, tender and throbbing, they reopen it.

Dr. Bartels narrates an interesting case of a certain North American Indian chief, who received a severe thoracic wound, which bled severely until a cough drove a piece of lung into the wound. The faculty of the village were amazed, and after long consultation decided to leave the lappet of lung in the wound, but to cut off the part which projected beyond the level of the skin; this projecting portion was to be fried and eaten by the patient. Under this treatment, strange to relate, healing by granulation occurred and all went well.

Amputations are rarely performed by uncivilised man.

The Loyalty Islanders attempted at one time to remove injured fingers with a hammer and chisel, but the results were so bad that the practice was abandoned.

In Africa it is common for the hand to be hacked off at the wrist without any attempt at flaps, and the stump plunged in boiling pitch to stop hæmorrhage. Such is only done for penal purposes.

Hernia constitutes a great puzzle to our more primitive brethren; most tribes, finding fomentations will not cure, try pressure, sometimes effecting temporary reduction. In Morocco, trusses made of leather, sticks, and iron balls are used.

Abscesses are usually opened where they point, and then washed freely. After this, in South Australia hot ashes are applied to the base, while in North America it is cauterised with a red-hot brand.

Dislocations are almost beyond the powers of the savage faculty, but it may be recorded as of interest, that among the Nias Islanders only those born by breech presentations are allowed to manipulate these injuries. For fractures, splints are in general use, and are usually padded with various materials, and worn until complete union is re-established. Many tribes, however, are quite ignorant of the advisability of preliminary extension before applying the splints. The natives of Australia treat fractures by extension of the injured limb, which is maintained while moist clay is moulded round the limb, then hardened in the sun, and worn until union is complete. The results of this method are usually excellent. Fractured jaw is treated by extraction of a tooth and then moulding clay all round the chin and face, which is kept on for some weeks, the patient

being fed with liquid food through a reed inserted in the gap left by the extracted tooth.

Ritual operations are very common among races in a low grade of culture, and comprise circumcision and external urethrotomy on the male; clitoridectomy, sewing up of the labiæ, splitting of the perineum, and even oöphorectomy on the female. Lithotomy is practised in Ashanti, China, and Rajputana. A finger is introduced into the rectum, the stone pressed forward from within against the perineum, at once cut down upon in this situation and removed with the fingers. After-treatment is confined to frequent washing of the external wound. In the 'Obstetrical Transactions of Edinburgh' for 1883 Dr. Felkin gives a full description of a successful performance of Cæsarian section by native operators he actually witnessed in Uganda. A young primipara, who had been some little time in labour, was laid on her back on a native couch, and fastened down by bands around her thorax and legs. She had previously received a large dose of banana wine, which had rendered her hopelessly intoxicated. The operator stood on the left side of the patient with a knife in his right hand, and murmured an incantation. He then washed his hands, the knife, and the patient's belly, first with banana wine—and subsequently with pure water; uttered a loud cry, answered by the assembled multitude without, and with one cut divided the entire abdominal wall in the mid-line from the pubes to the umbilicus. The edges of the wound were held apart by assistants, and bleeding checked by an application of the actual cautery. The uterus was then incised, the child removed and, the cord being cut and compressed, given to a special assistant. The knife was then laid aside, and the uterus rubbed with the fingers until it contracted; the placenta was then peeled off by the fingers of the right hand, and all clots washed out of the uterus with clean water.

The sides of the cut in the uterine wall were pressed together, and the uterus again kneaded; no stitches were inserted. During this time a special assistant had prevented the escape of intestine or omentum through the abdominal wound, the edges of which were now brought together, and fastened by the insertion of seven large well-polished iron nails, round which strips of bark cloth were bound in a figure of eight. The dressings consisted of a layer of banana leaves, a fomentation, more leaves, and a broad bark-cloth bandage. The patient had recovered from all shock an hour after the operation, and in another hour the child was put to the breast. The temperature the next day was 99° F., on the second night 101° F., with a pulse of 108, thence falling to normal. The dressings were changed on the third morning, and thence on daily. The needles were removed on the fourth, fifth, and sixth days, after a little suppuration round the points of insertion. On the eleventh day the wound had healed, and the patient got up

and returned to work on the fourteenth day, the subsequent history being quite satisfactory.

The origin of trephining is lost in the mists of antiquity; it certainly was frequently practised in Europe during the neolithic age.

Skulls from the south of France, Portugal, Belgium, Switzerland, Germany, Russia, and elsewhere bear witness both to the operation and to the fact that it was sometimes successful. Similar evidence from Algeria, the Canaries, North America, and Peru show how wide-spread the custom was among neolithic man. Trephined skulls of the bronze period have been found in Scotland, France, and ancient Egypt. Explorers of all periods from the middle ages to the present day give accounts of having seen the operation performed. Ella in the *Medical Times and Gazette*, vol. i, 1874, describes the procedure as he actually witnessed it in the South Pacific.

"A notion prevails there that headache, neuralgia, vertigo, and other cerebral affections proceed from a crack in the head, or the pressure of the skull on the brain. The remedy is to lay open the scalp with a cross or T-shaped incision, then scrape the cranium gently with a shark's tooth, or, as is the more modern custom, with a piece of glass, until a hole is made into the skull down to the dura mater. In the best hands about half of those who undergo the operation die from it. These same islanders employ bone-scraping as a treatment for rheumatism in old people. The cuticle is incised longitudinally, and the ulna or tibia laid bare, then the surface of the bone is scraped until a large portion of the external lamina is removed."

Mr. Ella says, "I have never found anyone who underwent this operation that said it had been efficacious in the object sought." Strange to say, from all the varied accounts of this operation and its sequelæ which we possess we have no notice of any septic infection taking place. Savage and prehistoric man selected very various spots as the best region for operation; most, however, chose the parietal region. As Cartailhac points out, in all times surgeons seem to have respected the part of the cranium not covered by hair, without doubt from æsthetic reasons. It is evident from the appearances of prehistoric skulls that the wounds could not have been produced by a single blow from any known weapon of the period, and many skulls show various incomplete stages of the operation, possibly because it was abandoned on the death from pain and exhaustion of the patient. Bethencourt described the operation in the Canaries as lasting many hours.

In the Aures the operation is performed as follows, according to Dr. Védicines.—A semicircular flap of scalp is defined by one cut with a knife, then raised by the fingers and a wooden lever, separating pericranium from bone. An area of bone is then marked out by a small series of holes drilled by a pointed bronze or iron rod through the bone, any large projection being cut off with a

saw. A dressing of butter, honey and saffron is then applied, covered by resin and fomentations of herbs. Twenty-four days later (the dressing having been changed every day) the piece of bone is removed by a crochet. If then the surface of brain is seen to pulsate, all is held to be going well. If, on the other hand, the pulsations are not seen, the wound exhales an evil odour, and the surface of the brain is blackish grey, the prognosis is grave, and special treatment employed. This consists in applying an oil obtained by roasting yolk of egg on a dish. After the final operation, should the patient survive, as often happens, a dressing of pure honey and the milk of a woman who has prayed to their gods is applied as before. Hæmorrhage is checked by the actual cautery at a dull red heat. The operation is usually performed for fracture of the skull, and is at once exploratory and curative. The cicatrices left are white, smooth, often depressed, and of an irregular outline; they are usually kept covered during the remainder of life.

Although this by no means exhausts savage surgery, which in one way or another has, and often attempts with fair success, to deal with the same problems as our own, considerations of space and time set a limit to their further notice. Savage midwifery is too large a subject to be considered at present.

### Nasal Diphtheria masked by Measles.

By WILLIAM WYLLYS, M.R.C.S.Eng., L.R.C.P. and L.S.A.LOND.

THE following notes of a case of post-diphtheritic paralysis following an attack of measles, associated with muco-purulent nasal catarrh, the origin of which was not detected at the time, I deem of sufficient interest to record.

The patient, a boy æt. 5 years, had been under my care suffering from a typical attack of measles, his little sisters, aged three and two years respectively, being at the same time similarly affected. The only suspicious circumstance was the protracted and obstinate nature of the nasal catarrh in all three cases, which was purulent, and in the case of the elder girl had existed for two weeks prior to the appearance of the measles rash. In no instance was sore throat complained of, nor was any membrane found in the fauces. The two girls made a perfect and permanent recovery, but the boy, about a week after the subsidence of all symptoms and signs of measles, became so weak and debilitated that I ordered him back to bed; in a few days, however, he appeared better, and was allowed to get up; and, as the weather was fine, was able to go out of doors about a week later, when he walked to my house, though still obviously weak. Ten days afterwards his father carried him up, as he said the child seemed to have lost the use of

his legs, tottering about when he tried to walk, and that he dropped his head to the left, and that his manner seemed curious. I accordingly once more ordered him to bed, and on my visit next day found he had a cough of a clashing, hollow character, which was quite ineffective in bringing up any phlegm, though, after repeated paroxysms, he retched and expelled mucus and food through his nose. My suspicions being aroused, I examined the palate, and found it paralysed, as were the muscles of extraordinary expiration; the patellar tendon reflexes could not be elicited, and the pupils were dilated and sluggish to the action of light, his expression was vacant, and there was internal strabismus (left).

Bronchitis supervened, and though of itself not of a serious character, was rendered so by the impaired expiratory powers, and the boy's condition soon became critical, the repeated paroxysms of cough coupled with the sitting posture occasioned by orthopnea telling severely upon the circulatory system. Grave fears were entertained lest, the cardiac nerves becoming involved, death from syncope would ensue; fortunately this did not happen.

Gradually increasing doses of liq. atrych.  $\text{mij}$ , and liq. ferri perch.  $\text{miv}$  three times a day, and friction of chest muscles with camphorated oil so improved the child's condition, that in three weeks he could sit up comfortably in bed and play with his toys. Two further attacks of catarrhal bronchitis occurred, and, though obstinate, were satisfactorily dealt with by stimulant expectorants and the use of a steam kettle. The boy's hearing was markedly impaired on both sides during convalescence, but gradually improved, as did his power of deglutition and the twangy nature of his voice.

As paresis of the chest muscles persisted, the legs were much wasted, and the knee-jerks still absent at end of six weeks, I prescribed massage to be employed for thirty minutes, followed by application of the galvanic current, which was done for a fortnight, a striking and rapid improvement soon becoming manifest in his respiratory movements, and in the size and power of his lower limbs, the child being enabled thereby to walk a little, though the gait was of a tottering character.

A year has elapsed; the boy now enjoys fair health except for occasional bronchitic attacks, he walks and runs well, hears naturally, speaks with but a slight nasal twang, the thoracic movements are good, the knee-jerks have returned, though only in a minor degree, and the strabismus is only obvious when he is over-tired.

The chief interest in this case centres in the fact that the patient undoubtedly had nasal diphtheria coincidently with measles, and that, although his sister had a far worse purulent nasal discharge both during and before her attack of measles, she developed no post-diphtheritic signs. The rarity of the concurrence of diphtheria with measles is my

excuse for publishing these notes, and I trust accounts for my failure to detect the condition of mixed infection.

### The Treatment of Septic Wounds.

An Abstract of a Paper read before the Abernethian Society on November 8th, 1900.

By H. J. PATERSON, F.R.C.S.

**S**EP TIC wounds, as the result of a surgeon's knife, are, fortunately, now so rare that they need not be considered, so that we have only to deal with wounds the result of accident. It is, of course, impossible to say at the time of the accident whether any given wound is inoculated with micro-organisms or not. For practical purposes we may, I think, assume that the majority of accidental wounds are so infected. Whether the wound suppurates or not depends on the quantity of micro-organisms introduced, and also on the power of the tissues to destroy these invaders. If the micro-organisms are not in vast numbers, Nature may, by means of her trusty henchmen, the leucocytes, utterly destroy them; but—and this is a point on which I venture to insist—mistaken zeal on the part of the surgeon may hasten the very event which he is desirous of preventing. I believe that in many cases too vigorous antiseptic measures actually conduce to suppuration by impairing the resisting action of the tissues, and so hindering Nature's own power of repelling the intruders into her domain. Comparative pathology affords us a suggestive lesson in this matter; for it is a remarkable fact that the wounds of animals, even when severe, rarely suppurate, and usually heal rapidly and without complications. This may be due to some extent to constitutional causes, such as, for instance, the temperature of animals; for I suppose no one has ever heard of an animal developing delirium tremens after an accident. Nevertheless the determining causes of suppuration in wounds are mainly local; and this rarity of suppuration among the lower animals is at least suggestive.

There are certain general indications for treatment applicable to all wounds, which may be summed up thus:

To search for and remove foreign bodies.

To arrest hemorrhage.

To cleanse the wound.

Apposition of the wound.

Drainage.

Suturing.

Pressure.

And lastly, but not least important, the truth contained in John Hunter's aphorism, "The first and great requisite for the restoration of injured parts is rest."

These principles and their application are familiar to all of you, and I only propose to discuss two of them, namely, the cleansing of the wound, and drainage, and especially the drainage of acute cellulitis following a punctured or other wound.

For convenience we may classify wounds under four headings—

Incised wounds.

Lacerated wounds.

Contused wounds.

Punctured or other wounds, resulting in cellulitis.

**Incised wounds.** About incised wounds little need be said. They are not usually impregnated with dirt, and consequently there are no indications for vigorous wound-cleansing; gentle bathing with some antiseptic is generally all that is required. Occasionally a wire drain may be advisable, but, as a rule, drainage is sufficiently provided for by not suturing the wound too tightly.

**Lacerated wounds.**—In lacerated wounds the conditions are somewhat different, as such wounds are generally impregnated with dirt. The frequency with which these wounds suppurate, in spite of the most rigorous antiseptic measures, was the occasion of much perplexity and disappointment to me during part of the time I was Mr. Willett's house surgeon. Lacerated scalp wounds more especially, suppurated with a pernicious regularity. Two cases, both of which were admitted during the same period of duty, made a great impression on my mind, and set me thinking. I will very briefly record them.

The first case was that of a man who was thrown out of a dog-cart in a street collision. He had a lacerated wound on the left side of his head, a flap of the scalp extending from the external angular process to the occipital protuberance being torn down for a distance of three inches. There was much mud in the wound, and I spent over an hour, with the patient under an anesthetic, in thoroughly (as I thought) cleansing the wound. The flap was replaced and kept in place by a few sutures, and free drainage provided at the most dependent part of the wound. Nevertheless the patient's temperature gradually rose, and there was free suppuration, which extended beyond the limits of the original wound, and required free incisions.

The second patient was a boy aged ten, who was knocked down by an omnibus, the vehicle passing over his elbow, causing an extensive lacerated wound involving the joint. In spite of careful antiseptic treatment, free suppuration ensued, leading to sloughing of a considerable area of the skin. Both cases were very disappointing. Antiseptic treatment quite failed in each case. I would readily have believed that these failures were due to some want of care or mistake on my part, but I so frequently saw the same sequence of events in the practice of others that I was forced to believe that such was not an adequate explanation. I well remember about this time seeing a woman admitted into the hospital with a lacerated wound of the leg. The house surgeon took every precaution and care in thoroughly removing the dirt and mud from the wound, yet there followed free and extensive suppuration, and eventually the limb had to be amputated above the knee. I wondered what would have occurred in these cases had Nature been left more to her own resources. There can be little doubt that the scrubbing necessary to remove the dirt from such wounds as I have described must seriously impair the resistance of the tissues. I determined, therefore, when next I had an opportunity, to try less vigorous measures, and to trust more to the *vis medicatrix naturæ*. I had not long to wait, for during Mr. Willett's next period of duty a man was admitted who had been knocked down by a truck on the railway, and sustained a very similar scalp wound to the one already described. On this occasion no anesthetic was given (the patient had internal injuries, which would in any case have rendered the giving of an anesthetic inadvisable), but the wound was simply bathed with perchloride of mercury lotion, and the flap maintained loosely in position with two loosely tied sutures. Rather to my surprise, the wound rapidly healed, with only slight suppuration from granulation tissue at its margin. Nature seemed to justify the confidence reposed in her. After that experience I avoided any attempts at thoroughly cleansing lacerated wounds, and never had occasion to repent so doing. It is true that suppuration in lacerated wounds was not abolished, but it was indubitably less frequent, and when it did occur was comparatively trifling. I venture, therefore, to suggest that it is inadvisable to aim at thorough cleansing of a dirty lacerated wound, and that a vigorous attempt—and the attempt must be vigorous if there is much dirt in the wound—at thorough cleansing will probably do more harm than good, by impairing the resistance of the tissues to the micro-organisms which remain. It will, I think, be admitted that to ensure the removal of all organisms and foreign matter is practically impossible. Were it possible, the case would be different, as then the resisting power of the tissues would be of less moment than the removal of all foreign matter. As the case stands, there are two alternative conditions before us, and we have to determine which of the two is the lesser evil.—

1. Presence of dirt (micro-organisms), but unimpaired tissue resistance.

2. Less dirt (fewer micro-organisms), but impaired tissue resisting power.

From my own experience, I incline to the view that the presence of more foreign matter, but with unimpaired tissue resistance, is the more favourable condition. A similar view is now generally held with regard to septic matter in the peritoneal cavity. The practice of "washing out" the peritoneal cavity is far less often resorted to than formerly, as it is more recognised that it is impossible to thoroughly cleanse the peritoneal cavity by flushing. Now many surgeons, after removing the more visible pus by gentle sponging, prefer to leave the remainder inside the abdomen rather than risk injuring, and so impairing the resisting power of, the peritoneal membrane by prolonged flushing of the cavity with water or antiseptics.

I trust I have made my meaning clear. I am not for one moment attempting to under estimate the value of judicious antiseptic treatment, but simply questioning the advisability of prolonged attempts by scrubbing or strong antiseptics to thoroughly rid a lacerated wound of all foreign matter, when, from the nature of the wound, such an ideal is practically impossible of attainment.

On one other point I wish to lay emphasis, and that is the importance of trimming the edges of the wound with scissors. This simple precaution in itself removes much of the dirt, and tends to facilitate rapid healing, without in any way injuring the resisting power of the tissues.

Of contused wounds I have nothing particular to say, and so will pass on to the consideration of wounds which have resulted in cellulitis, and mention a few points in connection with the treatment of this condition.

Cellulitis is apt to occur in punctured wounds, or in wounds that have been neglected in broken-down, and especially in alcoholic subjects. Three main varieties of cellulitis following wounds may be described:

1. Acute localised cellulitis.

2. Acute oedematous cellulitis.

3. Acute (subcutic) spreading cellulitis.

The general objects of treatment in these several varieties are similar, and are fourfold in number, viz.:

1. To arrest the progress of the inflammation.

2. To relieve tension.

3. To maintain free drainage.

4. To prevent constitutional infection (sapremia, septicæmia, and pyæmia).

The clinical course of these varieties are somewhat different, so that I will briefly allude to each.

1. **Acute localised cellulitis.**—This is the common acute abscess, and by far the commonest variety. The treatment is simple. A free incision to let out the contained pus, and careful after-dressing, usually speedily ends the trouble.

2. **Acute oedematous cellulitis.**—This usually results from the introduction of a specially virulent poison, which very speedily causes a heavy, oedematous swelling. If incisions be made no pus is discovered, but only blood-stained serum. Such cases run a very rapid course, and the patient may die within two or three days from septicæmia. No treatment seems of any avail.

3. **Spreading cellulitis.**—In this variety the process, although at first possibly acute, tends to assume rather a subacute or even chronic type. When the case comes under observation there is a more or less extensive area of dull red, unhealthy looking skin. Fluctuation is readily detected in the affected area. There is little or no oedema, and signs of acute inflammation are absent. When an incision is made there is found a cavity containing pus, and the skin is thinned, and may be undermined more extensively than the external appearances would lead us to suspect. Notwithstanding incision, the undermining of the skin at the periphery may continue, while the skin in the centre of the area gradually melts away, the pus tends to collect in pockets under the skin, decomposes, and the patient will be in danger of becoming poisoned from the absorption of the products produced by the decomposing pus. This is, perhaps, the most troublesome variety of cellulitis to treat; but I believe that in many cases the reason is that the incisions made in the first instance are not sufficiently extensive. Let me record two illustrative cases. A man aged 50 was admitted with cellulitis of the lower limb. Three weeks before admission he had slipped and sustained a wound on the outer aspect of the knee. Pain and swelling followed shortly afterwards, and two weeks later an incision was made from which there was a copious discharge of pus. The swelling continued to spread up and down the limb, and on admission the skin was reddened and undermined down the upper third of the leg, and up the thigh to within four inches of Poupard's ligament. Under an anesthetic I enlarged the original incision, and made further incisions in the leg, on the inner aspect of the knee, and on the outer aspect of the thigh. All the incisions were drained. The cellulitis continued to spread, so two weeks later all the incisions on the outer side of the limb were connected, forming one long incision. Still the undermining of the skin continued, so that, as a last resort, the whole of the undermined skin was cut away right to the margin of the cavity, leaving a large ulcerating surface extending from Poupard's ligament, and the iliac crest, exposing Scarpa's triangle as in a dissection, and extending down the outer side of the thigh as far as the middle of the leg, and averaging about five inches wide. Nor was it a mere superficial wound, as the femoral vessels could be plainly seen therein, and on the outer side of the limb the vastus externus and biceps femoris muscles were exposed. No further extension of the cellulitis ensued, and the large ulcer was treated in the way to be presently described. The other patient was a woman who was admitted with a small patch of cellulitis following injury on the outer side of her leg. An incision and counter-incision was made, and the cavity drained. The cellulitis

continued almost imperceptibly to spread, slowly but surely undermining the surrounding skin. On nine subsequent occasions, under nitrous oxide gas, I made more incisions, and inserted more drainage-tubes, until the patient's leg had rather the appearance of Medusa's head. Finally, one long incision was made from end to end of the affected area, and the flaps of undermined skin were turned back, discovering numerous pockets of the most offensive pus I have ever smelt, except perhaps in cases of facial abscess. The whole of the undermined skin was cut away. After this radical treatment there was no further spread of the cellulitis, and the large ulcer resulting was treated in the way to be detailed presently. These two cases are, I think, typical of what so frequently happens in cases of cellulitis. Unless very free exit is provided for the pus, it collects in pockets, gradually undermines more and more skin, decomposes, and so causes sepsæmia. In my opinion the usual treatment of these cases by incision and counter incision, or by multiple small incisions, does not as a rule provide adequate drainage, and I maintain that the best, and in the long run the quickest plan, is to open up the abscess cavity from end to end, and by cutting away all, or at any rate most, of the undermined skin to convert the abscess into an ulcer. I admit that this sounds very severe treatment, but we must bear in mind that in many of these cases it may come to the question of the patient losing a limb, or even life itself; so that heroic treatment, if it obviates these eventualities, is amply justified. But even so, this treatment is not so severe as appears at first sight, when we realise that the resulting ulcer can be completely covered over by means of Thiersch's grafting. This was done in both the cases above described. The ultimate result is a more useful, soundly healed, limb, and a more ornamental one, than if the cellulitis had been treated with multiple incisions and drainage-tubes, which leave many puckered scars. Thiersch's grafting is not a difficult operation, and is one of great value in the treatment of large ulcers. Success depends on strict attention to details, and on the exercise of considerable patience. As the technique has not, so far as I know, been fully described in any of the ordinary text-books, I think I cannot do better than conclude these disjointed remarks by giving a brief account of the method of performing this operation which after trial of various modifications I have found most satisfactory.

Two conditions are important for success: first and foremost the ulcer must be situated in a region where very firm pressure can be applied over the grafts; and secondly, the ulcer should have commenced to heal.

For convenience of description I will describe the procedure under three headings:

- (1) Preparatory treatment.
- (2) The performance of the grafting.
- (3) The after treatment.

1. *Preparatory treatment.*—The first step is to get the ulcer clean. The surrounding skin is shaved, and the whole ulcer and surrounding skin thoroughly washed with soap and water. For a day or longer I recommend the use of Sanitos fomentations, frequently changed. They are of much value in getting the ulcer clean and sweet. Twelve hours before the time fixed for the grafting the whole region should be again thoroughly washed, the skin being rubbed with ether, bathed with biniodide of mercury lotion, and enveloped in sterilised lint or gauze wrung out in hot carbolic lotion (1 in 30), and covered with protective and bandaged. At the same time the skin from which the grafts are to be taken should be prepared by shaving, thorough washing with soap and water, then with ether, and finally with biniodide of mercury (1 in 2000) lotion. It is then covered with a dressing similar to that placed on the ulcer. The flexor aspects of the forearms are the most suitable regions from which to take the grafts, the skin there being fine, comparatively free from hairs, and easily kept on the stretch while the grafts are being cut. If more grafts are required than can be obtained from these regions, they may be taken from the extensor aspect of the thighs.

2. *The performance of the grafting.*—The instruments required are a Volkmann's spoon, two pairs of dissecting forceps, a probe, a pair of scissors, and a knife with which to cut the grafts. I have found the knife known as Thiersch's work admirably. It should be sharpened after each occasion on which it is used. A razor has not sufficient weight to give it the steadiness necessary for cutting large grafts.

The patient having been anaesthetised, the ulcer is finally prepared for receiving the grafts. The whole of the superficial tabby part of the granulation tissue on the base of the ulcer is scraped away with a Volkmann's spoon. It is advisable at the same time

to scrape away the thin blue epithelial film at the healing margins of the ulcer. The whole surface is then scrubbed with a sterilised nail brush and soap and water. This prepares a level bed upon which to place the grafts. Finally, after free irrigation with hot biniodide lotion, the surface is sponged dry and enveloped in gutta-percha tissue or proteovine, which has been kept for a few hours in carbolic lotion (1 in 20) and dipped before application in hot saline solution. Firm pressure is then applied by means of a bandage. This arrests the haemorrhage. If this be not effectually done, when the grafts are applied blood will collect between them and the surface of the ulcer, with the result that the grafts will die. Gutta-percha tissue is placed in immediate contact with the ulcer in preference to sponges or gauze, as it does not tend to stick to the granulations, and thus start the bleeding afresh when it is removed. The operator should now again thoroughly disinfect his hands, and for the rest of the operation antiseptic lotions should be avoided, as the chemicals might injure the delicate grafts.

In cutting the grafts the skin must be kept *lightly* on the stretch in the long axis of the limb by an assistant. This is most important. The operator then stretches and flattens the skin from side to side while cutting the grafts with the knife in his right hand. The grafts should be cut with a somewhat saving motion, the handle of the knife being manipulated so as to make the blade follow the contour of the limb. In this way grafts may be cut measuring two and a half inches wide, and, if necessary, five inches long, or even longer if the limb be a large one. While cutting the knife should be kept wet with hot saline solution (one teaspoonful of common salt to a pint of hot water), and each graft as it is cut should be placed in a bowl of the same solution at a temperature of from 95° to 100° F. In cutting the grafts care must be taken not to cut too deeply, otherwise scarring will ensue. The part removed should consist of the whole of the horny layer, and the superficial part of the Malpighian layer of the skin, the tops of the papillæ being just removed, so that a surface covered with minute drops of blood is left, each drop corresponding to a cut papilla. With this precaution there will be absolutely no scarring; in fact, after a time the same place may be utilised for the providing of other grafts. The part from which the grafts have been taken should then be sponged with biniodide lotion and dressed with antiseptic gauze. This dressing may be left untouched for a couple of weeks, by which time the surface will have usually quite healed.

*All the grafts required should be cut, and the part from which they have been taken covered up provisionally, removing the temporary dressing which has been placed on the ulcer in the meantime,* with particularity to emphasise this point, as several writers have advised that each graft should be transferred directly if it is cut on the knife to the ulcer. If this be done there is great risk of infecting the raw surface from which the grafts have been taken with some of the pus from the ulcer. In this way I myself have seen ulceration ensuing over an area more extensive than that of the ulcer for the cure of which the grafting was undertaken. As additional reasons for cutting all the grafts at once it may be remarked, that a longer time is thus allowed for pressure to be exerted on the ulcer after it has been prepared by scraping, consequently the haemorrhage is more likely to be completely arrested, a condition most essential for success, and that when the grafts are placed in position as they are cut there is much more likelihood of those already placed *in situ* being disturbed by the manipulations incidental to the cutting of further grafts. The vitality of the grafts is effectually preserved for an hour or even more if the temperature of the saline solution be maintained by the addition of hot water.

Grafts from a freshly amputated and healthy limb may be used instead of grafts from the patient. This is of especial service if the patient's condition be such as to render a long operation under an anaesthetic inadvisable. The scraping of the ulcer may be accomplished while the patient is under the influence of nitrous oxide gas, and the actual placing of the grafts quietly finished without an anaesthetic. I have several times adopted this procedure with success.

The next step is the placing of the grafts in position. The dressings having been removed, the ulcer is surrounded with sterilised towels. The grafts are removed one by one from the saline solution with a pair of dissecting forceps, and spread out on the ulcer, raw surface undermost. If it be remembered that the grafts always curl *towards* the raw surface, no difficulty will be experienced in spreading them out correctly. Round the margin of the ulcer the grafts should overlap the skin for about one eighth of an inch. Over the base of the ulcer the grafts should be placed in close contact, no intervening islets of granulation tissue being left. The

grafts must be completely uncurled and evenly spread out. For this purpose I have found no instruments answer so well as two pairs of dissecting forceps, aided by a probe. The grafts should be handled with the utmost gentleness, and no air or fluid should be allowed to remain between them and the floor of the ulcer. This is the most tedious and tiring part of the operation, and requires much care and patience. Any attempt at hurrying will probably result in the displacement of some of the grafts already placed in position. If the ulcer be large, or the discharge profuse, it may be advisable to divide it into several smaller ulcers, by placing several broad grafts across it. The intervening ulcers may be covered in at a later period, when the first grafts have become vigorous. This plan was adopted in the first case recorded above.

Some authorities have advocated stitching the grafts in position. This is quite unnecessary, and would greatly lengthen an already prolonged operation.

Next as to retaining the grafts in position. As already insisted upon very firm pressure is most essential for ensuring success. The grafts having been placed in position they are covered with strips, two inches wide, of isinglass plaster, each strip being first dipped in hot saline solution, and then firmly applied over the grafted area. Over each of these strips a piece of antiseptic gauze of similar size is placed, and kept in position by a strip of Leslie's strapping of sufficient length to get a firm hold on the skin beyond the ulcer. The strapping is best heated in the flame of a spirit lamp; this makes it stick better, and at the same time sterilises it. Over the plaster is laid a thick layer of wool, and the whole part firmly bandaged with a Domette bandage. If the part grafted be a limb, it should be slightly raised for the first few days. If the ulcer is near a joint, this must be securely fixed by some splint.

3. *The after treatment.*—The dressing should be left undisturbed for at least four days, but if there be no rise of temperature, no discharge through the dressings, the first dressing may be advantageously postponed until the fifth or sixth day. I prefer to let the gauze and isinglass plaster soak off unaided, by placing the patient, if necessary the patient, in a hot bath, having first of all removed the bandage and wool, and loosened the Leslie's strapping. In a successful case the result may at first sight appear to be a failure. The grafts are now pinkish or red in appearance, and the granulation tissue below shows through them, so that their presence is not very evident. If the grafts are conspicuously white, we may be certain that they are no longer living. If the grafts are living, the dressings are applied as before, except that the Leslie's strapping may now be dispensed with. After ten days an ordinary dressing of gauze and wool is sufficient.

In my opinion the very satisfactory results obtainable by grafting in this way remove the chief objection to the treating of cases of spreading cellulitis in the way I have suggested.

## Irreducible Inguinal Hernia.

An Abstract of a Paper read before the Abernethian Society,

By W. McADAM ECCLES, M.S., F.R.C.S.

GENTLEMEN,—It is my intention to-night to briefly review the present position of opinion with regard to the treatment of irreducible inguinal hernia.

Irreducibility of a hernial protrusion is a term that depends to a great extent upon the value put upon the definition.

When the contents of a hernial sac do not return of their own accord when the patient assumes the horizontal posture, and are not reducible on the application of taxis either on the part of the patient himself or of the medical attendant, but at the same time there is no other usual condition present within the sac, then the case may be said to be one of simple irreducibility.

This state of the parts has to be carefully distinguished from the irreducibility associated with an interference with the circulation of blood in the bowel wall, or obstruction of the lumen of the gut. Such conditions would be either strangulation or incarceration, and not simple irreducibility.

It is well to remember also that irreducibility may be merely a temporary condition, for a hernia that is irreducible to-day may be

reducible to-morrow, and one that is irreducible in the hands of one surgeon may be returned by the efforts of another.

To understand aright the treatment of irreducible inguinal hernia it is necessary to indicate the causes of simple irreducibility.

FIG. 1.



FIG. 2.



The contents after protrusion may increase in their bulk, and consequently become unable to return through the opening leading into the abdomen. This increase may be brought about by the deposition of fat, by the addition of fibrous tissue, or by the formation of cysts or new growths in the viscera within the sac.

The neck of the peritoneal pouch containing the protruded organs may become narrowed after their descent, and thus the way back into the abdomen rendered so constricted that the viscera cannot be induced to return.

FIG. 3.



It is rare for an incomplete inguinal hernia to be the seat of imprisoned contents, but, on the other hand, it is common for a complete hernia to have its interior filled with viscera which will not go back into their normal abode.

The signs and symptoms as well as the diagnosis of an irreducible inguinal hernia do not concern us at the present time, and we pass on to the all-important question of the rational treatment of such a condition.

To return the contents of the sac and to prevent their further protrusion should obviously be the aim of the surgeon. The ideal method in which to obtain this satisfactory result is to perform herniotomy, to reduce or remove the contents of the sac, and to close the mouth of the pouch of peritoneum and the apertures through which it has passed.

Operation is therefore indicated in the large majority of cases of irreducible inguinal hernia. It is nearly always advisable in the somewhat rare irreducible bubonocoele, and in many, even large, scrotal hernia. There are, however, a considerable number of cases in which it is sheer madness to attempt an operation, but in which much may be done by properly applied palliative means.

It is not my intention to discuss all the points that arise in connection with a radical operation upon an irreducible inguinal

hernia, but I think that it might be useful to allude to a few of the important details. First as to the position in which the incision is to be made. It should be placed, even when the sac has advanced into the scrotal tissues, over the line of the inguinal canal—that is, it should commence at or a little outside the site of the aponeurosis of the external oblique muscle will then be exposed, and its fibres are divided over the line of the canal, thus opening up that passage. Within it will be found the neck of the sac. This is next dissected free from the coverings that lie superficial to it. It is then carefully opened, so that no damage may be done to the structures that lie within it. Omentum, as a rule, and less frequently intestine, occupy the neck of the sac. The omental tissue may present itself as quite a narrow band, easily untravelled, or a thick cord densely compressed may be present. The omentum is to be discreetly displaced, and a search made for any bowel hidden behind it or even within it.

Whether bowel is found or not to a great extent determines the next step in the operation. If gut is prolapsed, in most cases it is not adherent, and with a little manipulation it can be reduced.

Should adhesions exist, then the case becomes one of great difficulty, for the separation of the intestine may be a hazardous measure if the connections that tether it are firm. It may become necessary to leave a portion of the sac wall attached to the bowel, and reduce it with the gut rather than risk injury of the intestinal wall by persistent efforts to separate it. The intestine, if any is present, having been returned, it is the turn of the omentum to be dealt with. If feasible, this should be untravelled and ligatured with interlocked silk ligatures as close to the site of the deep abdominal ring as possible. In order to effectively carry this out, it may be needful to separate adhesions, but it is not so very frequent to find them in the neck of the sac. When the omentum has been securely tied, it is divided below the ligatures, and the stump, if bloodless, returned within the abdomen.

The contents of the scrotal portion of the sac now require attention. By pressure upon them, and some traction on the part lying in the neck, the omentum, even if adherent, may be made to present at the wound, the tissues of the sac being often thereby inverted. As a rule it is not advisable or necessary to remove the scrotal portion of the sac, but merely to separate the usually adherent omentum and arrest any hemorrhage, and to then return the peritoneal pouch into the tissues of the scrotum. The neck of the sac is now carefully separated from the cord lying behind it, and transfixed with a silk ligature flush with the parietal peritoneum at the site of the deep abdominal ring, and the distal portion cut away.

The next step in the operation is the insertion of sutures to bring the arching fibres of the internal oblique and transversalis muscles into contact with the posterior surface of Poupart's ligament. Personally I prefer to use silk for these buried sutures, and to leave the spermatic cord in its normal position, that is behind the internal oblique, instead of transplanting it in front of that muscle, or even in front of the aponeurosis of the external oblique. Two or three stitches are usually sufficient to effectively close the space which has been made apparent by the dilatation of the inguinal canal in consequence of the presence of the hernial protrusion. Next the aponeurosis of the external oblique is sutured with interrupted silk stitches, and finally the skin and subcutaneous tissues are brought together by interrupted sutures of silk-worm gut. It will be observed that the three tiers of sutures are not directly one behind the other, so that their disposition also aids in the strengthening of the part.

As to the use of a truss after such an operation upon an irreducible hernia, my experience is that it is advisable to order one, at any rate for a year or so subsequent to the operative procedures.

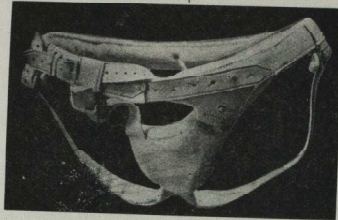
These cases occur often in men whose work is very laborious, or in subjects who are affected with a marked tendency to the production of a hernia, and in many who are very careless of the way in which they manage their hernial protrusions.

Passing now to those instances—and unfortunately they are by no means uncommon—in which an operation for the relief of the hernia is out of the question on account of severe lung or other visceral trouble, or in which the age and general condition of the patient contra-indicate a successful or safe operation. If one has to deal with an irreducible hernia in such a person, it is altogether inadvisable to leave the protrusion alone, a plan that is so often followed. Also it is not good surgery, except in a few special cases, to adjust a so-called bag truss, which is merely a false security, having no power to prevent the descent of further viscera, or to promote the return of those already prolapsed.

There is, however, a truss which has properties that make it of great advantage in the treatment of these irreducible inguinal herniæ.

This is the hinged-cup truss. It will be seen by the figure (see Fig. 4) that it consists of the ordinary inguinal pad, to which there are added two additional parts; one is the hinged-cup, and the other is the

FIG. 4.



forked-tongue piece. The hinged cup is made up of a triangular frame of metal covered with chamois leather, so as to form a very shallow bag, and it is attached by one of its upper angles to the lower part of the pad by an ordinary hinge, which allows the cup to move only in a direction upwards and backwards. The other upper angle has fastened to it a strap which passes to a buckle placed on the cross-strap. From the lower angle are prolonged two straps, which pass to be fastened to movable buckles on the spring of the truss. The forked-tongue piece projects at the upper and inner angle of the pad, and is prolonged into a strap which is fastened to a fixed buckle at the front of the shoulder of the truss, on the opposite side to that on which the hernia is found.

In adjusting this form of truss the pad rests over the inguinal canal, and tends to prevent the descent of any further viscera, while the hinged-cup is placed over the scrotal portion of the irreducible contents, and from the pull exerted by the under straps causes a well-marked pressure upon the hernia. This action will promote reduction of the contents, and the further forward the buckles are placed on the spring of the truss the greater will be the pull produced, and the more will be the pressure brought to bear upon the contents of the hernia.

It is interesting to observe what a small amount of discomfort, comparatively speaking, this form of truss gives rise to. The truss has to be worn day and night, and is only to be removed for the purposes of cleanliness. Each morning taxis should be applied by the patient or surgeon. Reduction is effected in varying lengths of time after the adjustment of the truss, but in over 60 per cent. of the cases in which it is used, it leads in the end to the complete return of all the viscera that have been imprisoned in the sac. Proper dieting to reduce fat will also materially aid in promoting reduction. When this happy result has been brought about, it is necessary to apply a correct form of truss in order to prevent further prolapse of omentum or intestine, and the possibility of their again becoming irreducible.

### Notes.

SIR DYCE DICKWORTH has been appointed a Consulting Physician to the Italian Hospital, Queen Square.

DR. C. RIVIERE has been appointed Pathologist to the East London Hospital for Children, Shadwell.

MR. T. P. LEGG has been appointed Assistant Surgeon to the Royal Free Hospital, Gray's Inn Road.

MARITIME SANITARY SERVICE, SUEZ.—Dr. D. Harvey Attfield has been appointed by the unanimous vote of the

International Sanitary Council in Egypt, Medical Director of the Maritime Sanitary and Quarantine Service at Suez. Dr. Harvey Attfield filled one of the three junior positions from 1894 to 1897. He was Medical Officer of Health for Watford from 1898 to 1900. Dr. Harvey Attfield is the son of Dr. John Attfield, F.R.S., who was Demonstrator of Chemistry at St. Bartholomew's from 1854 to 1862, and editor of the *British Pharmacopœia*, 1898. He studied at Bart.'s from 1888 to 1892.

MESSRS. F. A. BAINBRIDGE and F. C. SHRUBSALL have taken the degree of M.B. at Cambridge University.

MR. F. A. BAINBRIDGE has been admitted to the membership of the Royal College of Physicians.

The following candidates have been successful in the recent examinations for the Indian Medical Service:—J. K. S. Fleming, H. W. Illius, J. W. Illius, E. C. Hepper.

MR. BUTLIN asks us to point out an error in his Abernethian address, reported in our last issue. Dr. W. S. A. Griffith is President of the Medical Defence Union, not Mr. Victor Horsley, as stated.

In the death of Mr. Vernon the Hospital has sustained a deep loss; his figure—so well known to all,—his courtly manner, his kindly words of encouragement, and above all his valued teaching, will be sadly missed. We of a younger generation had learnt to look on him as more than a skilled surgeon or a great teacher, rather as a personal friend; his example alone was enough to make those who worked under him respect his personality, and prize their acquaintance with him. Learned not only in the science of ophthalmology, but conversant with the history and literature of his subject, his demonstrations in the theatre of the eye ward were made for the younger men full of interest, and many a hard fact will be retained in our memories by the picturesque setting that Mr. Vernon was able to give it.

His favourite books to recommend for the foundations of eye work were Mackenzie, "the French edition if possible;" Donders, the "master of refraction;" and Stellweg von Carion, a selection in which he showed no mean literary as well as scientific discrimination. And of Donders he was wont to add that "he was a man who, approaching his subject with little else than theoretical knowledge, had written the only practical work on refraction."

But Mr. Vernon's chief merit in our eyes, commanding, it may have been, even greater respect than his manner or teaching, was his love for and loyalty to his Hospital. "You men did not make the reputation of this Hospital,

my generation did not make it, but our forefathers made it many centuries ago, and it is our duty to see that it loses nothing of its lustre in our keeping." How often has he preached this sermon at "Out-patients," when he asked some peripatetic patient why he had deserted other hospitals to come to Bart.'s.

It was in his treatment of what are to many men trifling complaints that Mr. Vernon stood on a plane by himself, his wealth of resource and unerring prevision rendering the most ordinary corneal ulcer an interesting clinical study. The care which he bestowed on his patients, his first thought always of their comfort, tended to give to his teaching a practical value, which his dressers would learn perhaps later to appreciate, when on the patient's comfort depends the practitioner's bread and butter. And many a worried doctor, and parent too, will bless the day when Mr. Vernon admitted into the wards a howling specimen of intractable photophobia in the young subject.

His house surgeons will know how any excuse was enough to bring him down seven days in the week instead of six only. His one fear latterly seemed to be that old age would soon rob him of the work he prized so highly; and deeply as we deplore his loss, to him it would have been an impossibility to lead an invalid life without the work and interest in the Hospital in which he was so bound up.

And if the students of his day have caught something of his manner, though all his teaching may be forgotten—that at least will be reflected through generations of Bart.'s men of the future, when the latest scientific discovery is the amusing blunder of a bygone century.

Conservative in his profession he may have been, but he was never afraid to adopt what was modern on account of its novelty, nor prone to retain what was old for its venerable antiquity. He had eyes for everything, and forgot nothing, even to the family history of a hospital patient whom he had not seen for ten years; and he had a habit, at times a little startling, of giving some so-called "new method" its proper place in history, and reminding us that it had been tried and discredited when the century was young.

We regret to announce the death of Mr. Cecil F. Gordon, recently Medical Officer to ss. "Columbia." Gordon fell a victim to phthisis in 1894, but after twelve months' rest and treatment returned to Bart.'s, and qualified in 1896. Since that time he has spent the greater part of the year travelling. He succumbed to his disease at his home in Hampstead, on the 11th of this month.



It is reported that at a recent meeting of the Abernethian Society Dr. W. J. Collins converted many of the members of the Resident Staff to Progressive principles by his views on the question of "Insanitary Areas" and the "Rehousing of the Very Poor." The affected class were much touched by his sympathetic words, and are now advocating the claims of the L.C.C. to jurisdiction within the City boundaries.

\* \* \*

AFTER the meeting Dr. Collins was seen investigating the Resident Quarters.

\* \* \*

FROM our contemporary the *Westminster Hospital Gazette* we copy the following "fragment from the hitherto unpublished works of MOREORLESSAT HOMER," which seems to shed some light on one of history's shadiest scenes:—" . . . and it came to pass that about the time of harvest a certain soothsayer called DOWÆ arrived at the city; and he spake to the nations, saying:—"Why bow the knee to ÆSCULAPIUS? Am I not mighty in incantation? Come, then, let us found a city, to which I will admit you by immersion, and heal all ills by the same fluid measures; and lest any feel degraded by the holding of menial office, I myself will be CUSTOS PECUNIE, and take all the *uf*! \* . . . And then did he assemble a public meeting, to which all were invited save and except those unfortunate people to whom it pleased him not to grant tickets. But the disciples of GALEN were exceeding wroth, and rose in their thousands, from the temple of GUI and that of the KING, not forgetting picked men LATE VLE; † and they went to the meeting with trumpets and with songs.

\* \* \*

"But DOWÆ sent messages to the tribes of the BOBBI and PELORES beseeching their help, wherefore they came and surrounded the *Atrium* and the *Medici*, fierce conflict ensuing.

"And it came to pass that a wind from the South did much damage to the forces of the charlatan, who were worsted with the loss of the whole of their dignity and the greater part of their temper. Yet certain prisoners, the smallest obtainable, took they, and barbarously subjected them to the ordeal of the Vine; but as to the meeting, behold! it failed.

\* \* \*

"Now, DOWÆ said . . . [about a page here is *undeipherable*] and departed for the North, where certain young men whose minds were . . . [a blank] came unto him, and also some others of the opposite sex; and he received these with open arms, and . . . [the rest is *missing*]."

\* A rare Roman coin.

† Of the BROAD WAY.

## Amalgamated Clubs.

### RUGBY FOOTBALL CLUB.

#### ST. BART.'S v. PORTSMOUTH.

Played at Portsmouth on November 17th. The Hospital took down a very weak team, and consequently got a bad beating, Portsmouth scoring 2 goals and 4 tries to *nil*.

#### ST. BART.'S v. OLD PAULINES.

Played at Winchmore Hill, and resulted in a win for the Hospital by 1 goal and a try to *nil*. Team:

F. R. Carrol (back); D. M. Stone, T. O'Neill, J. Corbin, C. Cross, W. H. Hamilton (halves); H. T. Wilson, G. H. Adam, F. Harvey, H. E. Stanger-Leathes, J. West, J. M. Plews, K. C. McDonagh, Algernon Ridgeway (forwards).

#### ST. BART.'S v. NORTHAMPTON.

Played at Northampton on November 24th, and resulted in a win for Northampton, chiefly due to the superiority of their three-quarter line, as the Hospital forwards were quite a match for the opposing eight. Although the score against us was rather heavy, the game was by no means one-sided, as nearly all their tries were obtained after long runs from their half-way; they also obtained a very lucky drop and field goal. Our try was scored by Stone, who took advantage of a fumble on the part of their back to score a good try after a long run. Team:

E. S. Marshall (back); D. M. Stone, G. Drury, G. Ellet, N. M. Wilson (three-quarters); W. H. Hamilton, T. O'Neill (halves); A. O'Neill, H. T. Wilson, F. Harvey, H. E. Stanger-Leathes, R. Miller, A. G. West, J. M. Plews, R. C. McDonagh (forwards).

#### ST. BART.'S v. CATFORD BRIDGE.

Played at Catford Bridge on November 20th. The Hospital were fairly well represented and, the ground being in good condition, a good game resulted in a win for the Hospital by 2 goals and a try to *nil*. The first try was obtained by H. Wilson from a tricky pass by Harvey. A. O'Neill being the next to score, after a dash through his opponents, both of these being converted. The final bag was obtained by Neilgan after a good run by Stone. The game was remarkable for the way in which the Hospital outlasted their opponents. Team:

E. S. Marshall (back); D. M. Stone, G. Ellet, G. Drury, J. B. Gillies (three-quarters); W. H. Hamilton, T. O'Neill (halves); A. O'Neill, H. T. Wilson, A. R. Neilgan, F. Harvey, J. M. Plews, R. Miller, R. C. McDonagh, H. E. Stanger-Leathes (forwards).

### HOCKEY.

#### ST. BART.'S v. ROYAL ARTILLERY.

On Wednesday, January 16th, Bart.'s went down to Woolwich to play the return match with the Royal Artillery, and, after a big scoring game, retired beaten by 5 goals to 4.

The ground was very heavy after the frost. The game was throughout very evenly contested. At half-time the score was 3 goals all. On resuming the home team did rather more pressing, and were able to score 2 goals to the visitors one. The goals for Bart.'s were shot by Adam (3) and Nixon (1).

Bart.'s was not fully represented. Adam and Collingridge played very well, the former shot hard, and on several occasions only just missed scoring with some fast shots. Team: Muirhead (goal); Furber and L. Gray (backs); Murphy, Collingridge, and Cross (halves); H. Gray, Wilmot, Adam, Nixon, and Hallows (forwards).

#### ST. BART.'S v. KEW.

The Bart.'s team, consisting of ten men, was only moderately represented in this match at Kew. The ground was frosty, but after a fast game Bart.'s won by 2 goals to 1.

During the first half of the game the visitors did most of the pressing, but were only able to score once, through Beckett. Shortly after the game was restarted the home team equalised, and play became more level, but Beckett again scored for Bart.'s, who won as above stated. The backs defended very well, and Murphy played a good game at half. Team:

Dickson (goal); Fowler and Upton (backs); Hill, Murphy, and A. N. Other (halves); Jackson, Beckett, Nixon, and Hallows (forwards).

### SWIMMING CLUB.

At a meeting of the above Club, held on February 11th in the College, the following officers were elected:

*President*.—Howard Marsh, Esq., F.R.C.S.  
*Vice-Presidents*.—W. P. Herringham, Esq., M.D., L. P. Thorne-Thorne, Esq., M.D., W. Fay Bennett, Esq., M.R.C.S., L.R.C.P.,—Mundy, Esq., F.R.C.S.  
*Captain*.—A. H. Blossome.  
*Hon. Sec.*.—D. M. Stone.  
*Committee*.—L. B. Scott, C. Dix, W. H. G. Thorne, V. J. Daigan, M. B. Scott, A. M. Amsler, J. G. Watkins, V. Upton.

## Abernethian Society.



FEBRUARY 7th, 1901, Mr. G. E. Gask, President, in the chair. Dr. Collins read a paper "On Public Health and Public Office in London." He began by stating that this was the tenth occasion on which he had distracted and wearied members of the oldest medical society in London. Before entering on the subject of his paper Dr. Collins made sympathetic reference to the death of Mr. Vernon, whose house surgeon he had been just twenty years previously. He then went on to trace the growth of public opinion with regard to Public Health from the beginning of the reign of William IV, when the Statute-book contained no general law of sanitary import, except (in so far as this deserves to be counted an exception) the Act providing for Quarantine, down to the present time, with its innumerable Health, Improvement, Medical, and Local Government Acts, all passed during the sixty-four years of her Majesty's reign. He said that he thought that a medical training peculiarly fitted and assistance in public councils, and he hoped that a time would come when the medical profession would be as well represented as the sister profession, Law.

He next dealt with the different governing boards of London, passing in review their areas of jurisdiction, their powers, and the public works they control, giving particular account of the three central governing bodies whose jurisdiction extends over the whole area of greater London, viz. the London County Council, the School Board, and the Metropolitan Asylums Board, saying of the last that it furnishes a splendid example of how much good, mingled with some bad, can be effected by a body whose composition and origin were a compromise and a makeshift, and whose continued existence is an anomaly. He gave a full account of its constitution, origin, the work it has done, and has at present in hand. He pointed out the lessened mortality due to scarlet fever and diphtheria, and said that, in spite of the recognition of the conscientious objector by the Government, smallpox was almost extinct.

Dealing with the London School Board, he said that, acting on the suggestion propounded some years ago, that much of what passes as stupidity in the board schools is in reality amblyopia due to errors of refraction, had the eyesight of the children coming under its supervision tested, and had also established fifty-three centres where children who were physically and mentally deficient might have the special individual care and attention which they needed.

The last part of Dr. Collins' paper was more especially devoted to an account of the work of the London County Council. He said that amongst other works it has under its control are main drainage, water-supply, and housing of the poor. It has seven Asylums under its care housing over 15,000 lunatics. To the asylum at Claybury is attached a pathological laboratory, where every convenience and appliance is provided for utilising the clinical material which before the last few years had been so wantonly allowed to run to waste.

In conclusion, Dr. Collins said that it had given him great pleasure to return once more to the scenes of some of the happiest evenings in his life.

Before the paper Mr. Paterson showed a very interesting case of a patient on whom he had performed extensive skin-grafting seven years previously.

### NEW LAWS OF THE SOCIETY.

Below is the most important of the recent changes made in the Rules of this Society. It will be seen that it refers to the method of election of officers. Minor alterations were rendered necessary by the amalgamation of the Clubs and the incorporation of the Abernethian Society with these, but these are unimportant.

#### Election (1892 Rule).

X. (a) The Officers shall be elected annually from Members of the Society. Outgoing Officers shall be eligible for re-election.

(b) The names of Candidates proposed by Members shall be sent to the Secretaries at least eight days before the Annual General Meeting, with the names of their proposers and seconders, and shall be read by the Secretaries at the Ordinary Meeting one week before the Annual General Meeting, and afterwards posted on the Notice Board. No nomination after that date shall be valid.

(c) The election shall be by Ballot, and the names of all Candidates shall appear on the balloting list.

(d) On the day of election some Member appointed by the Committee, and not himself a Candidate, shall attend in the Society's room, between 12.30 and 1.30, to receive the voting papers of such Members as are unable to attend at the evening meeting, and a list of Members who have voted in this manner shall be read out at the evening meeting, when if any such Member be present he shall be requested to withdraw.

#### Election (1900 Rule).

VIII. (a) The Officers shall be elected annually from Members of the Society. Outgoing Officers shall be eligible for re-election.

(b) The names of Candidates proposed by Members shall be sent to the Secretaries at least eight days before the Annual General Meeting, with the names of their proposers and seconders, and shall be read by the Secretaries at the Ordinary Meeting one week before the Annual General Meeting, and afterwards posted on the Notice Board. No nomination after that date shall be valid.

(c) Only those Members who have attended at least "three" Ordinary Meetings during the preceding twelve months shall be allowed to take part in the Election of Officers.

(d) A list of Members who have attended three Ordinary Meetings shall be prepared by the Secretaries, and posted on the Notice Board eight clear days before the Election.

(e) The election shall be by Ballot, and the names of all opposed Candidates shall appear on the balloting list.

(f) On the day of election some Member appointed by the Committee, and not himself a Candidate, shall attend in the Society's room, between 12.30 and 1.30, to receive the voting papers of such Members as are unable to attend at the evening meeting.

## Gate.



DREAMED a dream and I seemed to see

The mystic home of the Sisters three—

Clotho filling the human reel,

Atropos clicking the deadly shears,  
Lachesis, who rules o'er the hopes and fears,  
The sorrows and joys that we mortals feel,  
Sitting aside o'er another wheel.—

I heard the rattling roulette's whirr,  
The clattering click of the fateful ball . . .  
And I knew that the Fortune lay with her  
If Examiners' victims rise or fall.

J. R. R. T.

## The Rahere Lodge, No. 2546.



Ordinary meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, on Tuesday, February 12th, 1901, W. Bro. Walter Gripper, M.B., W.M., in the chair. Bros. Heppburn and Bokenham were raised to the Third Degree, and Bros. Ware, Whitaker, and Beadles were passed to the Second Degree. A grant of fifteen guineas was made to a professional brother in urgent distress, a donation of one guinea was given to the maintenance of "Our Brother's Bod" in the Home for the Dying, and a sum of twenty guineas was voted to the Royal Medical Benevolent College at Epsom, on the proposition of W. Bro. E. C. Cripps. In consequence of the much-lamented death of H.M. the Queen there was no banquet after the meeting, but a few members of the Lodge dined together informally.

## Calendar.

March, 1901.

Fri.,	Mar. 1.	Sir Dyce Duckworth and Mr. Marsh's duty. Sir Dyce Duckworth's Clinical Lecture at 1 p.m. Hiebens Prize Examination.
Sat.,	2.	A. F. C. v. Old Easthournians at Winchmore.
Tues.,	5.	Dr. Hensley and Mr. Butlin's duty.
Wed.,	6.	Mr. Marsh's Clinical Lecture at 2.45 p.m. Hockey v. R. M. A. Woolwich at Woolwich.
Thurs.,	7.	Abernethian Meeting at 8 p.m.
Fri.,	8.	Sir L. Brunton and Mr. Walsham's duty. Sir Dyce Duckworth's Clinical Lecture at 1 p.m.
Sat.,	9.	R. F. C. v. Ilford Wanderers at Ilford. Hockey v. Herts County at Winchmore.
Tues.,	12.	Sir W. Church and Mr. Willett's duty.
Wed.,	13.	Mr. Marsh's Clinical Lecture at 2.45 p.m.
Thurs.,	14.	Abernethian Society. Annual General Meeting at 8 p.m.
Fri.,	15.	Dr. Gee and Mr. Langton's duty. Sir L. Brunton's Clinical Lecture at 1 p.m. Examinations for Harvey Prize and Kirkes Scholarship and Gold Medal (Paper).
Sat.,	16.	Hockey v. Uxbridge at Uxbridge.
Mon.,	18.	Junior Practical Anatomy Examination.
Tues.,	19.	Sir Dyce Duckworth and Mr. Marsh's duty.
Wed.,	20.	Junior Scholarships. Senior Scholarship.
Thurs.,	21.	Senior Scholarship (continued). Senior Practical Anatomy Examination.
Fri.,	22.	Dr. Hensley and Mr. Butlin's duty. Kirkes Scholarship and Gold Medal (Clinical).
Sat.,	23.	Hockey v. Teddington II at Winchmore.
Tues.,	26.	Sir L. Brunton and Mr. Walsham's duty.
Fri.,	29.	Sir W. Church and Mr. Willett's duty.
Sat.,	30.	Essays for Wix and Bentley Prizes to be sent in. WINTER SESSION ENDS.

## Examinations.

UNIVERSITY OF LONDON.

Intermediate Examination in Medicine.

Entire Examination; Second Division.—J. Ferguson, R. Holby, N. Macfadyen, A. C. A. Van Buren.

Excluding Physiology.—W. C. F. Harland, H. B. Hill, H. A. Kellond-Knight, A. K. Neligan.

Physiology only; First Division.—E. B. Smith, R. J. Waugh, E. C. Williams. Second Division.—R. A. S. Sunderland, W. P. Yetts.

## Preliminary Scientific Examination.

Entire Examination; First Division.—E. T. Glenny. Second Division.—A. A. Abrahams, W. W. Hume.

Chemistry and Physics.—A. Barber, T. W. H. Burne, G. S. Morse.

Biology.—G. J. Eady.

## First Examination.—Conjoint Board.

Chemistry.—E. B. Aylward, P. V. Bhatt, R. A. Bowling, C. P. Charles, P. A. Dingle, R. V. Favell, W. R. Favell, W. E. L. Fowler, W. G. Loughborough, J. E. R. McDonagh, F. Weber, C. O. O. Williams.

Practical Pharmacy.—A. H. Bloxsome, G. E. Cathcart, R. J. Douglas, E. S. Marshall, C. V. Nicoll.

Biology.—A. K. Armstrong, J. E. R. McDonagh, J. R. R. Trist, E. L. Wright.

## Second Examination.—Anatomy and Physiology.

T. Bates, J. A. Bell, S. E. Crawford, S. H. Gibson, V. H. J. Giragosian, T. B. A. Haggard, H. B. Hill, R. Holby, R. V. G. Monckton, A. P. Salt.

The following have completed the examinations of the Conjoint Board, and taken the diplomas of M.R.C.S., L.R.C.P.:

Blackman, S. S. F., Thomas, A. E., White, F. N., Walker, H., Urwick, R. H., Ross, P. A., Mellor, A. S., Klumpp, E. G., Cope, R., McLaren, N., Orton, G. H., Home, P. C. H., Compton, A. T., Cathcart, G. F., Jones, Fvan, Rastrick, R. J., Waters, A. C. S., Sale, J. C., Whitwell, H.

## Appointments.

BROWN, A. B., M.R.C.S., L.R.C.P., appointed House Surgeon to the Bridgton and South Shropshire Infirmary.

DOUGLAS, W. C., M.R.C.S., L.R.C.P., appointed Surgeon to the "Ajax" (Ocean Steamship Company).

GANDY, T. H., M.B.(Lond.), L.R.C.P., appointed Junior House Physician to the Great Northern Hospital, Holloway Road.

GAYNER, J. S., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the General Hospital, Cheltenham.

MALIM, J. W., M.B., B.C.(Camb.), appointed Junior House Surgeon to the Stanley Hospital, Liverpool.

PEARCE, T. M., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed House Surgeon to the Birmingham General Hospital.

## New Address.

W. LANGDON BROWN, 10, Dentinck Street, Manchester Square, W.

## Births.

CARRUTHERS.—On December 9th, 1900, at Riverside, Batheaston, the wife of A. E. Carruthers, M.A., M.D., D.C., D.P.H.(Camb.), of a son.

STEPHENS.—On January 23rd, at Laingsburg, Cape Colony, the wife of H. W. Stephens, of a daughter.

## Marriage.

HAYWARD—ROLLESTON.—On February 4th, at Christ Church, Lancaster Gate, W., by the Rev. H. London, M.A., John Arthur Hayward, M.D., elder son of the late John Hayward, of Rushall, Wilts, to Rosamund Grace, younger daughter of the late Professor Rolleston, F.R.S., of Oxford.

## St. Bartholomew's Hospital



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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.

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. BOOBY & 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,

MARCH, 1901.

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

## The Serjeant Surgeons of England and their Office.

By D'ARCY POWER, F.S.A.

THE announcement from the Lord Chamberlain's office, St. James's Palace, dated February 26th, 1901, will be welcomed by all students of the history of surgery in England, and by every alumnus of the ancient Hospital of St. Bartholomew in London. The announcement runs—"The King has been pleased to appoint Joseph, Lord Lister, to be Serjeant Surgeon in Ordinary to His Majesty. The King has also been pleased to appoint Sir William MacCormac, Bart., K.C.V.O., P.R.C.S., and Sir Thomas Smith, Bart., F.R.C.S., to be Honorary Serjeant Surgeons to His Majesty."

Lord Lister was appointed last year to the office of Serjeant Surgeon to Her late Majesty Queen Victoria in succession to Sir James Paget, and the present appointments prove that there is no intention to allow an ancient and interesting office to become obsolete.

The kind permission of the editor and proprietors of *Janus* enables me to reproduce for the readers of the *St. Bartholomew's Hospital Journal* the following notes upon the office, the majority of which appeared in *Janus* last year (vol. iv, 1900, p. 174).

The Serjeant Surgeons ranked above the King's Principal Surgeon, though on several occasions the two offices were held by the same individual. The Serjeant Surgeons were originally military surgeons, whose first duty was to attend the King upon the battle field. John Ranby was the last to perform this duty when he attended George II at the battle of Dettingen in 1743. The first Serjeant Surgeon appears to have been appointed in 1461, but from 1560 to 1891 there were two Serjeant Surgeons, whilst from time to time additional appointments were made with the title of "Serjeant Surgeon Extraordinary," this post usually carrying with it a reversion to the Principal Serjeant Surgency on the next vacancy. Each Serjeant Surgeon received a salary of 40 marks, equivalent to a sum of £26 13s. 4d. per annum, with an allowance of meat and drink, known technically as "a bouge of Court," with wine, wax, and all requisites for carrying out cures. The bouge of Court was a valuable perquisite, for in 1640, at the beginning of "the broken times" of the rebellion in England, Dr. William Harvey, the King's physician, exchanged his diet for an allowance of £200 a year. It is probable that the wax was a perquisite connected with the duty of embalming deceased members of the Royal Family, for Mr. Serjeant Surgeon Knight complains in September, 1662, that "he received the usual fee for embalming the Duke of Gloucester, but is now ordered to divide it with Richard Wiseman, Surgeon in Ordinary. He begs not to be made the only person who has had his fee taken from him." For many years past the salary of the Serjeant Surgeon has been a fixed

payment of £280 a year, though in 1780 each received £396 13s. 4d.

The office carried with it certain well-defined professional privileges. In the United Company of Barbers and Surgeons (1540—1745) the Serjeant Surgeon sat next the last Master of the Company "on the benches where the Master nowe usually doo sitt;" in the Surgeons' Company (1745—1796) the King's Serjeant Surgeon was admitted into the Council and Court of Examiners on the first vacancy, and was looked upon as a Past Master. At the Royal College of Surgeons of England (1800) the first Charter confirmed these rights to the Serjeant Surgeons. The Charter of 1822 enacts that the Serjeant Surgeons shall be elected to the Court of Examiners a lucrative and honourable position—upon the first vacancy, provided that they have been elected already members of the Council. But it provides expressly that the office of Serjeant Surgeon shall give no preference in respect of admission to the Council. The Charter of 1843 confirms these privileges, and it was not until 1852 that they fell into abeyance.

I have recently compiled the following list of Serjeant Surgeons, and it is published in the *British Medical Journal*, vol. 1, 1900, p. 583. It is confessedly incomplete, but as the office was held under a patent for life, the date of death in each case gives the approximate date of the next appointment.

1461. William Hobbes, who is said to be the first Serjeant Surgeon. Thomas Morstede (1415), William Bredewardyne (1416), and John Harwe (1423), the surgeons who attended Henry V in his French campaigns, did not receive this title, but are called simply "Surgeons to the King."
1513. August 6th. Marcellus de la More.
1530. April 29th. Thomas Vicary was granted the office of Serjeant Surgeon "as soon as Marcellus de la More shall die, or resign or forfeit his post." More died or disappeared from England at some time after Easter, 1535, when he received his last payment, and Vicary obtained his first quarter's salary as Serjeant Surgeon on September 20th, 1535. He filled the office under Henry VIII, Edward VI, Mary, and Elizabeth, until his death in 1561. Vicary's connection with St. Bartholomew's Hospital was long and intimate. He was appointed a Governor, says Dr. Norman Moore, his biographer in the *Dictionary of National Biography*, on September 29th, 1548, and was re-appointed yearly till June, 1552, when he was made "one of the assistants of this house for the term of his life." On October 2nd, 1554, it was ordered that he should have the oversight of all such officers as be within the Hospital, in the absence of the Governors. He lived in the

Hospital, where his house was kept in repair by the Governors, and he received an annual grant of livery "of fync new colour" of four yards at twelve shillings a yard. He was superior to the other surgeons of the Hospital, but there is evidence that he lived with them on friendly terms, for in his will he left to one his gown of brown-blue, lined and faced with black budge, a cassock of black satin, his best plaster box, a silver salvatory box, and all his silver instruments; to the other surgeon he left a doublet of crimson satin. He also bequeathed ten shillings apiece to the chaplain, matron, steward, cook, and porter of the Hospital. Somewhat to the detriment of his memory his friends made him pose, after his death, as an anatomist, for they issued in 1577 "*The Englishman's Treasure, with the True Anatomie of Man's Body*, compiled by that excellent Chyrurgion, Mr. Thomas Vicary," of which the Hospital library possesses the ninth edition, issued in 1641.

1562. Richard Ferris, who died in 1566.
1565. Robert Balthrop, Surgeon to Edward VI, and Serjeant Surgeon to Queen Elizabeth. He died December 9th, 1591, and is buried in the Church of St. Bartholomew the Less within St. Bartholomew's Hospital, to which he was surgeon. His tomb on the south wall of the Church just behind the organ is a handsome monument with this inscription, which I copied one day when the organ was temporarily removed for repairs:
- "Here Robert Balthrop lyes intombed, to Elizabeth our Queene,  
Who Sergeant of the Surgeons swote herte  
thirtye yeeres hath bene  
He died at sixty-nine of yeeres December's  
ninth the daye  
The yeere of Grace eight hundred twice deduct-  
inge nine a waye  
Let here his rotten bones repose, till angells  
trompet sounds,  
To wame the world of present chaunge, and  
raise the dead from grounde."
- VIVIT POST FUNERA VIRTUS.
- The shield on the monument is quarterly 1st and 4th argent, on a chevron sable, five fleur de lys of the 1st, 2nd, and 3rd; a bend between two eagles displayed, says Mr. Sidney Young in his '*Annals of the Barber Surgeons*.  
By his will he left to poor people in the discre-  
tion of his executrix, £10. To John Mason,

chirurgian, dwelling in Long Lane, 40s., and a few other small legacies. To my servants, John Deighton, Richard Neill, John Edwards, and William Taylor, 40s. each. To each of his wife's maids 20s.

1591. George Baker, who died in 1604. He quarrelled, we are told, with William Clowes, father of Mr. Serjeant Surgeon Clowes, and to the great scandal of the profession at the time the two opponents so "misused eche other, that they fought in the fields together."
1592. William Gooderus, who attended the wounded in the expedition to the Low Countries under the Earl of Leicester, in 1585.
1603. Gilbert Primrose, who had been surgeon to James I when he was King of Scotland. His son James, a pupil of Riolanus, was one of the most pestilent opponents of Harvey.
1609. Christopher Frederick. He attended an embassy to Spain in 1605, and died in 1623. His son Sir John Frederick was Lord Mayor of London in 1661.
1625. William Clowes the younger was appointed on the accession of Charles I, and died October 30th, 1648.

William Clowes addressed the following letter to the Barber-Surgeons' Company, which sets out the value placed upon the position of Serjeant Surgeon; it is dated 1625, soon after his appointment to the office:

"Right worthis Maister and Governours and Assistants of the Companie of Barbers and Surgions, in my true love I wish you all health and flourishinge government of your company to the glory of God, the honor of the kinge and the good of Gods people, Amen. Now whereas I have bin not only by many Brothers advertised, but also of your officer legally (by letter and otherwise), given to understand that you have chosen me renter warden of the Company from the which election I desired . . . I might be freed yett could not. I then knew well that in Duty I owed you an answer which might well beseme my reverence to your Authoritye, and my tender regarde of the Kinge my Maister's honour . . . and nowe not once questioninge the troublesomenes of the place nor other hindrances which God Almighty did then sende, I this answer (because I will be free of ambition or pride), that if you can make that appear upon your records that any of my predecessors did bare the office of Warden after he was sworne Serjeant Surgeon to any of

the Kings or Queens of England I shall humbly serve it: if not, I must praye your pardon, for I must not see poorly value the Kinge my Master as think him less mighty, less absolute a Prince than any kinge which-soever hath reigned before him. And so as his servant I expect from the Companie as good respect as any serjeant surgion heretofore hath had for my Master's honour. . . . And further because I am many tymes summoned to your Courts and other meetings, which service I am very willinge to performe when I shall knowe my place in the Company which I must leave to your grave consideration only if you please to take notice how the College of Physicians and the Company of Apothecaries of London have ranked the King's physitions and Apothecaries, you may thereby guess what place I expect."

The Court of the Barber-Surgeons' Company decided in consequence of this letter that "whereas he was chosen Renter Warden of this Companie for this yeare ensuinge, which place by reason of this contagious time [an epidemic of the plague—D.A. P.] and other respects he is not able to execute. It is therefore ordered by this Court that he shall be discharged from the said place of youngest warden and seconde warden of this Company. And it is further ordered that he shall take place next unto the youngest of our Assistants that hath served the place of Upper Warden."

1642. [The grant confirmed March, 1660—1.] Richard Pyle who married Catherine Clowes, a niece of Mr. Serjeant-Surgeon Clowes. Pyle was the surgeon in personal attendance upon Prince Charles, afterwards King Charles II, in the West of England Campaign of 1645—6. His place was taken at Jersey by Mr. Richard Wiseman, afterwards Serjeant Surgeon.
1661. Humphry Painter, who had probably been one of the surgeons in ordinary to King Charles I. He died in 1672, and was succeeded in the office by Richard Wiseman.
1661. John Knight was one of those who attended Charles II, on his voyage from the Hague to Dover, at the Restoration in 1660. He was constantly occupied with matters connected with sick and wounded seamen during the Dutch war. He was theretore mainly a naval surgeon, but as the two services were not then separate he also acted from time to time as Surgeon-General to the Army.
1665. Richard Wiseman was appointed Serjeant Surgeon

Extraordinary, and on February 15th, 1670-1, a warrant was issued appointing him Serjeant-Surgeon to the King in place of Humphry Painter, deceased. Wiseman had attended Charles II in his wanderings through France, Flanders, Holland, and Scotland. He was taken prisoner at the battle of Worcester, and was imprisoned for a time at Lambeth. He died in 1676, and is justly considered one of the founders of modern clinical surgery in England.

1687. Thomas Hobbs.

1697. Thomas Gardiner.

1702. Charles Bernard, an illustrious literary surgeon. He collected a valuable library with especial attention to the condition and binding of the books. It was sold by auction after his death in 1711. Swift, writing about it to Stella, says that he had an "itch to lay out some nine or ten pounds for some fine editions of fine authors" at the sale, but "they were in the middle of Physic books, so I bought none, and they are so dear I believe I shall buy none." Bernard's daughter Elizabeth married her father's apprentice, Ambrose Dickens, who succeeded him at Court.

1729. Ambrose Dickens, Surgeon to St. George's Hospital. He died in 1747, and was succeeded by Mr. Cæsar Hawkins.

1729. Claudius Amyand, also Surgeon to St. George's Hospital, who died in 1740. His eldest son was Under Secretary of State in 1750.

1740. John Ranby. He anticipated the use of quinine by showing that bark was more active when it was given with an elixir of vitriol. He died August 28th, 1773, and his tomb, lately restored, is easily seen in the burial ground of the Chelsea pensioners, as one walks up Queen's Road.

1747. (Sir) Cæsar Hawkins, a pupil of John Ranby and the first prominent member of a family which afterwards became illustrious in divinity, physic, and surgery. He was the inventor of the cutting gorget for lithotomy, and is said to have made a thousand pounds a year by phlebotomy alone. He died February 13th, 1786.

Before 1765. David Middleton.

Before 1769. Thomas Gataker, Serjeant Surgeon Extraordinary, the translator of Le Dran's Surgery.

1773. Robert Adair, Surgeon to the Forces at the siege of Quebec. He died in 1790.

Before 1783 but after 1753. Pennell Hawkins, Surgeon to the Middlesex Hospital and brother of Sir Cæsar Hawkins.

1786. Charles Hawkins, son of Sir Cæsar Hawkins, and the first Master, in 1800, of the Royal College of Surgeons in London. He was succeeded by Sir Everard Home.

1790. George Edward Hawkins, son of Pennell Hawkins and nephew of Sir Cæsar Hawkins.

1793. (Sir) David Dundas, a surgeon-apothecary at Richmond, whose appointment gave great umbrage to the London Surgeons.

1808. Sir Everard Home, the pupil and brother-in-law of John Hunter. He died August 31st, 1832.

1826. Sir Patrick Macgregor.

1828. Sir Astley Paston Cooper, the great surgeon who revolutionised the knowledge of his contemporaries about hernia and dislocations. He earned by his profession, in one year, no less than £21,000. He died February 12th, 1841.

1834. Sir Benjamin Collins Brodie, whose chief work was upon the treatment of joint disease and the surgery of breast tumours. He was President of the Royal Society, and died October 21st, 1862.

1837. Robert Keate, Inspector-General of Hospitals and nephew of Thomas Keate the colleague of John Hunter at St. George's Hospital. He died October 2nd, 1857, and with his death was ended the direct connection of the Serjeant-Surgeony with the army.

1857. Benjamin Travers, died March 6th, 1858.

1858. Sir William Lawrence, Surgeon to St. Bartholomew's Hospital, one of the most eloquent speakers and ablest surgeons of his time. He died July 5th, 1867. His son, Sir Trevor Lawrence, is now Treasurer of the Hospital.

1862. Cæsar Henry Hawkins, a grandson of Sir Cæsar Hawkins, who, though a good operator, was always more anxious to teach his pupil how to save a limb than how to remove it. He died July 20th, 1884.

1867. Sir William Fergusson, who died February 10th, 1877.

1877. Sir James Paget, who applied pathology to clinical surgery, and died December 30th, 1899.

1884. Sir Prescott Gardner Hewett, who died January 19th, 1891.

1900. Lord Lister, President of the Royal Society and the reformer of surgical technique.

1901. Sir William MacCormac, Bart., K.C.V.O., P.R.C.S. Eng., Consulting Surgeon to St. Thomas's Hospital.

1901. Sir Thomas Smith, Bart., Consulting Surgeon to St. Bartholomew's Hospital.

1901. Frederick Treves.

### Intermittent Fevers.

A Clinical Lecture delivered on January 18th, 1901, by  
DR. GEE.

(Reported by DR. HORDER.)



INTEND lecturing to-day on intermittent fevers, fevers, because "intermittent fever" has become synonymous with malaria, whereas in England to-day intermittent fevers seldom are malaria. Malaria is practically extinct in England, and the cases met with have been contracted abroad. This, then, is one of my reasons for choosing this subject, to consider what forms of intermittent fever occur in England.

An intermittent fever is one in which once at least in the twenty-four hours the body temperature becomes nearly or quite natural. If the temperature rises once in twenty-four hours the fever is termed quotidian, if once in forty-eight hours tertian, if once in seventy-two hours quartan.

1. *Quotidian intermittent fevers.* The temperature rising once in twenty-four hours, usually rising high, sometimes very high, and then subsiding to normal.

(i) *Malaria.*—When malaria did occur in England this, so far as my memory goes, was the commonest variety of the disease. Bacteriologists tell us that a malarial quotidian is a double tertian or a triple quartan. The ancients knew of double tertians, but they were not prepared to say that all quotidians were of this nature.

(ii) *Abscesses.* There are many kinds of microbes capable of producing pus, but this is a matter outside my subject to-day, which is clinical. I will merely give a few instances where abscesses produced quotidian intermittent fever.

(a) A lady, forty years of age, taken ill in Corsica, was brought home, and was found to be suffering from quotidian intermittent fever. Soon after she reached England I saw her. There was some diarrhoea, but I could find no pus in the stools, nor any local cause for the fever. She was taken ill in a malarial region, and by exclusion the most likely diagnosis seemed malarial fever. I said there was no local cause for the fever, but there are certain parts that are not examined unless attention is specially called to them, and a few days afterwards the nurse drew the doctor's attention to a swelling near the anus. This turned out to be an ischio-rectal abscess; it was opened, and the patient recovered rapidly.

(b) A man, aged seventy-four years, had suffered from ague-like attacks for nearly four years. When I saw him he had had these attacks daily for three days. More closely observed they were seen not to be regular like ague. The temperature sometimes reached 106° or 107°. There was considerable tenderness in the right hypochondrium, but never any pain there. There had never been jaundice. On account of the tenderness we thought of gall-stones, but there was no evidence in that direction. In two or three weeks he died of gradual exhaustion. Post mortem

we found that he had been suffering from gall-stones, which had ulcerated through into the liver, forming an abscess in which were a few of the stones.

(c) Hepatic intermitting fever is a condition closely allied to that in (b). It is due to inflammation of the bile-ducts. Any disease like gall-stones, or cancer of the head of the pancreas, causing stagnation of bile in the ducts, may lead to this hepatic intermitting fever, the ducts becoming infected from the duodenum, probably most often by the *B. coli communis*. The fever is due to a chronic inflammation—suppuration—of the ducts. It may be associated with abscess of the liver, but not necessarily.

(d) A gentleman, aged fifty-seven years, living at Chingford, had intermittent fever, which was said to be more or less of a tertian type. There is no ague at Chingford, nor in Essex either, so far as I know; but Essex has a bad character for ague. The patient seemed very much worse than ague would account for. Moreover, the doctor said that thorough treatment with quinine had been tried without benefit. There was much vomiting and pain in the belly, but careful examination failed to discover anything in the abdomen. There had never been any jaundice, or any other signs of gall-stones. One month afterwards he died, nothing definite having occurred. Post mortem an abscess was found in the pancreas containing four ounces of thick stinking pus, but no concretion. The spleen was not enlarged, and no cause was found for the abscess.

(e) The foregoing have been rare cases, but commoner diseases may produce the same effect:—empyema, which it is not always possible to find, and subdiaphragmatic abscess, which may be more difficult still. Before leaving this group of causes of intermittent fever I will mention one other case which is of interest.

(f) A gentleman, unknown to any one save himself, was addicted to morphia injections, and used very large quantities of the drug. He went to stay with a sister who lived in Essex. While there he developed a quotidian intermittent fever. The doctor naturally thought it was malaria, and accordingly treated it with quinine, but without the slightest benefit. One day the sister discovered the whole thing, and when he came to see me I found the patient's legs in an extraordinary state; the skin was ready to slough over the whole of both of them, and the patient told me that it was sometimes half an hour before he could find a tolerably healthy spot in which to make the injection. His condition was due to the use of a dirty syringe. It was a new experience to me, so I looked it up, and I found a few similar instances on record where the use of a dirty syringe had led to small abscesses, and these to a fever like a quotidian ague.

(iii) *Ulcerating endocarditis.*—This is very important and not very uncommon; and if no murmur can be discovered the diagnosis is impossible. I will give you an instance, a patient who was in hospital. He was twenty-six years of

age, and had had syphilis eighteen months before admission, which was probably the starting-point of his complaint. One month before admission shivering fits began, and occurred twice a day, accompanied by vomiting. The fever was remarkable—a duplicate quotidian the ancients would have called it—and each paroxysm went through three stages, just like malaria; shivering, heat, and sweating. The temperature often rose to 105° or 106°, and then became normal. The morning paroxysm began at 1 to 2 a.m. and ended at noon; the evening paroxysm at 1 to 2 p.m. and ended at midnight. The intervals free from fever were therefore very short. This state of things continued with great regularity until two or three weeks after admission. On admission the first sound at the apex was murmurish only, but it developed afterwards into a distinct but not loud systolic murmur. The spleen was found to be enlarged. Death took place at the end of two weeks from gradual exhaustion. Quinine, arsenic, phenazone, had all been tried without effect. Post mortem, there was a small aneurysm through the large tongue of the mitral valve which had burst; the edges of the rupture were fringed with long vegetations which projected into the auricle. The spleen was large and soft, but there were no infarcts in it or any other organ.

(iv) *Cerebro-spinal meningitis*.—Quotidian intermittence is the commonest form of fever. And this is easy to understand, when it is remembered that the disease is accompanied by suppuration of the pia mater. So this, again, is a pyogenic (as well as a pyrogenic) disease.

(v) *Tubercular phthisis of the lungs*.—If discovered the fever is easily enough understood, but it is not always discovered, or discoverable, and then one is at a loss to explain the fever.

(vi) *Lymphadenoma*.—There is a boy in the hospital at the present moment illustrating this: he has a quotidian intermittent fever. The condition is not uncommon.

(vii) *Syphilis*.—See a paper in the Clinical Society's 'Transactions,' which is the report of a Committee appointed to investigate the matter.\* The condition is usually associated in syphilis with periostitis or rheumatoid symptoms.

(viii) *Typhoid fever*.—Sometimes the fever is a quotidian intermittent throughout, the temperature falling to normal every day. This is unusual, but a fact.

(ix) *Pneumonia*.—Here also the fever may be a quotidian intermittent, as shown by this chart. And other evidence could be adduced if needed.

(x) *Broncho-pneumonia*.—The same remarks apply to this disease also.

2. *Tertian intermittent fever*.—So far as we know the only cause of this is malaria. The case of pancreatic abscess was said to be of this kind, but not from my

\* Vol. iii, p. 170.

own observation. If we counted it as such, suppuration may be a cause of a tertian intermittent; but excepting this the only cause is malaria.

3. *Quartan intermittent fevers*.—A remarkable case now in Hope led me to give this lecture.

A woman *æt.* 33 years, married. On November 10th of last year she was seized with cold shivers, then pains in the limbs and back, which settled in the legs. The ankles, knees, and calves of the legs suffered most. The patient vomited, and was constipated. The pains kept flitting about. On November 13th she sweated profusely. Her appetite was lost.

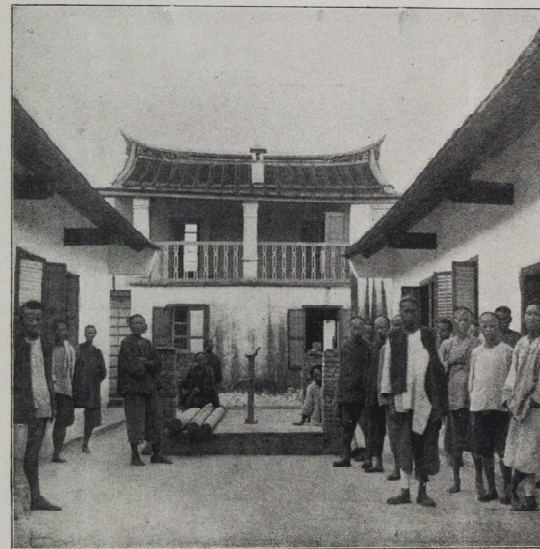
On admission there was much pain in the limbs, the skin was quite moist; some herpes on the lips. Both knee-joints were swollen, and there was effusion into them; the left elbow was also very painful. The patient herself thought her complaint was rheumatism, and we ourselves at first thought her suffering from rheumatic fever, and accordingly treated her with sodium salicylate, but without the slightest effect. There was no reason for believing the disease to be syphilis. Ten days after admission the note reads that "the fever has been of the intermittent type, sometimes tertian, but more often quartan." The possibility of suppuration was considered; also of malaria. So we examined the blood for malarial parasites on two occasions, and also drew off a fair quantity, and had this cultivated for pyogenic germs—*streptococci*, *B. coli*, etc. Both results were negative, so bacteriology afforded us no help. We made careful examinations *per vaginam* and *per rectum*,—equally negative. We left off the sodium salicylate and gave quinine, and when the quartan character of the fever became so marked, we treated the case as malaria, and gave big doses of quinine shortly before the attacks: ten grains and fifteen grains in single doses, but without the slightest effect. Then, as a sort of haphazard drug, we tried antipyrin. The quartan fever continued so markedly, that we could not get the notion of malaria out of our minds, so we determined to give arsenic,—for next to quinine arsenic is the best remedy in ague; it often cures when quinine does not. We gave as much arsenic as the patient could bear, ten minims of Fowler's solution three times a day for a week, and no longer; for if at the end of a week the drug has done no good, it is of no use continuing it. We did, indeed, in a week slightly poison the patient with the arsenic. For on January 1st the note says, "Patient has vomited, had pains in the bones, and has a regular arsenical tongue—silvery." So the patient was fully under the influence of the drug. And when that occurred, with a good deal of prostration of strength, the fever ceased, and from then till now (three weeks) there has not been any. I have not a moment's doubt that, whether the disease was malaria or not, the arsenic cured her. Now what was the nature of her complaint? I am doubtful, but in favour of regarding it as malaria. I do not

know any other quartan fever—a paroxysm once in seventy-two hours—than malaria. Then it was cured by arsenic, and I do not know any other intermittent fever save malaria that is cured by arsenic. Against the notion of malaria is the fact that the patient is not known to have been exposed to the malarial poison; she had only left London once, for Southend, some years ago. So she must have contracted the malaria, if the disease was this, in London. Then, again, no parasites were found in the laboratory. So there are points both for and against malaria. I myself have no very positive opinion, except that I should refuse to put

stand that to commence with, a hospital here does not roll in wealth, and everything has to be done on the most strictly economical lines.

The hospital I am about to describe is in the city of Chang-poo, an ancient city of about 16,000 inhabitants, surrounded by a fine old wall, rather resembling the walls of the city of York, only kept in very bad repair. The hospital has to supply all the needs of the city, and very many surrounding villages; in fact, there is no other Western medical man between here and Amoy, a distance of some fifty miles. The Chinese native doctors have no idea of surgery whatever, nor even have they any good system of empirical medicine.

Crossing the street from the mission compound, a street swarming with dogs and pigs, we enter the door of the hospital, and pass on the right the porter's lodge, where the hospital coolies live. Then through another door on the left we enter the hospital chapel, where a morning service precedes the work of the day; here the people listen with wonderful attention as the native hospital preacher



Chinese Mission Hospital, Changpoo.

the notion of malaria aside, on account of the reasons I have given you. The patient is now quite well.

### A Visit to a Chinese Hospital.

By J. L. MAXWELL, M.D.



CHINESE mission hospital is in every way so unlike what we are used at Bart.'s to think of as a hospital, that a short description of one out here may be not without interest. The hospital which my little sketch refers to is the one of which my brother now has charge, and is decidedly above the average of mission hospitals. Of course, you will under-

stands the morning worship. Owing to the Chinese customs, the chapel has to be divided into two halves by a longitudinally placed screen to keep the women separated from the men. The service over, the work of the day begins; the women troop off into an adjoining room, while the coolies supply the men with tickets in the order of their arrival. As every one in China talks at the top of his voice, the noise, even with the much fewer patients, is worse than the "surgery," even when uncontrolled by Sister. An average outpatient day here means from 100 to 200 patients.

Now leaving the chapel, we enter the front square of the hospital; straight in front of us is the consulting room and surgery, and the dispensary; on our right are the rooms occupied by the native students, to which even the Bart.'s quarters would seem luxurious; to the left are more students' rooms and store-rooms. Passing between these and the dispensary we enter the back square, and are now in the middle of the hospital. On each side is a large male ward holding some sixteen beds; further round on the left-hand side are a number of smaller rooms, each with two or three beds in

them; behind us, over the dispensary and surgery, is the operating theatre, and another small ward where very serious operation cases can be put. In the middle of the square is the well, and from a little way beyond this our picture has been taken. It shows the large wards on each side, and the operating theatre facing you, with the other places below. Beyond the wards are one or two more students' rooms, and on the right the kitchen; as rice is almost the only eatable commonly cooked, the kitchen arrangements are not very complicated. Altogether, however, the subsidiary work entails a good deal on the doctor, who, in addition to having to combine physician, surgeon, and gynaecologist, has to do the duties of steward, secretary, and treasurer as well. From the male part of the hospital we pass through a small door into the female part. This is a sort of repetition on a smaller scale; there is one large and several smaller wards, a room which is used as an operating theatre, and another well and kitchen. Over the female side there

medical cases malarial fever is the most common complaint, and here comes in a serious difficulty with regard to history. There is in the Chinese demology a special demon whose duty it is to administer attacks of fever; in getting the history this gives rise to one of two difficulties: either in order not to attract the fever demon the patient will refuse to answer any questions on the subject at all; or else, to assure the demon that he has already suffered enough from him, he will multiply the number of his attacks to an absurd amount. Thus a woman told my brother that in four days since she had been at the hospital before she had suffered from *visu* attacks of ague; she was suffering from quartan fever. Another difficulty in the surgical line is that a man having made up his mind that he wants an operation done, and that the foreign doctor can do it, will deliberately hide to the utmost of his power any previous illness that might make operating inadvisable. Especially is this the case with regard to opium smoking, as no surgeon will do any serious operation

is a Chinese woman as matron, who generally looks after the women, but can hardly be said to nurse them. As you see, I have said nothing about nurses, because they do not exist here; their place is filled by the relations of the patient, who attend, or rather neglect him while he remains in hospital.

Now we have just taken a run round the buildings I would ask you to accompany me to the more medical part. Out-patient days are twice a week, and on one of these days we will go into the surgery; here the patients troop in one after the other to be seen, each student taking so many, and dispensing their prescriptions afterwards. I suppose of surgical cases the ulcers predominate,—ulcers everywhere, from the head to the feet there appears to be no place where the Chinaman may not get a huge ulcer. Syphilitic ones are very common, for syphilis appears to be well-nigh universal, but many of them are non-specific, or at least not caused by any germ known to us to be specific. I am inclined to think that the bacteriology of ulcers at home would not cover all out here. Of

he can possibly avoid on an opium smoker; their tissues heal badly, and their general vitality is very greatly depressed. But we must not linger here too long, we will go and see what is going on in the other part of the hospital. The inner square presents a most quaint appearance; round the square, sitting on the ground, are the in-patients who are suffering from ulcers; they have unbandaged their various sores, and are admiring them, and waiting their turn to be dressed. In their centre is a large irrigator, holding about two gallons of 1 in 4000 Hyd. Perchlor. solution, and a large tub under standing over or in the tub for the purpose; then he retires again and has them dressed. Not only ulcers, but such wounds as fistula cases, which have been operated on, are dressed in this way, there being no suggestion of false modesty in a Chinaman's mind.

But now the twelve o'clock bell rings for dinner, and we will accompany the men into one of the large wards; the beds we notice are simply iron frames, on to which fit wooden boards, and a thin

mat is thrown over these for lying on. This method has the double advantage of cheapness and the ease of destroying everything after an infectious case or if infested with vermin—a not very rare condition in China. The natives do not indulge in anything so unnecessary as night clothing, being usually content with the one set of garments they always wear, the exact anatomy of which I do not yet profess to have mastered. They have, however, one large quilt, which is quite enough as additional clothing during the night. Discipline, in our sense of the word, is not practised in the wards, the only prohibited articles being private cooking dishes, small hand charcoal stoves, and opium pipes, the latter being seized and destroyed if discovered. A fair amount of discipline, however, is enforced by a system of fines for striking infringements of the rules, this touching the Chinaman at the most tender point. No attempt is made to prevent their smoking tobacco, which is freely done with their long bamboo pipes. Each patient pays sixty cash a day, about 1½d., for his food; this provides him with three good meals of rice, and if he can afford it he may purchase little additional condiments from a boy who comes round at meal times selling these. The only part of the hospital that would remind one of home work is the operating theatre; this is, as far as the means will allow, done up in European style; though of necessity a wooden structure, its appliances in the way of a good table and aseptic instrument tables, and a very fair assortment of instruments, are all up to date, and would compare favourably with many small hospitals at home. You might well think that under such difficult circumstances much major surgery could not be done, but it is wonderful how one can suit one's self to circumstances. Only the other day I was assisting my brother with a case that would attract a large crowd even at Bart's. It was a case of fracture dislocation of the humerus, the fracture being an impacted one of the head; operation was rendered imperative, as the man was suffering from pressure on the posterior cord, leading to wrist-drop, etc.; all attempts to reduce the dislocation having failed, my brother cut down on the head, and being still unable to replace it, excised the head. The man healed by first intention, and was getting excellent movement back when he decamped about twelve days after the operation; this is always a difficulty with the surgical cases, as they never see the force of staying in after a wound has healed; however, the man lives in a village on the road to the coast, and we shall no doubt hear further some day of his progress.

There is only one thing more that I have to tell of interest; I think you will like to hear something of the expenses of a hospital like this. The house surgeon receives the magnificent sum of \$5 a month, the matron \$2 a month, the preacher \$7 a month, the hospital servants, viz. three coolies and a cook, \$4 each a month, making in all \$360, or about £36 a year. Heat, lighting, and sundries come to about £22 a year, and drugs to about £100, thus making the whole working expenses not much more than £150 a year. The work, of course, is arduous, but is more than repaid by the amount of good that one sees resulting, appealing as a form of Christian kindness to the native mind in a way that nothing else can.

### A Chapter of Mistakes.

By G. P.



VENTURE to confess in penitence and sorrow to these mistakes, thinking they may help others to avoid what I have done. Each has made me wiser.

A. P.—, threatened abortion; exhausting hæmorrhage. To hasten matters I introduced a tent smeared with carbolic acid and glycerine, *equal parts!* I thought I was using 1 in 40. Considerable sloughing ensued before I discovered the mistake six hours afterwards. Abortion occurred with great pain. Six months afterwards nothing abnormal *p. v.*

J. D.—, aged 31, death certificate of acute yellow atrophy. Three days afterwards a brother brought me some phos-

phorus rat paste, asking me if she could have taken any. She died with convulsions six days from onset of symptoms. She had had much family trouble; her urine contained no leucin and tyrosin. I decided to let the matter drop.

E. T.— was about to be sent to hospital for operation on ovarian cyst. My diagnosis had been confirmed by another surgeon of repute. Suddenly she discharged one and a half gallons of clear fluid and two small foetuses.

E. R.—, aged 35, had had his hydrocele tapped many times by me. One day I was called in a hurry to tap it again because of much pain. I tapped the swelling, which this time was bowel (strangulated). I operated without, of course, trying taxis, and was very glad I had not.

T. A.—, aged 35, pernicious anæmia. Arsenic had reached 3ij daily, when he complained of tingling of hands. Arsenic was at once withdrawn, but peripheral neuritic signs persisted and increased, and caused death.

J. C. B.—, aged 55, chronic interstitial nephritis, the husband of a most fussy, wolf-crying wife who had thoroughly wearied me for two years. One day he felt somewhat giddy, and half dozed in an upright position for two hours from 11 a.m. I suggested sleepiness due to some dyspepsia he had. He quite recovered except for the presence of small, badly-to-light-reacting pupils. Next morning he suddenly became unconscious, and died in three hours comatose with much mucous rattling. I should have sent him to bed, given him saline purgative and a bromide mixture, and the lightest of diets. But I didn't.

F. A. C.—, aged 9, boy with chronic enlarged tonsils. I showed annoyance that mother would not let me excise them. She was about to try "another doctor," when I tried Pig. Acid. Tannic and glycerine and Ol. Morrhuæ. In two months they were normal and are so still (one year afterwards).

J. H.—, aged 11, a somewhat similar case. "Another doctor" had said, "No cure for the adenoids but operation." I gave Ol. Morrhuæ and a post-nasal spray, and an iodine vapour to inhale and valsalva. Deafness had gone, and appearance had much improved. But in two years they relapsed. Operation was asked for and I operated, but deafness shows signs of persistence. I ought not to have waited.

S. B.—, aged 71, melancholia. I said he would get worse unless "removed." This caused much distress and dislike to me. In six weeks with careful home treatment he improved considerably, and was easily managed.

G. L.—, aged 13. In influenza times I heard fine *râles* at left apex for six weeks. Told friends I thought (which I did) she had some chronic bronchitis, and a consultant, tuberculosis. Consultant agreed with me, and I told friends I had thought so too. After lots of anxiety and preparations for "going away," etc., and a few more bottles of a simple mixture, she got completely well. Consultant saw her again and said, "No tuberculosis." If I had only

stuck to my own judgment there would have been no anxiety, and my reputation would have improved.

J. M.—, aged 40, had a mitral systolic murmur, debility, and night sweats, without history or evidence of rheumatic fever. For some weeks I wondered what was wrong, and neglected to take the evening temperature. When I did the case was clearly ulcerative endocarditis. I ought to have thought of this before.

P. M.—, aged 14, had to stay at school for his holidays, and would not cat. I agreed with diagnosis of "homesickness;" but he couldn't eat, and had diphtheria.

A. C.—, aged 14, a schoolgirl with H. + 3 D. Both eyes ached badly in spite of the fact that glasses she was wearing were quite correct, and had been ordered by a specialist. Four weeks before she had been knocked down. After much waste of time I discovered both glasses had been centrally scratched. With new but similar glasses her symptoms disappeared.

J. S.—, aged 19, exophthalmic goitre and nervous symptoms. He had one brother an idiot, another epileptic, and his father had had melancholia; his mother was a neurotic. In inculcating care and a "change" I made this summary of his family history. I am not now the family doctor.

C. H.— had fecal vomiting and constipation for six days. No history of previous constipation. A dull swelling in left iliac fossa and distended belly. I prognosed death unless he underwent abdominal section. He refused. I got administered Enema Glycerini 5x (enemata, soap and water, etc., had been tried before) with the greatest success imaginable.

### Three Cases of Myxœdema of Varied Type.

By WILLIAM WYLLYS, M.R.C.S. Eng., L.R.C.P., and L.S.A. Lond.

**T**HE following three cases of myxœdema, which have come under my care in general practice during the last seven years, are of so varied a character, and ran such different courses, that a description of them may prove of interest, and possibly of some assistance to the diagnostician, from the insidious nature of the onset of the disease.

*Case A.*—A woman of about sixty years was first seen by my senior partner one night in response to a message, on account of very obstinate constipation combined with a curious alteration in her manner, and low state, causing her relatives some alarm. I saw her three days later, when I made this note:—"Pulse weak and slow, eyes puffy, body swollen, headache, bowels not open, hands stated to feel numb, mind deranged, urine to be tested."

I had not made up my mind what was the matter with my patient, though I was partly on the track. My partner, seeing her next day, made this note:—"Has a myxœdematous look, with slow speech, thickened features, etc.," with which I entirely agreed, and a correct diagnosis having been attained started to give patient thyroidin tablets, gr. v, three times a day. By this time, however, she had become so unmanageable, and suffered with so many delusions and hallucinations, that very few were taken.

Her powers of deglutition, too, were so involved that she could and would take but very little nourishment.

Respiration, except during paroxysms of mental excitement, was

slow and shallow. She became very suspicious at times, and at others extremely dull; on one occasion, during a bout of mental instability, she nailed the doors up in her house, and then stood still in the middle of her room for one and a half hours, not speaking, then broke into a hymn, finally falling down, though she did not become unconscious. Her skin was generally thickened, harsh and dry, and in places parchment-like, hands markedly so, and of a deep red tint. She was troubled much with flatulence and intractable constipation; there was marked proliferation of skin about nose, which desquamated freely.

Six weeks from first being seen she was so widely maniacal that her removal to the lunatic ward of the workhouse infirmary had to be effected, where she died about ten days later with acute mania.

Her family history was of moment, as both her father and brother died of "dropsy," and according to relations were affected much like my patient. Her eldest daughter died with "dropsy and mortification."

*Case B.*—Mrs. H.—, aged forty-five years, sent for me one morning at two o'clock, on account of an attack of diarrhœa with sickness, presumably caused by having taken the day before saunas, shrimps, and plaice (she was down for a holiday at Yarmouth, which may account for this curious dietary); her pulse was 78, temperature 97°, hands and feet very cold.

An effervescent mixture, with pills of calomel and opium, gr. ʒ of each, were given, and the intestinal symptoms abated, though her exhausted condition caused me some uneasiness. Her apathy and disinclination to get up when her condition improved aroused my suspicions, and with a history of a "sensation of closing up in her throat after talking," I thought neurosis was the fault.

For the next few days her temperature was 98° morning and evening, and pulse rate ranged between 60 and 68, of low tension and volume.

She complained that for the last twelve months she had easily tired, felt languid, and had repeatedly suffered from aching pains in her legs, and that she had noticed the skin of her face and hands had assumed a yellow tint, that her face had become puffy, and teeth and hair had fallen out, also that skin on legs had got rough.

She had suffered from menorrhagia, leucorrhœa, and chronic diarrhœa for some months; her speech was of a measured type, and her movements slow. With these symptoms and signs I deemed a diagnosis of myxœdema logical, and accordingly prescribed tabloid thyroidin gr. v, one night and morning, with the effect of which she was delighted, stating "that they make her feel much better," and asked me to write to her usual medical attendant saying what they were, and what I considered her complaint to be, so that she could go on with the treatment on her return home. I regret to say I did not examine the urine. A few days later she had to return home though still feeling very weak, and I shortly received a letter from her medical adviser saying that he quite concurred in the view I took of the case, and should proceed with the thyroid treatment.

The insidious nature of the disease and the very slight alteration in her stage from month to month no doubt made a correct conception of her malady very difficult, especially as I believe she had never been acutely ill enough to be confined to bed and have a thorough overhaul made; but viewed as it were with fresh eyes, and from a new standpoint, after a depressing attack which accentuated the mental apathy and nervo-muscular debility, a diagnosis of her malady was not so difficult a matter.

*Case C.*—A married woman, mother of many children, aged fifty-two years, with a history of having been "an ailing woman for two years," was visited professionally on account of an attack of sickness accompanied by loss of appetite and insomnia; her aspect was renal, her feet were œdematous, and a faint systolic murmur could be heard at base of heart; the urine acid, sp. gr. 1030, contained no albumen; urates were present.

Although resting in bed on a low diet vomiting persisted, and in a few days marked stupor became evident, and the case for a time looked as if it might be of cerebral origin; the urine was again tested with negative results so far as albumen was concerned, patient became weak, short-breathed, and apathetic; her breath was very loaded, bowels very constive, and tongue thickly furred, flabby, and large; the lips also looked full and livid, and face decidedly puffy. Increasing signs of mental failure, the chief being loss of memory, stupor, and giddiness, with melancholia, which had persisted for two months, falling out of hair, associated with bruit about aorta, pointed to syphilis as a cause, and Pot. lod. was tried, but without avail. The probability of myxœdema being the *fons et origo mali* next suggested itself, and thyroidin tablets were accordingly prescribed twice a day, with the result that in three days' time an

obvious change for the better had set in, the patient in her own words saying "she did not feel so dull," she began to sleep better than for weeks, and was more inclined for conversation, and looked decidedly better. The thyroid gland was felt far, but could not be made out. The dose of thyroidin was gradually increased (patient for first few weeks being kept in bed) from two to four tablets a day, and saline aperients given; and this line of treatment was persisted in for six months, the patient eventually being able to walk up to my house to see me, in very fair health and spirits, though inclined to shortness of breath and aching of legs. Her pulse had become of good volume and tension, the œdema of feet had disappeared, and her face and lips were but very little swollen. During the latter part of my attendance the dose of thyroid was reduced to two tablets a day, but for some long time she could not get on without less, beginning to feel faint directly she discontinued them.

The instructive points in this case from a diagnostic standpoint I consider—

1. Its resemblance to Bright's disease.
2. Symptoms pointing to brain disease.
3. Signs of atheroma.

Yet the real condition was myxœdema, which had existed for two years, as the result of six months of thyroid treatment clearly showed.

I have seen the patient again this week; it is now one year since she has taken any tablets, and found legs swollen, face puffy, with dyspœna and disinclination for mental effort, indicating clearly the re-administration of thyroid.

The sloppiness of conjunctivæ as seen in Bright's disease, but with absence of albumen in urine, referred to by Chapman as a frequent sign of myxœdema (see *Med. Rec.*, October 21st, 1899), was easily demonstrated.

### A Case of Poisoning by Dichromate of Potash.

By E. WETHERED, M.R.C.S., L.R.C.P.



**P.** et. 37, a strong muscular warehouseman, came up to the surgery on February 6th, with a history of having drunk ʒij to iv of saturated solution of dichromate of potash in 1 to 20 sulphuric acid, in mistake for beer, at 9.30 a.m. He immediately took some salt and water on finding out his mistake, and vomited. While in the surgery he again vomited some yellow fluid. He was immediately washed out (at 10.30 a.m.) and admitted to the surgery ward. He complained of having felt a burning sensation in his stomach immediately after having drunk the dichromate, which was relieved by vomiting. On admission he appeared perfectly well, and his pulse was steady and of good volume and tension. There were no signs in the mouth of having drunk poison. During the afternoon he complained of feeling cold, and his colour became paler and his pulse rather feeble. He slept well at night, and drank freely of milk. In the early morning his temperature rose to 104°, and he was somewhat restless, but complained of nothing. On the morning of the 7th his temperature had dropped to 101.8° but his pulse was extremely small and feeble.

He was then removed to Mark ward. His face was then somewhat flushed. His tongue rather dry and red at tip; no discoloration or charring of mouth. He complained of nothing. Looked and said he felt perfectly well.

His temperature was 101.8°, and his pulse 128, very small and feeble; regular, not running, each beat being distinct. *Respiration*, 32, quite easy. *Lungs*, normal. *Heart*, A, B, not felt; C, D, natural. *Sounds*, clear but feeble. *Abdomen*, soft, not full. No tenderness.

His bowels were opened twice in surgery and four times in Mark ward. They were small liquid light brown and rather offensive stools. As the afternoon went on he became rather languid and lethargic but talked cheerfully to his friends. Complained now and then of coldness of hands and feet, and colour became rather paler. Later on he became rather drowsy.

At 4.0 p.m. he sat up in bed to take his tea, but was immediately made to lie down again. At 5.30 p.m. he became more drowsy and his respiration more hurried, and his pulse, which had been getting more feeble, was scarcely perceptible. He continued in much the same condition until 7.30 p.m., when the nurse heard him suddenly begin to breathe rapidly and noisily. He was then found to be comatose

with stertorous breathing, and died in a few minutes. He had just before been talking to his friends. Up to nearly the end he was remarkably well, greatly out of proportion to the state of his pulse, only feeling a little languid and drowsy.

He complained of no pain, was in no distress, and only had slight irritation of the bowels; no vomiting after admission; was thirsty and took well.

His treatment consisted of milk diet, brandy, and ʒjss of strychnine. P. M. No signs of irritation were found in alimentary canal, except some loss of surface of epithelium in upper and lower one third of œsophagus; no staining; a few spots of hæmorrhage into mucus membrane of stomach, and some congestion of duodenum.

*Heart*.—Valves natural. Tricuspid orifice dilated. Right side dilated and full of blood. Heart muscle pale and rather soft; no fatty striation; weight, thirteen ounces.

Death therefore seems to have been due to the depressing effect of the potassium salt absorbed during the short time it was in the stomach, and perhaps accelerated by a slightly fatty heart, and differs somewhat from cases already on record, where death was due to gastro-intestinal irritation and collapse.

### Notes.

SIR THOMAS SMITH, Bart., F.R.C.S., has been appointed Honorary Serjeant-Surgeon to the King.

\* \* \*

MR. W. T. HOLMES SPICER, F.R.C.S., has been elected to the post of Ophthalmic Surgeon rendered vacant by the death of Mr. Vernon. We congratulate him and the Hospital on the appointment. Mr. Holmes Spicer has held the offices of House Surgeon and Ophthalmic House Surgeon at Bart's, and was formerly President of the Abernethian Society. He also holds, among others, the appointments of Surgeon to the Royal London (Moorfields) Ophthalmic Hospital, and Ophthalmic Surgeon to the Metropolitan Hospital, and has of recent years, on several occasions, done duty for the late Mr. Vernon at Out-patients when the latter was absent on his holidays.

\* \* \*

SIR THOMAS LAUDER BRUNTON, M.D., F.R.S., has resigned the Lectureship of Materia Medica, Pharmacology, and Therapeutics to the Hospital.

\* \* \*

DR. T. H. THURFIELD has been appointed Casualty Physician *vice* Dr. Horder.

\* \* \*

DR. HORTON SMITH has been re-appointed Junior Demonstrator of Materia Medica and Practical Pharmacy.

\* \* \*

DR. BAINBRIDGE and MR. G. E. GASK have been appointed Junior Demonstrators of Pathology.

\* \* \*

DR. H. D. ROBINSON has been appointed Assistant Obstetric Physician to the Westminster Hospital.

\* \* \*

DR. MORRISON has been appointed Physician-Accoucheur to the Farringdon General Dispensary and Lying-in Charity.

Mr. A. WILLETT, F.R.C.S. has resigned the office of Treasurer to the Abernethian Society, a position which he has filled for many years to the inestimable advantage of the Society.

So the Fates have spoken, and the Abernethian Society is to countenance smoking at its meetings. Even thus are revolutions wrought, at first a still small voice easily silenced by the vote of the majority; then, maybe years after, the still, but no longer small voice gathers force and becomes "Public Opinion"; and mindful of the encouragement its early efforts met with, relentlessly stifles (*absit omen*) the non-smoking minority.

The School Committee, to whom the Abernethian Society are indebted for the loan of the Reading Room, while allowing smoking at the meetings, stipulated that this should not be taken as a permission for smoking in the said room at any other times; it is to be hoped that members will respect this prohibition and not jeopardise the liberty now enjoyed at Abernethian Meetings, by disregarding the rules in this particular.

THE Sale of Papers from the Reading Room is announced for Wednesday, April 3rd; we had intended giving a summary of the average prices reached on these occasions, but on investigation refrained, for fear of injuring the reputations of the publications concerned.

THE following sisters and nurses have left the Hospital for South Africa.—Sister Sitwell (Miss Beadmore Smith), Sister Rahere (Miss Calverley), the late Sister Elizabeth (Miss Dauney), and Nurse Chadbourne.

WE trust that our respected Librarian, Mr. Madden, will shortly be able to resume his duties, and that reading will again become a possibility in the library. It has been justly said that silence is an acquired characteristic, which does not appear to be transmitted either hereditarily or otherwise.

THE *Harvey Prize of Practical Physiology* has been awarded to K. S. Wise. Certificates have been awarded to T. J. Faulder and H. M. Wilson.

THE *Hichen's Prize* has been awarded to T. H. Harker.

THE *Treasurer's Prize in Practical Anatomy* has been awarded to F. B. Ambler. Certificates have been awarded to E. H. Shaw, B. E. Moss, R. H. Bott, C. B. D. Dutcher, W. G. Ball, J. C. Mead.

THE *Foster Prize in Practical Anatomy* has been awarded to T. J. Faulder. Certificates have been awarded to K. S. Wise, W. H. Hamilton, H. Beckton, C. E. Denton, S. M. Lawrence, J. Morris.

WE draw attention to the alteration in the date for the Brackenbury Scholarships, which will begin on May 13th instead of May 3rd, as announced in the Calendar.

WE regret that in our last issue we omitted to acknowledge our indebtedness to the *Lancet* for the loan of the block from which Mr. Vernon's portrait was reproduced, the photograph being by Bradshaw of Newgate Street, to whom we also express our thanks.

WE regret that by an error Dr. J. P. Maxwell was in the November number stated to have changed his address. It should have been Dr. J. L. Maxwell. He has gone to the E. P. Mission, Tainantoo, Formosa, *via* Hong-Kong. His brother is still at Amoy, China.

### Amalgamated Clubs.

#### ASSOCIATION FOOTBALL CLUB.

##### MIDDLESEX HOSPITAL v. ST. BART'S.

This match in the Second Round of the Inter-Hospital Cup was played on Tuesday, February 5th, at Mill Hill Park, and resulted in a win for Bart.'s by 3 goals to *nil*.

The ground was in very bad condition, and in the first half Bart.'s had all the play, and scored twice by means of O'Brien. About ten minutes after the kick-off Bart.'s had the misfortune to lose Lister, who was hurt, and had to retire for the rest of the game.

In the second half Bart.'s scored again through Ward; this being the extent of the scoring, Bart.'s won a scrambling and not very exciting game as above stated. Team:

J. P. Griffin (goal); I. Orton, W. S. Nealer (backs); G. W. Miller, V. C. Upton, F. Gröne (halves); G. Ranking, R. C. Berryman, C. O'Brien, V. G. Ward, and F. S. Lister (forwards).

##### REIGATE v. ST. BART'S.

Played at Reigate on Saturday, the 23rd, in very fine weather, and resulted in a draw of 4 goals all.

The game was fast and exciting, each side scoring 1 goal in the first half, Bart.'s goal being scored by Ward after a very good run.

In the second half the game was, if anything, faster, and again each side scored 3 goals, the goals for the Hospital being got by O'Brien, chiefly as the result of their fourth goal, and so pulled the match out of the fire, and terminated what must be acknowledged to have been the best game we have had this season. St. Bart.'s goaler Butcher was in capital form, and saved some beauties.

Team:  
H. H. Butcher (goal); I. Orton, W. S. Nealer (backs); G. W. Miller, H. B. Scott, J. R. Lloyd (halves); N. E. Waterfield, H. N. Marrett, C. O'Brien, V. G. Ward, and F. Gröne (forwards).

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

##### Semi-Final of Inter-Hospital Cup.

This match was played at Chiswick on Tuesday, March 5th, in wet and windy weather, and in the end Guy's qualified to meet St. Mary's in the Final at Queen's Club. There were very few spectators present, which might be accounted for by the unpleasant state of the weather.

It was not a great game, for, although the play was always interesting, Guy's were always the superior side, and after leading by 2 goals at the interval, won very easily by 5 goals to love. For the losers, O'Brien played a capital game, but otherwise he was only poorly supported.

In the opening half T. F. Wilson and Baber both scored goals, and on changing ends, Noston, Croft, and Chigwell added further points, and the result was as stated above.

Bart.'s were very badly handicapped in losing the services of the mainstay of the team, V. G. Ward, and by the poor form of Upton, who was ill at the time, and so played much below his usual form. Butcher in goal was, as usual, good, and none of the goals scored can be said to have been due to any fault of his. The absence of Miller weakened the half-back line. Team:

H. H. Butcher (goal); L. Orton, W. S. Nealer (backs); V. C. Upton, T. Bates, H. B. Scott (halves); R. C. Berryman, H. N. Burroughes, C. O'Brien, F. Gröne, and N. E. Waterfield (forwards).

In the Final played at the Queen's Club St. Mary's beat Guy's by 2 to 1, and so have the Cup till next year, when, as has been said before, we hope to get it for one of our library ornaments.

#### RETROSPECT OF SEASON 1900—1901.

A glance back at the doings of the "Socker" Club during the season that is now almost over is not apt to fill the followers of the Club with any great amount of pride. We have had a bad season; we did not win the Senior Cup, and we were knocked out of the Junior Cup, and our ordinary matches were not a great success owing chiefly to the "experiment" of an Inter-Hospital League. We played one match under the auspices of this League; the rest, seven or eight in number, were scratched by our opponents, except in one case when we scratched. This, together with the scratchings owing to the Queen's death and the bad weather immediately after, made our list of matches played very small indeed.

The ground was not up to the usual standard. We lost some men owing to the war, namely, H. E. Thomas and the late W. H. Maserman, and others owing to various other causes, chief among which might be said accidents. All through the season one or other of the team kept getting "crooked."

The season's results briefly are as follows:

Matches played.	Goals			
	Won.	Last.	Drawn.	For. Against.
14	6	6	2	34 37

Our prospects for next season, unless we are honoured with some very useful Freshmen, are not very bright, as we shall lose the help of H. Butcher, V. G. Ward, L. Orton, G. W. Miller, and F. Gröne, and the equal of these men is not met with very often, as a glance back at the services, especially of the first three, rendered during the last five years will show. They have played regularly and well during this period, and deserve the thanks and praise of all those who take any interest at all in "Socker" at this Hospital.

C. O'BRIEN, Hon. Sec.

#### HOCKEY.

##### ST. BART'S v. EPPING.

This return fixture was decided at Winchmore Hill on Saturday, February 6th. The ground was in its usual heavy condition, and the game, though slow, was keenly contested throughout. Bart.'s started well, and pressed the visitors' goal, and shortly scored a goal by Hallows, this being the score at half-time.

During the second half the visitors were seen to greater advantage and equalised, Pearson scoring with a very hard shot. The Bart.'s men palpably tired during the latter part of the game. The game thus ended in a draw of 1 goal all. Team:

L. E. Dickson (goal); L. G. Furber, M. B. Scott (backs); W. F. Fowler, H. B. Hill, L. Murphy (halves); A. Hallows, G. H. Adam, F. M. Beckett, R. C. Wilmot, and H. Gray (forwards).

##### ST. BART'S v. WANSTEAD.

Played on the Club ground at Winchmore Hill on Wednesday, February 27th, the ground again being in a very heavy state.

Bart.'s started attacking from the first, and Glenny scored 2 goals in quick succession, followed by one from Gray. The visitors then attacked, and opened their score, a good shot by Rivington beating Dickson. Glenny again showed good form, and scored twice to the

visitors' once, so that at half-time the score stood—Bart.'s 5, Wanstead 2.

After half-time the play slowed down considerably, and the only goal scored was by Wanstead, who thus retired beaten by 5 goals to 3.

There was a marked improvement in the Bart.'s forwards, due mostly to the presence of Glenny, this being the first time during the season that he has helped the Hospital. The backs hit well. Team:

L. E. Dickson (goal); L. G. Furber, M. B. Scott (backs); W. E. Fowler, L. Murphy, V. C. Upton (halves); A. Hallows, J. A. Nixon, F. M. Beckett, E. T. Glenny, and H. Gray (forwards).

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

This match, which was the Second Round of the Inter-Hospital Competition, was played at Surbiton on Thursday, February 28th, and resulted in a win for Bart.'s by 6 goals to 2.

Guy's pressed at the start, and Dickson saved well; but Glenny, obtaining the ball, got away, and owing to "sticks" from Guy's failed to score. Wedd made a good run for Guy's, but was stopped by Furber. The Bart.'s forwards then got possession of the ball, and after some pretty combination Beckett scored the first goal. Glenny immediately afterwards made an excellent shot, but was ruled "off-side." Play then became fairly even, but some good combination enabled Glenny to score with a good shot. Guy's got away, but were unable to get through the Bart.'s defence, and play was again conveyed to the Guy's "25." Glenny again scoring for Bart.'s, and shortly afterwards a good run by Hallows enabled Beckett to score with a hard shot. Guy's then pressed, but Dickson saved well, but eventually Morris scored for Guy's. At half-time the scores were—Bart.'s 4, Guy's 1.

In the second half Guy's pressed, but Furber stopped the rush, and the Bart.'s backs cleared well, and after some hard passing between Beckett and Glenny the former scored. Guy's were then dangerous, and were awarded a penalty "bully," but the Bart.'s forwards obtained the ball, and Hallows enabled Beckett to again score with an excellent shot. Then Guy's, by some good combination, were able to score again through Cooper, shortly followed by a splendid run by Gray, who was somewhat unlucky in not being able to score. Time was then called.

For Bart.'s, Dickson, Furber, Glenny, Beckett, and Hallows were best, while Leckie, Wedd, and Morris played well for Guy's. Team:

L. E. Dickson (goal); L. G. Furber, M. B. Scott (backs); W. E. Fowler, L. Murphy, V. C. Upton (halves); A. Hallows, J. A. Nixon, F. M. Beckett, E. T. Glenny, and H. Gray (forwards).

##### ST. BART'S v. R.M.A.

This return match between the above teams was decided at Charlton Park on Wednesday, March 6th, and resulted in a somewhat easy win for the Hospital by 6 goals to 3. The ground was in a very "bumpy" condition, and this naturally robbed the game of good combination.

The home team had the advantage of the slope during the first half of the game, and at the interval were leading by 2 goals to 1.

On resuming, however, the visitors had much the best of the exchanges, and were able to score five times to their opponents' once; the goals being scored by Glenny (2), Beckett (2), Fowler (1), and H. Gray (1). Team:

L. E. Dickson (goal); L. G. Furber, M. B. Scott (backs); L. Orton, W. E. Fowler, L. Murphy (halves); R. C. Wilmot, G. H. Adam, F. M. Beckett, E. T. Glenny, and H. Gray (forwards).

#### UNITED HOSPITAL HARE AND HOUNDS.

At a meeting held in December it was decided to resuscitate the above Club. Great interest was taken in the proceedings, more especially by the Guy's men.

By the courtesy of the Blackheath Harriers the Club is able to use their dressing-rooms and run over the Blackheath course, which embraces all sorts of going, from road to plough.

This arrangement also ensures a good trail being laid every Saturday, and a healthy competition against good and experienced cross-country men. Many members have quickly availed themselves of these opportunities, amongst whom are several runners of merit, which augurs well for our chance of securing the Inter-Hospital Cup. We have not completed for this trophy for several years, Guy's having held it for about six years almost unchallenged.



The date fixed for this year's race is March 16th. It will be run over the Blackheath Harriers' ten mile course, starting from their headquarters at the "Green Man." The course is an easy one, chiefly road and grass, what plough there is being fairly light. A sealed handicap will be decided in conjunction with the Cup race. It is necessarily difficult to handicap together men from various hospitals; the only alternative, however, is to do away with this individual competition, and such a course seems undesirable.

A fairly good team would have competed against the "Thames Hare and Hounds" on January 31st, but owing to the Queen's funeral the match was postponed.

Our team for the Cup race will include J. G. Gibb, H. E. Graham, H. Gibb, B. N. Ash, L. Barnett, the first three men from any team to come. Unfortunately, P. Goss and F. S. Lister have both been crooked quite recently, or would otherwise have run.

Having made so good a start, it is hoped that greater support will be forthcoming in future, so as to enable us to compete with the "Varsities" and the better London clubs. A challenge has been received from Dublin University. The Club at present has hardly a sufficient status to warrant such a financial outlay, otherwise it would be most enjoyable.

### Abernethian Society.

**T**HE fifteenth ordinary meeting was held on February 14th, 1901, Mr. Nixon being in the chair. Before Mr. Burrows' paper on "Euthanasia" Mr. Schöberg's motion "that an enlarged portrait of the late Mr. Vernon should be hung on the walls of the Abernethian Reading Rooms," seconded by Mr. Wethered was carried unanimously. Mr. Burrows divided his paper into two parts. The first dealt with the act of dying, the conditions that helped to render it painful or distressing, and the best means for alleviating the distress. The second part of the paper dealt with the advisability or not of administering morphia or other drugs to cause relief from suffering in incurable cases, by death. He considered this portion of his subject from the legal, religious, and public health standpoints, and briefly sketched the arguments for and against the practice. The meeting was well attended, and there was a good discussion at the conclusion of his paper.

February 21st, 1901. A Clinical Evening was held on this date Mr. Gask (President) in the chair. Mr. Jennings showed a case of a patient with retraction of the upper lip, fibrillar twitchings of the tongue, and difficulty of speech and swallowing. He thought it was a case of bulbar paralysis; the alternative suggested was hysteria.

Mr. Nixon showed the case of a man with dermatitis herpetiformis, the eruption being symmetrically distributed on the hands, arms, legs, buttocks, and scrotum.

Mr. Thomas showed two cases of ataxia, one a typical case of Friedreich's ataxia in a girl of fourteen. The typical gait, hyperextension of the great toe, extensor plantar reflex and some slight incoordination of the muscles of the upper extremity being present. The other was a typical case of locomotor ataxia in a woman in whom there was a history of specific disease ten years previously.

Mr. Thomas also showed two other cases, one a case of primary muscular atrophy of the facio-scapulo humeral type in a man of forty, the other a case of a boy who two years previously was apparently a healthy, normally intelligent boy, but who, since then, had gradually been becoming fatter and markedly less intelligent. At present patient is very obese, and much less intelligent than a normal boy of the same age. Has partial loss of vision, and is partially ataxic.

Dr. J. W. W. Stephens gave an interesting demonstration of the different phases in the life-history of the malarial parasite.

In conjunction with Mr. Schöberg he demonstrated the method of finding the isotonic point of blood.

Mr. Curbin showed a case of a man with Charcot's disease of both knees. Patient attracted considerable attention from the fact that in addition to the clinical interest attaching to his case he had been up to the examination hall over a hundred times.

Mr. Wethered showed the case of a man with a large abdominal tumour, which he himself thought to be a displaced spleen. Other views were that it was a malignant growth of the stomach, colon, spleen, or omentum.

Mr. Brewerton gave a very interesting demonstration of some ex-

cellent eye-specimens, consisting of gliomata, pseudo-gliomata, cystic degeneration of the retina, and sarcoma. He also described his method of mounting and preparing the specimens.

The nineteenth ordinary meeting was held on March 14th. Mr. Gask being in the chair. This meeting was noticeable because it was the first meeting at which smoking has been allowed. The result of this innovation by those who have the welfare of the Society at heart. Mr. Atkinson and Mr. Elmslie were appointed to audit the accounts of the last session, and the names of those members who offered themselves for election to the various offices in the Society were read, together with their proposers and seconders. Mr. Peterson showed a specimen of a large pyonephrotic kidney, which he had removed on account of frequent occurrences of pus and blood in the urine. It was decided to try and come to some arrangement by which washing requisite should be provided at meetings where cases or specimens are shown. Mr. Everington read a paper entitled "Some Points in the Management of Sick Children." There was a large attendance of members, who followed his remarks with interest. His paper was practical and interesting, and at the close of it there was a good discussion.

### To Smoke, or not to Smoke.

**T**HE usual staid and proper proceedings of the Ancient and Honourable Abernethian Society were suddenly arrested, as it were by a bomb, when on February 21st a member rose to give notice that at the next meeting of the Society he would bring forward a motion proposing that smoking be allowed at its ordinary meetings. The President gasped for breath, the Secretary's pen refused to write, the whole house also was mute with amazement; but at length, as after all he braced himself together, the Secretary, gripping the pen which had fallen from his nerveless fingers, hastened to commit to writing the momentous proposal which for ages to come will enter the whole history, constitution, and personnel of the Society, the far-reaching effects of which not even the soul of the Hospital poet in its wildest flights of fancy can ever dream of. Members having recovered from such a shock, the like of which has periodically assailed the Society since its foundation, greeted the hero, the indomitable hero, who had dared to raise his voice to pride any innovation in the customs and laws of the Ancient and Honourable Society, founded, as is proclaimed with pardonable exaggeration on all its literature, in 1705, with thunders of applause, during which he resumed his seat. The rest of the evening was calm and uneventful.

Never before within the memory of the oldest chronic had the hall been so packed day after day with a buzzing murmuring crowd, eagerly scanning the notice board of the Ancient and Honourable Society whose name it bears, and whose antiquity it announces to all the world. Unwonted excitement is even noticeable in the square, little groups of three and four eagerly discussing the sensation of the week.

At length February 28th comes round, in due course the President has taken the chair, the minutes of the last meeting have been read and confirmed, and other private business hurriedly transacted. With President of the severe and august Society calls upon Mr. — to bring forward the motion standing in his name. Calmly, sedately, and with quiet deliberation, the member, so well known to even the most timid fresher, rises, and with genial smile utters the time-worn formula, "Mr. President and Gentlemen," amidst salvos of applause from one of the two parties into which it is now obvious the house is rent in twain. A member rises to ask whether it is an order that the motion be discussed at an ordinary meeting, and the question being settled by the President, in a speech full of pleasant phrases, and rounded and well-chosen sentences, the proposer keeps the house capt in admiration and attention for fully twenty minutes. When the hon. member resumed his seat, he did so amidst raves of approval from his own followers and walls of despair from the Opposition, who recognised that after such a torrent of eloquence and flood of oratory their cause was well-nigh hopeless.

The high standard of excellence set forth in the speech of the proposer was well maintained by the member who seconded the motion, although so soft and silvery was his voice that it was scarcely audible to members sitting in far corners of the room.

The Opposition were now determined to keep the ball rolling until a quarter to nine, when by the laws of the Ancient and Honourable Society the debate must stand adjourned. This they ably succeeded in doing, the best speech of the evening being made by the reader of the paper, who startled the house and raised their attention to a high pitch by declaring that in the speech of the proposer of the motion there was not a single sound argument advanced to support it. The house, I ween, had on consideration begun to suspect this; but, just as one is loth to cut a wedding-cake, it looks so beautiful from the outside, until this pioneer and ruthless destroyer arose from the outside, had been loth to spoil the pleasing though false image formed in their minds. However, in language plain and forcible, one by one the seemingly sound arguments of the proposer were shattered, and the startlingly false deductions were exposed.

The hopes of the Opposition had risen to normal. Quarter to nine, the debate stood adjourned.

March 7th.—A crowd of new members who had been attracted by glowing accounts of the entertainment provided at the two previous meetings, and who came evidently with the intention of enjoying themselves, having been admitted, the private business before the house was proceeded with. The first question to be settled was whether the ruling given by the President at the previous meeting was to be allowed to stand. The honourable member who had had the temerity to question it rose, and leaning on the house through his glasses, in a speech such as he is often wont to delight the house with, brimming over with humour and wit, bristling with quotations from the ancients who lived even before the days of the founding of the Ancient and Honourable Society, showed evidently to his own satisfaction that his interpretation of the law was right, and that of the President wrong. But as all castles of sand, however massive and apparently firm, have to go down before the advancing tide, even so in this case was the bold member's structure wrecked and shattered by the voice of public opinion which his speech called forth; and when the motion was put before the house, the ruling of the President was upheld by a large majority.

The adjourned debate on the original motion was now continued. The Opposition, who were now without their doughty champion of the meeting before, made but a feeble attempt to stem the advancing tide; they recognised that sooner or later the crisis must be faced. It came: those in favour, those against. The meeting ended in "Smoke."

### Review.

ST. BARTHOLOMEW'S HOSPITAL REPORTS, Vol. XXXVI, 1900. (Smith, Elder, & Co. Price 8s. 6d.; to subscribers 6s.)

The volume presents its familiar arrangement into two parts: the first general, consisting for the greater part of reports on cases admitted into the Hospital during the past year; and the second mainly statistical.

The title of the volume implies that it should present a full account of the work of the Hospital during the past year. Applying this test to both parts of the volume, incompleteness is obvious. In the first or general part, large departments of the Hospital work are totally unrepresented.

Thus there is no article upon any subject relating to diseases of women or pathology. The second or statistical portion is similarly deficient. No record apparently is kept of the out-patient departments. Again, so far as the volume is concerned the X-ray and the electrical departments are non-existent.

The first two articles are biographical. The life of Sir James Paget is sympathetically treated by Howard Marsh, and should be read by all lovers of their Hospital.

The biography of Sir Richard Thorne Thorne is mostly a catalogue of the important events of his life, and it is a matter of regret that it was not put into more sympathetic hands.

Mr. D'Arcy Power gives an interesting and readable article on "The Lessons of a Year's Surgical Experience."

Mr. Herbert Mundy describes "A Peculiar Form of Spinal Deformity." The author believes he has described a new disease, but the manner in which the symptoms differ from those of other cases of kyphosis does not appear obvious.

Dr. Sandilands describes certain points of interest in connection with the Aden Epidemic of the Plague in 1900.

The longest article in the volume is that by Dr. Hedges on "The Aetiology, immediate, and remote Prognosis of Primary Pleurisy with Serous Effusion." He investigates the subject both from the clinical and bacteriological aspects. His conclusions do not differ in the main from those usually current. He perhaps rather under than over estimates the frequency of the tubercular causation. In discussing the treatment of effusion by aspiration he says, "It is as well, when performing the operation on a highly sensitive patient, to give a whiff of gas until the needle is inserted." Surely few prudent operators would adopt this course.

Mr. Gill writes in an interesting manner on "Three Cases illustrating Exceptions drawn from recent Chloroform Practice." The object of the paper is "to illustrate the assurance which the contracted pupil gives on the presence of abnormal conditions."

Mr. Maxwell records a case of Landry's paralysis.

Dr. Derwent Parker, in his attempt to elucidate rheumatoid arthritis, only serves to still further complicate it.

A. M. Ware writes a short description of a case of tetanus neonatorum.

Capt. R. Bird describes five cases of volvulus of the sigmoid flexure.

Eustace Talbot contributes an article upon "Cases of Hæmorrhage into the Supra-renal Capsules."

Drs. Batten and Fletcher give an account of a rare case of myasthenia gravis.

J. F. Steedman, in an account of some "Accidents on the Cricket Ground," incidentally points out the value of radiography in minor surgical accidents.

Dr. Bowes records a case of membranous colitis at the unusually early age of four years.

Stanley Bousfield draws attention to the occurrence of primary optic atrophy in two cases of diabetes insipidus.

Dr. Claye Shaw writes in a highly interesting paper "On the Expression of Emotion."

Mr. Jessop records several ophthalmic cases, including three of eclipse blindness.

On the whole the Reports attain their usual standard, but whether they are worthy of a large and important medical school must be open to question.

## Calendar.

April, 1901.

Tues.,	April 2.	—Dr. Gee and Mr. Langton's duty.
Fri.,	" 5.	—GOOD FRIDAY. Sir Dyce Duckworth and Mr. Marsh's duty.
Sun.,	" 7.	—EASTER DAY.
Mon.,	" 8.	—BANK HOLIDAY.
Tues.,	" 9.	—Dr. Hensley and Mr. Butlin's duty. Conjoint Board. Final Examinations begin.
Fri.,	" 12.	—Sir T. Lauder Brunton and Mr. Walsham's duty.
Tues.,	" 10.	—Sir W. S. Church and Mr. Willett's duty.
Fri.,	" 19.	—Dr. Gee and Mr. Langton's duty.
Tues.,	" 23.	—Sir Dyce Duckworth and Mr. Marsh's duty. Cambridge Third M.B. Examination begins.
Fri.,	" 26.	—Dr. Hensley and Mr. Butlin's duty.
Tues.,	" 30.	—Sir T. Lauder Brunton and Mr. Walsham's duty.

## Junior Staff for April—October, 1901.

## HOUSE PHYSICIANS.

<i>Senior.</i>		<i>Junior.</i>
Sir William Church.		
T. Gillespie.	A. H. Hayes.	
Dr. Gee.		
W. P. S. Branson.	A. T. Pridham.	
Sir Dyce Duckworth.		
W. S. Darby.	F. C. Shrubsall.	
Dr. Hensley.		
J. A. Nixon.	S. Hey.	
Sir Lauder Brunton.		
C. W. von Bergen.	A. H. Bostock.	

## HOUSE SURGEONS.

<i>Senior.</i>		<i>Junior.</i>
Mr. Willett.		
H. B. Gibbins.	C. E. West.	
Mr. Langton.		
C. A. S. Ridout.	F. E. Brunner.	
Mr. Marsh.		
J. G. Cooke.	W. S. Danks.	
Mr. Butlin.		
F. A. Rose.	H. G. Pinker.	
Mr. Walsham.		
C. S. Hawes.	R. T. Worthington.	

## RESIDENT MIDWIFERY ASSISTANT.

J. A. Willett.

## OPHTHALMIC HOUSE SURGEON.

L. E. Whitaker.

## ASSISTANT CHLOROPORMISTS.

W. F. Cross and H. S. Ward.

## EXTERN MIDWIFERY ASSISTANT—April.

S. R. Scott.

## EXTERN MIDWIFERY ASSISTANT—July.

H. Vaughan Pryce.

## Appointments.

ADAMS, P. E., M.D.(Lond.), appointed a Surgeon to the Hospital Ship "Simla."

ALLEN, L. L., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon at the County Hospital, Lincoln.

COPE, R., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon at the York County Hospital.

HAY, K. R., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Children's Hospital, Shadwell.

NANCE, H. C., F.R.C.S.(Eng.), appointed Surgeon to the Jenny Lind Hospital for Sick Children, Norwich.

SCOTT, R. B., B.C.(Cantab.), appointed Assistant House Surgeon to the Gloucester General Infirmary.

SKELDING, HENRY, M.B., B.C.(Camb.), M.R.C.S., appointed Honorary Surgeon to the County Hospital, Bedford.

## New Addresses.

BREWER, A. H., Cotswold, Fairholt Road, Stamford Hill, N.  
 HARRISON, L. H., 320, Humberstone Road, Leicester.  
 HORDER, T. J., 141, Harley Street, W.  
 LEGG, T. P., 141, Harley Street, W.  
 MAXWELL, J. L., F. P. Mission, Tainanfoo, Formosa, Hong-Kong.  
 ROBINSON, C. A., Gladwin's, Limpfield.  
 THOMSON, C. C. B., Chepstow, Mon.  
 VINCENT, K., 1, Harley Street, W.  
 WINTER, L. A., 27, Cedars Road, Beckenham.

## Marriages.

COCHRANE—RICHARDSON.—On February 28th at Gurdaspur, Punjab, by the Venerable the Archdeacon of Lahore, Archer Cochrane, M.B., F.R.C.S., Captain I.M.S., Punjab Asylum, Lahore, India, to Winifred, daughter of Colonel Richardson, I.M.S. (retired), of College Gardens, Dulwich.

THORNE—SINGLETON.—On the 21st inst., at Christ Church, Lancaster Gate, W., by the Rev. G. R. P. Preston, M.A.(Oxon.), Leslie Thorne Thorne, M.D., of 45, Inverness Terrace, W., second son of the late Sir Richard Thorne Thorne, K.C.B., F.R.S., of Marcella Mildred, second daughter of Edward Singleton, Esq., of East Brook, Teignmouth, and granddaughter of the late Hugh Singleton, of Hazelwood, co. Clare.

## St. Bartholomew's Hospital



## JOURNAL.

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APRIL, 1901.

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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.

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, 1901.

"Equam momento rebus in arduis  
 Servare mentem."—Horace, Book ii, Ode iii

## To the Reader.

THE Editorial Chair is vacant, and the JOURNAL makes its appearance this month without a guiding hand at the helm, and it perchance we should offend a contemporary or a contributor, there is this satisfaction, that there is no one responsible for this issue who can be reviled or slain. For close on two years the late Editor has been in charge of this Journal, and in that time has deserved well of all its readers. For, like Pharaoh's cattle, there have been fat months and lean months; now a glut of copy, and some contributor will open his JOURNAL to find with wrath that his "magnum opus" has been

crowded out; and a time when the editorial brain is racked to fill the gaping columns. Yet through such crises has the JOURNAL come unscathed, and one man has lived who at times could truly say, "Alone I did it."

And now what is to be the lot of this orphan paper—for is not the editor its father and mother? This month it appears, but whence it comes or whither it goes who shall say?

That it can maintain its former standard is almost too much to hope. Yet if the learned among us would but write, in season and out of season, early and late; of things medical, of things surgical; of things they have seen and heard, and of that which no man has seen or heard; then may we look for a Journal which, if not as worthy of perusal as in recent years, will still contain as many pages, and appear as regularly.

For there are those who read their JOURNAL and say, "Go to, what are these things that are written of? where shall I look for news of the Ping-Pong Club?": while he that speaks is its secretary, and knows full well that if he writes not, none will.

Another communes within himself (yet not openly, for he is fearful of the mob): "How comes it that I find no voice raised against Vivisection?": when he alone could raise that voice.

Gentle readers, is it thus that you help us? Does this make copy? Better far were it that a wet towel were tied round your heads and ye were thrown into the Editorial Chair: for thus you would write of those things you love to read of.

How shall an Editor know the minds of his readers? If he writes in humorous vein he is called flippant, and if his style is more weighty he is dull; but if the readers of this Journal write, each in his own style, the witty reading it that they may laugh at their own humour, and the solemn that they may admire the depth of their learning, then we shall have no more resignations of Editors, for their lives will be full of joy and void of care, and the JOURNAL will continue, as before, a storehouse of Wit and Wisdom.