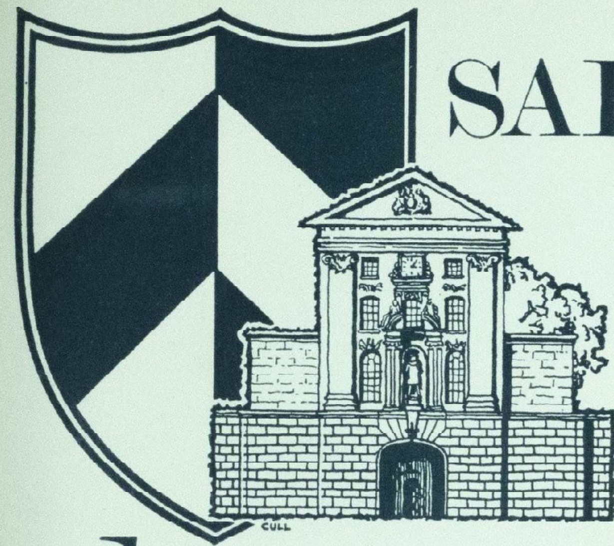
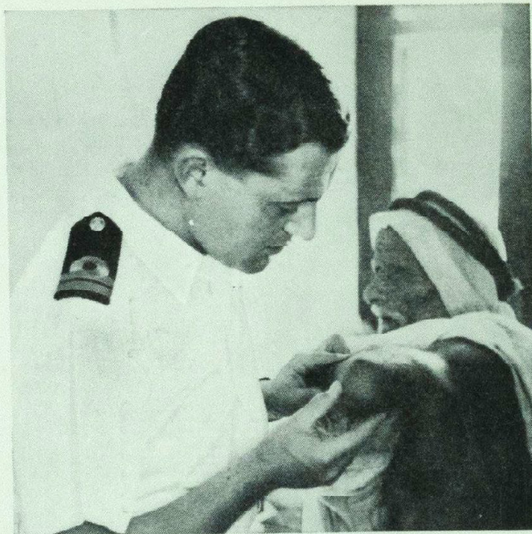
Cataract Surgery by H. B. Stallard.



SAINT · BARTHOLOMEW'S · HOSPITAL · JOURNAL

VOL. LXXI No. 1

JANUARY 1st, 1967



How you can see the world and gain valuable medical experience

(before you settle into general practice)

Would you like to see the Far East, the Mediterranean, or the West Indies? Study the new sciences of aviation, underwater or nuclear medicine? Have complete clinical freedom, modern medical equipment and the opportunity to practise a very wide and varied field of medicine? Lead an active, exciting outdoor life against a world-wide backcloth?

These are some of the opportunities open to you as a Medical Officer in today's modern and expanding Royal Navy. During a 5-year Short Service Commission you can gain valuable, practical medical experience, treating both Royal Navy personnel and civilian families.

And you'll see something of the world—before you settle into the routine of general practice. You will be well paid, with a starting salary higher than that of a civilian hospital registrar. Marriage and other allowances can add considerably to your income. And, if you wish, you can apply for a Permanent Commission after 1 year's service. Later, you can study (with financial backing) for higher degrees, and you could aim for consultant status.

3 Ways of Entry.

1. As a fully registered doctor; civilian experience counts towards your seniority.
2. During your pre-registration year.
3. As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26FR6, Empress State Building, London, S.W.6.

AIDS TO LABORATORY DIAGNOSIS

Catalogues and lists available :-

★ Biological Stains and Reagents, list L.
★ Instruments and Accessories for Microscopy.
★ "WELLCOME" Diagnostic Reagents and Materials.
★ "WELLCOME" Transaminase Reagents.
★ Service Bulletins.

Specialists in Biological Stains Since 1915

GEORGE T. GURR LTD.

136-144, New King's Road, London, S.W.6.

Cables: Microstain: London, S.W.6. Tel: RENown 5482/4

Engagement Rings

FROM CRAFTSMAN TO WEARER

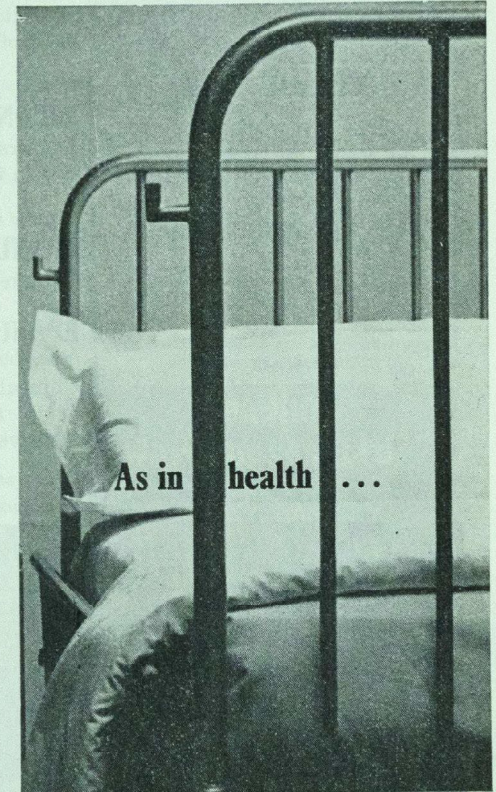
25% DISCOUNT

"FINEJEWELS"

88-90 HATTON GARDEN, E.C.1

Telephone: HOLborn 8058

Weekdays 9.30-5.30, Sat. 9.30-1



Trufood spans the dietary needs of children both in sickness and in health. Its range, in this important respect, is extensive and is the result of 40 years of specialised experience. We are glad to make special efforts—and special products—to provide wherever possible the right food for every baby however exacting his needs may be.

Minafen · Galactomin · Locasol · Edosol

TRUFOOD LTD

THE MEDICAL DEPARTMENT, THE TRUFOOD CREAMERIES, WRENBURY, NANTWICH, CHESHIRE.

The **PARKE-DAVIS** range of anticonvulsants provides comprehensive control in the epilepsies

ZARONTIN* *(ethosuximide, Parke-Davis)*
Extremely effective in the treatment of *petit mal.*[1] Represents a real advance in the development of anticonvulsant drugs.[1]

In *petit mal*
MILONTIN* *(phensuximide, Parke-Davis)*
The first of the succinimides found to be effective in the treatment of *petit mal.*[1]

In *grand mal* and psychomotor seizures
EPANUTIN* *(phenytoin sodium B.P., Parke-Davis)*
The first of the hydantoins and still the best.[1]

EPANUTIN and PHENOBARBITONE
(phenytoin sodium B.P., Parke-Davis and phenobarbitone B.P.)
Clinical evidence confirms that when the two drugs are used together their effects are additive.[1]

1 TODAY'S DRUGS. ANTICONVULSANTS, BRIT. MED. J. 2:919, 1963

*Trade mark

O-1230

PARKE-DAVIS HOUNSLOW · LONDON · TELEPHONE: HOUNSLOW 2361

SAVE up to 7/6 in the £

off the basic price on all your purchases

Almost anything can be supplied at most favourable discounts and delivery can be arranged anywhere in the country.

Furniture, Carpets, Watches 25%. Cutlery, Venetian Blinds 20½%. Tape Recorders, Projectors 20%. Record Players, Binoculars 20%. Radio, TV, Sewing Machines 20%. Screens, Lenses, Enlargers, etc. 20% Electrical Goods, Oil Heaters, Washing Machines, Spin Driers, Razors, Heaters, Food Mixers, etc. 17½% to 15%. Refrigerators, Mowers, Power Tools 12½% to 15%. Gas Appliances 12½%. Cars 10%

All goods supplied are brand new and fully guaranteed

Reading Warehouses Ltd.
(Dept. BM)
TADLEY, HANTS.
Phone: TADLEY 3704

H. K. LEWIS & Co. Ltd.

BAILEY & LOVE'S SHORT PRACTICE OF SURGERY
Thirteenth Edition revised by A. J. Harding Rains, M.S., F.R.C.S., and W. Melville Capper, F.R.C.S. Consulting Editor: McNeill Love, M.S., F.R.C.S. With 1677 illus. (286 coloured). 9¾ in. x 6⅝ in. **£4 4s.**, postage 6s.

RAWLING'S LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY
Ninth Edition revised by J. O. Robinson, F.R.C.S. 8½in. x 5½in. 38 illus. **17s. 6d. net**, postage 1s. 1d.

BASIC PRINCIPLES OF ACCIDENT SURGERY
By M. C. T. Morrison, F.R.C.S. 8½ in. x 5½ in. 29 illustrations. **£1 1s. net**, postage 10d.

ELEMENTARY PATHOLOGICAL HISTOLOGY
By W. G. Barnard, F.R.C.P. Third Edition. With 185 illustrations. 9¾ in. x 7¼ in. **17s. 6d. net**, postage 1s. 1d.

THE DIAGNOSIS OF THE ACUTE ABDOMEN IN RHYME
By "Zeta". Fourth Edition, with drawings by Peter Collingwood. 7¼ in. x 4¾ in. **10s. 6d. net**, postage 10d.

ROXBURGH'S COMMON SKIN DISEASES
12th Edition by Peter Borrie, M.A., M.D., F.R.C.P. 8½ in. x 5½ in. 239 illustrations. **£2 10s. net**, postage 3s.

OBSTETRICS AND GYNAECOLOGY Combined for Students
By Elliot Philipp, M.A., M.B., B.Ch., F.R.C.S., F.R.C.O.G., 9¾ in. x 6⅝ in., 203 illustrations. **£3 15s. net**, postage 3s. 3d.

POCKET BOOK OF PHYSICAL SIGNS IN MEDICINE
By H. Fuld, M.D., F.R.C.P. 8½ in. x 5½ in. **£1 5s. net**, postage 1s.

NOTABLE NAMES IN MEDICINE AND SURGERY
By Hamilton Bailey, F.R.C.S., and W. J. Bishop, F.L.A. Third Edition. With 241 illustrations. 8½ in. x 5½ in. **£1 15s. net**, postage 1s. 3d.

THE MECHANISM OF LABOUR FOR STUDENTS
By D. B. Bower, F.R.C.S., M.R.C.O.G., D.Obst. With 36 illustrations 7¼ in. x 4¾ in. **(Nearly Ready)**

136 GOWER STREET, LONDON, W.C.1
Telegrams: "Publicavit, London," W.C.1 Telephone: EUSton 4282 (7 lines)

The Business Houses' Discount Buying Service

49 BOW LANE, CHEAPSIDE, LONDON, E.C.4.
Telephone: CENtral 7225

Authorised Suppliers of BRANDED MERCHANDISE to Staff Associations and members of Approved Organised Groups.

DISCOUNTS AVAILABLE LISTED ALPHABETICALLY

Item		Discount
Batteries (car)	UP TO	17½%
Bicycles	,, ,,	17½%
Branded Shirts	,, ,,	20%
Beds	,, ,,	17½%
Bedding (sheets, blankets, b/spreads)	,, ,,	17½%
Bathroom fittings	,, ,,	17½%
Blankets (electric)	,, ,,	17½%
BRANDED CARPETS	,, ,,	30%
Cars	,, ,,	10%
Car radios	,, ,,	17½%
Camping equipment	,, ,,	17½%
Car accessories	,, ,,	17½%
Clocks	,, ,,	17½%
Cookers (large)	,, ,,	10%
Cookers (small)	,, ,,	15%
Curtain fittings	,, ,,	17½%
Cutlery	,, ,,	33⅓%
Dressing table sets	,, ,,	30%
Electrical appliances	,, ,,	17½%
Furniture		
Bedroom	,, ,,	17½%
Kitchen	,, ,,	17½%
Lounge	,, ,,	17½%
Office (re-conditioned)	,, ,,	HALF PRICE
Fridges	,, ,,	12½%
Gardening and General tools	,, ,,	17½%
Glassware	,, ,,	20%

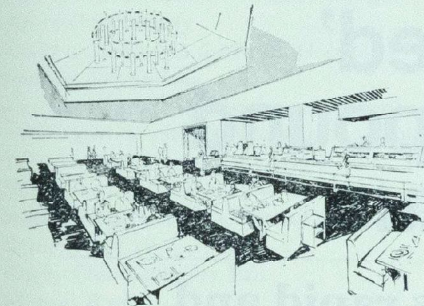
Item		Discount
Hi-Fi equipment	,, ,,	20%
Kitchen equipment and gadgets	,, ,,	17½%
Lawn mowers (hand)	,, ,,	17½%
Lawn mowers (power)	,, ,,	12½%
Leather goods	,, ,,	20%
Light fittings	,, ,,	17½%
Nylons (assorted)	,, ,,	30%
PHOTOGRAPHIC EQUIPMENT INCLUDING FILMS	,, ,,	17½%
Pen sets	,, ,,	10%
Perfume (French)	,, ,,	20%
Radios	,, ,,	17½%
Radiograms	,, ,,	20%
Record players	,, ,,	20%
Suitcases	,, ,,	17½%
Tape recorders	,, ,,	20%
Television sets	,, ,,	20%
Table lamps	,, ,,	17½%
Tyres (FITTED FREE)	,, ,,	17½%
Tools (POWER) and accessories	,, ,,	17½%
Typewriters	,, ,,	12½%
Towels	,, ,,	17½%
Venetian blinds	,, ,,	20%
Watches	,, ,,	17½%

This list is intended only as a guide to the range of merchandise we are able to offer. In addition to items listed, there are many others available at comparable discounts. The company reserves the right to amend prices and discounts without notification.

A DIVISION OF
THE RYAMS ORGANISATION (Southern) LTD

Have you tried it yet?

GAMAGES
NEW "CRYSTAL DOME"
Self-Service Restaurant
With Table Licence



GAMAGES HOLBORN E.C.I

Completely redesigned and fully re-equipped. Finished in an attractive contemporary decor.

Enjoy perfectly cooked, appetising meals in luxurious comfort. A widely varied Luncheon Menu available from 11.30 a.m.-3.30 p.m. Morning Coffee, Snacks, Teas, etc., available during Store hours.

The "Crystal Dome" adjoins the Cocktail Bar and Sandwich Lounge on the 3rd Floor and is served by three direct lifts.

NO WAITING. POPULAR PRICES.
Why not try it ? NOW !

9 a.m.-5 p.m. (Thursdays 7 p.m.) Sats. 1 p.m.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

The annual Subscription to THE JOURNAL is only 25/- per year (42/- post paid anywhere in the world). Perhaps you know someone who would like to become a subscriber.

Further information may be obtained from:

The Assistant Manager (Subscriptions),
St. Bartholomew's Hospital Journal,
St. Bartholomew's Hospital,
London, E.C.1.

FIRST FOR CARPETS
Dodson Bull

UP TO 30% DISCOUNT ON BRANDED CARPETS

Wiltons • Axminsters • Orientals • Tufted
£200,000 Carpets on display
in our extensive London and Northern Showrooms

- All makes available with full Manufacturers Guarantees.
- Free Delivery U.K.
- NO IMPERFECT GOODS SOLD
- Expert fitting service available most areas

Write stating requirements or for introduction to showrooms in most main cities

Open 9.30 to 5.30 Mon. to Fri. 9.00 to 12 noon Sats.

DODSON-BULL CARPET CO LTD
2, 4 & 5, Little Britain London EC1 (1 min St Paul's)
Tel: MON 7171 (10 Lines)

For the **cough**
and **congestion**
of **bronchitis**
and **colds**

'Actifed' Compound Linctus

provides rapid and effective relief

It combines the decongestant properties of pseudoephedrine and the antihistamine effect of triprolidine with the proven cough-controlling action of codeine.

Dosage:
Every 4 to 6 hours

Adults and children over 12 years
2 teaspoonfuls (10 ml.)

Children 6-12 years
1½ teaspoonfuls (7.5 ml.)

Children 1-6 years
1 teaspoonful (5 ml.)

Infants up to 12 months
½ teaspoonful (2.5 ml.)

Formula
30 mg. pseudoephedrine hydrochloride, 1.25 mg. triprolidine hydrochloride, B.P.C. and 10 mg. codeine phosphate, B.P. in each 5 ml.

N.B. Although pseudoephedrine causes virtually no pressor effect in persons with normal blood pressure, 'Actifed' Compound Linctus should be used with caution in patients with cardiovascular disorders.

when the complaint is cough—
'Actifed'brand **Compound Linctus**

Also available: 'Actifed' Tablets and Syrup each containing pseudoephedrine and triprolidine for the relief of nasal and respiratory congestion.

CONTENTS

Vol. LXXI No. 1 January 1st 1967

The Teaching Hospital ...	2
Letters to the Editor ...	3
News ...	3
Finals Results ...	5
House Appointments, January 1967 ...	6
Retirement; Sir Clifford Naunton Morgan ...	7
Abernethian Society ...	8
Cardinal Heenan at the Royal Hospital ...	11
Nursery Productions ...	12
Cararact Surgery: its History and Evolution by H. B. Stallard ...	13
Twillingate Hospital Newfoundland; a summer visit by M. R. B. Keighley ...	20
Milk for Water, a case of Chyluria by C. S. B. Roch-Berry ...	24
More than meets the eye, No. 2; Forensic Medicine by R. D. Teare ...	27
Annual Report of the Chairman of the Students' Union ...	29
Cartoon by Cull ...	30
Rugby Club Centenary Ball ...	31
Medical Books ...	32
Sports News: Editorial ...	33
Rugby Club ...	33
Golf Club ...	33
Motor Club ...	34
Cross-Country Club ...	34
Soccer Club ...	35
Boat Club ...	36
Hockey Club ...	38
Sailing Club ...	40
Judo Club ...	40
Swimming Club ...	40
Ladies' Hockey ...	40

THE JOURNAL STAFF

Editor: **J. A. Sills**

News Sub-Editor: **Miss E. A. MacDonald**
Review Sub-Editor: **J. D. Fraser**
Social Sub-Editor: **Miss D. Morley Evans**
Photographic Sub-Editor: **C. G. Fagg**
Sports Sub-Editor: **P. A. Ashby**

Manager: **J. P. D. Reckless**
Assistant Managers: **P. M. Quinn**
C. S. B. Roch-Berry
N. Goodchild
M. Castleden
Charterhouse Representative: **P. Swain**
Nurses' Representatives: **Miss E. Ferriera**
Miss P. M. Kilshaw

THE TEACHING HOSPITAL

The continued efficacy of the National Health Service depends not only upon the present generation of practising medical men, but also upon the preparation of suitably qualified men and women to fill the vacant posts that inevitably arise. In past centuries apprentice attachment was considered adequate training, but nowadays with the frightening complexity of modern medicine additional instruction in a more formal manner is the universal practice. This necessitates the assembly of a teaching staff in a suitable institution and thus we have the Teaching Hospitals.

Although medicine is more scientific than formerly it must not be forgotten that medicine still revolves around the personal relationship between the patient and the doctor. This relationship does not come automatically and a most important part of medical training is learning how to talk to patients and how to gain the confidence of people who may naturally in a medical atmosphere be frightened, anxious, reticent or aggressive. The examination of patients too (under the eyes of a chaperone where necessary) is an art that can only be learned by experience, for recognition of the abnormal depends upon complete familiarity with the range of normality.

Thus the Teaching Hospitals have a dual responsibility, which is executed by the teaching staff, to the patients *and* to the students, the latter have to learn and they learn by contact with patients and by example from their peers. Thus all patients attending these Hospitals should be aware of the special nature of the Teaching Hospital and of the possibility of their being used as teaching material; the responsibility for the dissemination of this information rests largely with the General Practitioners who refer the patients. However it must be added that as a matter of common courtesy the patients' formal consent should be obtained before the start of the Teaching session, especially in the out-patient departments.

It is common in most professions for some privilege to exist for individuals within, or connected with the profession. That it exists in the Medical Profession is not denied. But should it be decried? Can it not be accepted as one of the few indications of autonomy in a Profession that at times appears to be in danger of being swamped by bureaucracy and strangled by inadequate financial support.

Privilege, of a greater degree may be bought, and where an individual undergoes Private treatment in a Teaching Hospital it also buys immunity from being used as teaching material. In Saint Bartholomew's Hospital where there are no Private beds, there is no dual population of patients and the consultant staff are able to devote their time more fairly to each patient, instead of biasing towards their Private patients. This surely gives the patients a great advantage over their fellows in other Teaching Hospitals? This difference is due to the unique character of this Hospital's Charter; and besides allowing each patient more consultant time it makes each one potential teaching material. Some minor professional privilege may be experienced if the patient be connected with the Profession, but if the particular patient's condition is interesting this will not preclude the instruction of students.

This may vary between Departments, but in some, where a fair proportion of referrals are within the profession there is no privilege. Such is the case in the Department of Obstetrics and Gynaecology, where all patients may be used as teaching material.

The Journal Staff wish all readers a Happy and Prosperous New Year

LETTERS TO THE EDITOR

THE RUGBY CLUB BALL

Sir,—Probably one of our more unfortunate legacies from the early nineteenth century is the phenomenon of organised sport. Allowing that the new classes which emerged at that time had to experiment with something to give their sons some sense of security and responsibility, the English sportsman would have been a plausible enough imposition for a limited period—but alas, this has not proved to be the case. Part of living in England today necessitates the patience to have to suffer the sport-religion, and its dreary followers. One learns to accept the figure whose only capacity to stand up as a man is when supported, either by a bar, or by fellow insecurees in the scrum, despite his likely retardation to civilization. However, there are instances when the barbarian in him emerges a little more than usual and last night's Rugby Club Ball was certainly one such occasion. The predictably bad cabaret and unimaginative dance music were no worse than one might have expected from a function supported and, one presumes, organised by the species I have referred to earlier. Within its limited context it could have been quite an enjoyable affair, but for the interesting behaviour of *Ruggermensch* at the supper table. Food fights, one realizes, are part of growing up, and for the sporting fraternity, apparently continue into later life, coupled with other forms of adolescent behaviour. However, one would have thought that the attendance of ladies might have provided those responsible with at least enough security for an evening without reverting to the fourth form. Sadly this was apparently not so, and Sportsman revealed himself in characteristically murky colours. The most appalling facet of the whole affair was lack of sense of occasion, which can only point to mindlessness.

Yours faithfully,

DAVID J. BAKER,
Radiobiology Unit,
The Medical College of
St. Bartholomew's Hospital,
Charterhouse Square,
London, E.C.1.

2nd December.

Engagements

BRUETON-MAY.—The engagement is announced between Martin J. Brueton and Miss Patricia A. May.

GALLOP-PACKE.—The engagement is announced between Dr. Andrew M. Gallop and Miss Margaret Packe.

HUSBAND-ARMSTRONG.—The engagment is announced between Dr. P. Robin Husband and Miss Priscilla J. Armstrong.

JOHNSON-HAYNES.—The engagement is announced between Robert Johnson and Miss Ursula Haynes.

MATTHIAS-LEUCHARS.—The engagement is announced between Dr. John Q. Matthias and Miss Elizabeth Leuchars.

RAVEN-LEE.—The engagement is announced between Simon N. Raven and Miss Susan P. S. Lee.

Births

GLOVER.—On Nov. 25, to Gay (née Royle) and Dr. David Glover, a daughter.

ROSS.—On Nov. 1, to Anne (née Briggs) and Dr. Alexander (Paddy) Ross, a daughter (Caroline Joanna).

Deaths

DRAWMER.—On Nov. 14, C. Stephens Drawmer, M.R.C.S., L.R.C.P. Qualified 1924.

KINDERSLEY.—On Nov. 20, Charles Edward Kindersley, F.R.C.S., aged 76. Qualified 1916.

R.C.S. England

The Begley Prize has been awarded to O. J. A. Gilmore.

Department of Psychological Medicine:

November Clinical Meeting.

"Convulsive Therapy"

Dr. Louis Rose

Dr. Rose suggested the use of the term *Klonotherapy*, which would imply a treatment based on producing an automatic discharge within the central nervous system—the usual way of producing such a discharge is with an electric current (electro-convulsive therapy—E.C.T.). Recently Dr. Rose has been investigating Flurothyl (Indoklon) which produces such an intra-cerebral autonomic discharge when administered by inhalation. Such a treatment, while at least as effective as the standard E.C.T. would seem to have the advantages of producing less post-treatment confusion and less memory disturbance. Dr. Rose also showed a film to illustrate the use of Indoklon.

It is of particular interest to those of us at this hospital that these investigations are the first of their kind to be carried out anywhere in the United Kingdom, and research into the various aspects of *Klonotherapy*, including a comparative study of Indoklon and E.C.T., are being pursued at St. Bartholomew's Hospital by Dr. Rose and his colleagues.

ELEVENTH DECENNIAL CLUB

This Club will hold its 32nd Annual Dinner on Thursday, 9th March, 1967 at Simpson's-in-the-Strand.

Professor L. P. Garrod, M.D., F.R.C.P., will take the Chair and it is hoped that as many of his contemporaries as possible will support one who did so much for Bart's in his day.

Cards will be sent to members who have provided their addresses to the Secretary, but owing to changes of address many of these seem to go astray, and there may be some who never have, but might like to join the Club. In either event please communicate with:—F. C. W. Capps, 108 Harley Street, W.1.

January Duty Calendar

Sat. & Sun., 31st Dec. & 1st Jan.
Prof. Taylor
Prof. Scowen
Mr. Burrows
Mr. Ellis
Mr. Dowie

Sat. & Sun., 7th & 8th
Mr. Hunt
Sir Ronald Bodley Scott
Mr. Aston
Dr. Ballantine
Mr. Fuller

Sat. & Sun., 14th & 15th
Mr. Ellison Nash
Dr. Black
Mr. Manning
Dr. Jackson
Mr. Cope

Sat. & Sun., 21st & 22nd
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Boulton
Mr. McNab Jones

Sat. & Sun., 28th & 29th
Mr. Tuckwell
Dr. Oswald
Mr. Aston
Dr. Cole
Mr. Dowie

Physician Accoucheur for January is Mr. J. Howkins.

FINALS RESULTS

UNIVERSITY OF LONDON FINAL M.B., B.S. EXAMINATION OCTOBER 1966

Pass

Atkinson, R. E.
Bailey, A. R.
Brodribb, A. J. M.
Clarke, P. C.
Edelsten, A. D.
Graham-Pole, J. R.
Herbert, J. P.
Langley, J. F. A.
Mountjoy, C. Q.
Phillips, S. J.
Sanders, L. R.
Todd, V. A.
Vartan, C. P.
Ayers, A. B.
Billington, T. R. M.
Browne, G. R. W.
Cooper, R. L.
Gilmore, O. J. A.
Guthrie, T.
James, S. L.
Macdonald, A. M. S.
Nicola, A.
Rendall, C. M. S.
Smith-Walker, M. T.
Tricker, J. A.
Wright, J. J.
Bacon, A. K.
Bishop, C. A. H.
Castleden, W. M.
Day, C. J.
Gorvette, D. P. L.
Hall, M. C.
Kelly, C. J.
Morgan, B. L.
Peek, I. M.
Sadza, D. N.
Sturgess, R.
Turvill, P.

Supplementary Pass List

Part I

Barber, E. R.
Browne, D. S.
Church, C. G.
Cooper, D.
Etheridge, R. J.
Foster, E. A.
Hares, M. M.
Holt, A. A.
Keighley, M. R. B.
Newbold, M.
Porcherot, R. C.
Roberts, M. E.
Sykes, C. A.
Watkins, C. J.
Barnett, R. J.
Burgess, E. M.
Church, J. J.
Coulson, J.
Evans, G. A.
Foulkes, J. E. B.
Harfitt, R.
Jeffries, J. D.
Mathur, V. K.
Pindred, J. R.
Quinn, P. M.
Rousseau, S. A.
Sykes, E. E.
Woodward, R. M.
Brown, A. A.
Challen, P. D.
Coltart, D. J.
Cupitt, C.
Ferguson, A.
Griffiths, N. J.
Higgs, R. J. E. D.
Jennings, J. A.
Miller, R.
Pope, D. C.
Riddell, R. H.
Savage, P. E.
Thomas, W. O. H.

Part III

Evans, C. W.
Wilson, P. B.
Woodward, R. M.

Part IV

Evans, C. W.
Freeth, M. O.
Woodward, R.M.

CONJOINT BOARD FINAL EXAMINATION OCTOBER, 1966

Pathology

Chesney, D.
Dunn, G. O.
Brown, A. A.
Johnson, G. W. E. J.
Cameron, D. J.
Townsend, J. A.

Medicine

James, S. L.
Purcell, J.
Cooper, R. L.
Tricker, J. A.
Morgan, B. L.
Phillips, S. J.
Day, C. J.
Guthrie, T.
Allen, C. L. O.
Rendall, C. M. S.
Blackburne, J. S.
Bolton, J. C.
Clarke, P. C.
Sanders, L. R.
Mountjoy, C. Q.
Bacon, A. K.

Midwifery

Day, C. J.
Freeth, M. O.
Castleden, W. M.
Purcell, J.
Turner, J. M. M.
Anderson, J. K.
Wheeler, T.

Surgery

Day, C. J.
Guthrie, T.
Allen, C. L. O.
Rendall, C. M. S.
Turner, J. M. M.
Gilmore, O. J. A.
Brodribb, A. J. M.
Sadza, D. M.
Graham-Pole, J. R.
Bolton, J. C.
Clarke, P. C.
Sanders, L. R.
Mountjoy, C. Q.
Chesney, D.
Ayers, A. B.
Vartan, C. P.
Macdonald, A. M. S.
Kelly, C. J.
Purcell, J.
Cooper, R. L.
Tricker, J. A.
Morgan, B. L.
Billington, T. R. M.
Atkinson, R. E.
Sturgess, R.
Nicola, A. K.

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

Chesney, D.
James, S. L.
Cooper, R. L.
Tricker, J. A.
Morgan, B. L.
Billington, T. R. M.
Atkinson, R. E.
Sturgess, R.
Nicola, A. K.
Castleden, W. M.
Day, C. J.
Guthrie, T.
Allen, C. L. O.
Rendall, C. M. S.
Bacon, A. K.
Gilmore, O. J. A.
Brodribb, A. J. M.
Sadza, D. N.
Graham-Pole, J. R.
Purcell, J.
Clarke, P. C.
Sanders, L. R.
Mountjoy, C. Q.
Phillips, S. J.
Ayers, A. B.
Vartan, C. P.
Macdonald, A. M. S.
Kelly, C. J.

HOUSE APPOINTMENTS—JANUARY 1967

FIRST APPOINTMENT

Appointment	Name
Jun. H.P. to Sir Ronald Bodley Scott	Kumar, P. J.
Jun. H.P. to Dr. Hayward	Downham, M. A. P. S.
Jun. H.P. to Dr. Black	Kerrigan, G. N. W.
Jun. H.P. to Dr. Oswald	Bailey, A. R.
Jun. H.P. to Professor Scowen	Edwards, C. R. W.
Casualty House Physician	Boston, J. R.
Jun. H.S. to Mr. Hunt	Gilmore, O. J. A.
Jun. H.S. to Mr. Badenoch	Vartan, C. P.
Jun. H.S. to Mr. Tuckwell	Castleden, W. M.
Jun. H.S. to Mr. Nash	Tricker, J. A.
Jun. H.S. to Professor Taylor	Kersley, J. B.
Casualty H.S.	Offen, D. N.
Jun. H.P. to Dept. of Child Health	Purcell, J.
H.S. to Orthopaedic Dept.	Bateman, A. M.
	Graham-Pole, J. R.
	Kelly, C. J.
H.S. to Ear, Nose & Throat Dept.	Atkinson, R. E.
Rotating locums	Vacant

REGIONAL BOARD HOSPITALS

Appointment	Name
H.S. to Harold Wood Hospital	James, S. L.
H.P. (3) to Rochford General Hospital	Gilbertson, R. C.
	Moon, J. A.
	Brodribb, A. J. M.
H.P. (2) to Rochford General Hospital	Moon, J. R. A.
	Blackburne, J. S.
H.P. to Southend General Hospital	Sutcliff, J. R. H.
H.S. (3) to Southend General Hospital	Cooper, R. L.
	Nicola, A. K.
	Macdonald, A. M. S.
H.P. to Whipps Cross Hospital	Browne, G. R. W.
H.S. (2) to Whipps Cross Hospital	Burgess, A. M.
	Weller, R. M.
H.S. to Redhill General Hospital	Billington, T. R. M.
H.S. (3) to Royal Berks Hospital	Rendall, C. M. S.
	Thornback, P. C.
	Crowther, A. N.
H.P. (2) to Prince of Wales's Hospital	Edelsten, A. D.
	Tatham, P. F.
H.S. to Prince of Wales's Hospital	Phillips, S. J.
H.S. to North Middlesex Hospital	Bacon, A. K.
H.P. to Connaught Hospital	Gately, J. F.
H.P. to Royal Cornwall Hospital	Sadza, D. M.
H.P. (2) to St. Leonard's Hospital	Ayers, A. B.
	Todd, V. A.

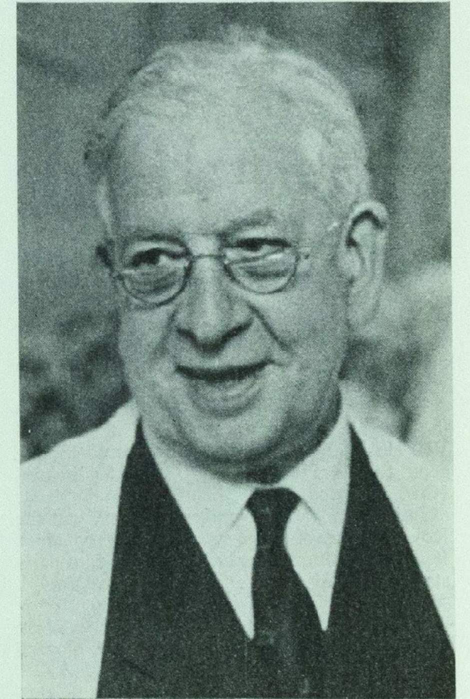
SECOND & THIRD APPOINTMENTS

Appointment	Name	
H.P. to the Children's Department	Gibson, J. A.	
H.S. to the E.N.T. Department	Cole, I. E.	
H.P. to the Skin & V.D. Departments	Petty, H. R.	
H.S. to the Ophthalmic Department	Leaver, P. K.	
	Magauran, D. M.	
H.O. in Obs. & Gynae	Harper, D. R.	Obs.
	Owen, D. G.	Obs.
	Smart, C. J.	Gynae.
	Wilkinson, J. M.	Gynae.
H.S. to the Thoracic Department	Cooke, T. J. C.	
	Kettlewell, M. G. W.	
H.S. to the Neurosurgical Department	Davis-Dawson, L.	
	Khadjeh Nouri, D.	
H.P. to Depts. of Neurology & Psychological Medicine	Anderson, C. R. S.	
H.O. Radiotherapy Department	Waterworth, M. W.	

At the time of going to press this list was subject to confirmation.

Retirement

Sir Clifford Naunton Morgan



Who's Who gives us the bare outline of the man so many have come to respect and love. It cannot however convey anything of his character or of those attributes which have endeared him to so many. Born at Penygraig in 1901, qualified M.B. 1924, passed F.R.C.S. 1926, demonstrator of anatomy 1929. These are the facts. It is true Clifford Naunton Morgan was never a house surgeon at Bart's but the impression he made on Charles Gordon Watson at St. Mark's Hospital was such that he insisted that he should become his Chief Assistant at Bart's in 1930, the same year as he became surgeon to the Metropolitan Hospital. From this period there date a number of true and apocryphal stories of the association of these two great rectal surgeons; when assisting Sir Charles who was demonstrating radium implantation to some French surgeons, Clifford Naunton Morgan was trying to hold the "old man" back by sotto voce warnings. At last Sir Charles could stand it no longer and put everything down saying "kindly let me do my own operation my own way". Clifford Naunton Morgan at once apologised and the operation went on, and at once, the internal iliac vein was severed, whereupon Sir Charles said "there you are Morgan, look what you made me do". However very soon afterwards when Sir Charles' wife was ill, he requested that Naunton Morgan be asked to assist Sir Thomas Dunhill at the operation. There are innumerable stories about Clifford Naunton Morgan but usually they express the confidence and affection all and sundry have in him and for him.

It was at the earliest moment in Naunton Morgan's career that he became interested in colon and rectal surgery. During his association with Gordon Watson and Percy Lockhart-Mummery, he determined to improve upon the then routine procedures. His early publications disclose this fact. In 1927 in the St. Bartholomew's Hospital Journal* there was a paper on "*Practical considerations on the pathology, diagnosis and treatment of ano-rectal fistula*". In 1929 there was a paper on perianal infections, 1938 papers on pilonidal sinus, familial polyposis, excisions of the rectum and resection for diverticulitis. Several things stand out in these papers. Firstly that they were in advance of their time, secondly that anatomy and pathology are stressed, and thirdly the approach to the patient, "The probe is an unnecessary and painful instrument in the diagnosis of an anal fistula" he wrote in 1927. This lesson still needs underlining to-day.

There are however, at least three papers which may be regarded as classic milestones in proctology. The descriptions of the ligature and excision operation for haemorrhoids with E. T. C. Milligan, of the anatomy of the ischio-rectal fossae and the relationship to fistula-in-ano which was his presidential address at the Proctological Section of the Royal

*St. B.H.J., *May*, 1927: Vol. XXXIV, No. 8, p. 495

Society of Medicine, and his paper with F. Avery Jones in the St. Bartholomew's Hospital Reports 1938 and later at the R.S.M. on the administration of fluids to surgical patients. All these should be read by students and doctors to-day and it is perhaps the last mentioned which has been of the most universal usefulness, being the practical basis of intravenous treatment to-day. The N/5 saline/glucose solution is known as *Bart's solution* by many outside these walls.

In 1938 he carried out with O. V. Lloyd-Davies the first synchronous combined abdomino-perineal excision of the rectum. This however was not to be published until 1948, for when war came, Naunton Morgan left Bart's at once, serving in the Middle East first as O.C. 42nd General, and later at the 15th Scottish General Hospital in Cairo. He then became Consultant Surgeon to the Persia-Iraq Force and later to East Africa Command. Since the war he has been Consultant Surgeon to the Navy, Army and Air Force which must be a very rare distinction.

Naunton Morgan is Consultant Surgeon to the Royal Masonic Hospital, King Edward VII Hospital of Officers and Consultant Surgeon to the Hospital for Tropical Diseases. How he manages all this and his duties as examiner to various universities, and at the Royal College of Surgeons, one cannot imagine. It is his devotion, energy, and love of an early start to the day which enable him to accomplish so much.

Honours have come to Naunton. He is an honorary member of most of the proctological societies in the world. An F.R.C.O.G., F.A.C.S. and so on. He has been Commonwealth Professor, Sims Travelling Professor, Bradshaw Lecturer and has given many Memorial Lectures in the United States. Next year he gives the Tom Jones Memorial Lecture in Cleveland, which must please him greatly as Tom Jones was a doyen of American Surgery, who inspired him personally at an early age. The Council of the Royal College of Surgeons of England has been graced by him for some time, first as an ordinary member and later as Vice-President. Many feel that if he had been a better committee man he would have been its President. Committees however, were synonymous with inactivity to Naunton and though he attended them, he could not really abide them. Latterly he has been honoured by the Swedish Royal Family and by our own Sovereign: an honour so richly deserved. Yet with all this Sir Clifford remains a surgeon with humility, humanity and green fingers, born out of a mind which enquired into the *whys* and *wherefores* of anatomy and pathology and a will to improve techniques.

One may wonder if Sir Clifford has any love other than surgery. This he certainly has: for his family, of whom he is justifiably proud, and for his farm at Inkpen where he has a herd of pedigree Ayrshire cattle.

It was with sadness in our hearts that we said goodbye to Sir Clifford this December. However, it must give him great satisfaction that his immediate successor is John Griffiths, trained and guided by himself, just as in earlier days he had been so splendidly by Sir Charles Gordon Watson.

Patients, students and staff bid him a fond farewell wishing him a long, healthy, happy and richly deserved retirement.

I.P.T.

Abernethian Society

Thursday, 17th. November:

Professor R. R. A. Coombs, Ph.D., F.R.S.

"The Allergic Reactions and Medicine".

The distinguished immunologist, Professor R. R. A. Coombs, first addressed the Society in 1958, but we were fortunate enough to capture him for a return visit. Professor Coombs, who was recently elected F.R.S., became the sixth Fellow of the Royal Society to visit the Society in the last half-dozen years. He has just been appointed to the Quick Chair of Experimental Biology at Cambridge University.

The Professor began by referring to the prevailing confusion in immunological terminology. He adopted von Pirquet's original definition (1906) of allergy as an altered biological reactivity, regardless of whether it led to states of immunity or hypersensitivity (terms which, he suggested should be restricted to the description of purely clinical states). Having stressed the immense importance of immunoprophylaxis in modern medicine he went on to describe the many different immunoglobulins which could now be isolated from human serum; he suggested that the unitarian theory of antibodies—that is, one antibody capable of performing many different functions (agglutination, complement-fixation etc.)—had now become obsolete, and should be replaced by a concept of "one antibody, one function". These various functions were performed by the different immunoglobulin fractions (IgA, IgM etc.).

Professor Coombs devoted most of the rest of his lecture to his classification of the allergic reactions*, including a number of illustrations of each type.

In the *Type I* reaction antibodies passively absorbed onto the cell membrane sensitise that cell to react with the specific antigen, with the release of histamine and other pharmacological mediators. This reaction is responsible for immediate-type hypersensitivity. It is the underlying reaction of anaphylaxis, both general (broncho-constriction, collapse etc.) and local (hay fever, asthma, urticaria). The reaction depends upon the formation of atopic or reaginic antibodies which show a strong affinity for the cell surface. These antibodies have eluded in vitro determination until recently, when it was found that they would passively sensitise primate (but not guinea-pig) skin.

The speaker presented a hypothesis for the aetiology of the cot death syndrome based upon a Type I reaction, but emphasized that it had not yet been proved. Infants fed on cows' milk could often be shown to have been sensitised to protein constituents in that milk. The suggestion was, therefore, that while the infant was asleep it regurgitated milk into the lungs where a localised and fatal anaphylaxis was set up. It had been possible to produce a very similar and fatal reaction in a sensitised guinea-pig by trickling milk down its larynx, provided the animal had been anaesthetised.

In the *Type II* reaction antibody combines with antigen which is carried on the cell membrane or becomes closely bound to it, and cell destruction then takes place in the presence of complement. This is the basis of transfusion reactions, and similarly haemolytic disease of the newborn could be considered as a Type II allergic reaction. In this context the Professor explained the theory behind giving anti-rhesus serum to mothers at risk, immediately after labour, to destroy any rhesus-positive foetal cells which had leaked across the placenta. Type II mechanisms were incriminated in the thrombocytopenic purpura of Sedormid (and quinidine) hypersensitivity, and possibly in the pathogenesis of acute nephritis and rheumatic fever.

Type III reactions were characterised by the formation of antigen-antibody-complement complexes within the circulation which had irritating and toxic properties especially on the vessel wall. Such a mechanism underlies the Arthus reaction and serum sickness. It was suggested that penicillin hypersensitivity might also result in this fashion, with antibody formed against the drug over a period of some ten days, and then reacting back. It seemed that this reaction might play a part in the connective tissue and rheumatoid diseases, too.

Type IV reactions are responsible for delayed-type hypersensitivity, and appear to be mediated not by serum antibodies but by "actively allergised cells", probably small lymphocytes. The reaction plays a vital role in the aetiology of tuberculosis, and underlies the mechanism for graft rejection and contact dermatitis.

Professor Coombs spoke with immense enthusiasm for more than an hour and touched on a number of topics in addition to those already mentioned. He explained that auto-allergic drug reactions were only different from other allergic reactions with regard to the special nature of their antigens, and that one of the benefits of his classification was that they could all be suitably included. His enormously stimulating lecture made one thing very clear: what a pity it is that the current curriculum pays such scant attention to the teaching of immunology.

Dr. O'Grady kindly proposed a vote of thanks to the speaker.

Thursday, 24th. November:

Dr. Richard Hunter, M.D., M.R.C.P., D.P.M.

"The Insanity of King George III".

A large audience came to listen to Dr. Richard Hunter, consultant psychiatrist at the National Hospital, Queen's Square, who has recently published (together with Dr. Ida Macalpine) a new and remarkable theory on the illness of Mad King George.† They were amply rewarded with a most entertaining lecture. Dr. Hunter advanced his theory so cogently that one was left wondering why on

*This classification has been devised by Professors Gell and Coombs and is included in their textbook, *Clinical Aspects of Immunology*. It is based upon the initiating antigen-antibody reactions.

†B.M.J., 27, 1966, i, 65.

earth nobody else had had the same idea. We learnt in fact that there had only been two scientific analyses of the subject (both by Americans) since the King's death in 1820, which was all the more remarkable, as the speaker pointed out, in view of the political and historical repercussions of the royal "insanity".

Drs. Hunter and Macalpine have had access to four primary sources for the first time in a clinical study of the King's illness, and they have thoroughly surveyed much of the contemporary literature on the subject, including the diaries of the King's physician, Sir George Baker, and others. From these it became clear that the King's mental symptoms were closely associated with a number of physical features, including abdominal pain, weakness and symptoms of peripheral neuritis. Convulsions and delirium preceded his "entire alienation of mind" in every case, and after the King recovered from his first serious bout of "insanity" in the spring of 1789—an event which was received with nation-wide joy and thanksgiving*—he enjoyed some ten or so years completely free of symptoms. And even in his final illness, from 1811 until his death, the attacks continued to be intermittent, and the King, now blind, deaf and in his seventies, still showed amazing powers of recovery.

Dr. Hunter gave a fascinating and detailed account of the attack of 1788-89, the first in which it was deemed necessary to consult those doctors skilled in the study of "intellectual maladies". No-one was more dismayed at this irrevocable step than the King himself who, realising the implications, supposed that he would be ashamed thereafter to show his face in public. A cleric, one Dr. Francis Willis, was summoned from the care of his madhouse in Lincolnshire to take charge of the unfortunate monarch, but mercifully George recovered before being made to suffer too much at the hands of his zealous physicians.

"The report of the physicians is worded as foolishly as ever" observed Lord Grenville, Prime Minister at the time, after one of the less informative daily bulletins. Certainly the doctors were greatly handicapped by etiquette; they could only speak when spoken to, so that whole interviews might pass in total silence.

Dr. Hunter argued convincingly that the King suffered from acute intermittent porphyria, and that his "insanity" was a classic example of the toxic confusional state frequently found in this disease. He and Dr. Macalpine have assembled a great deal of evidence to support their theory which would make George III the first recorded case of the disease. It certainly seems a more reasonable diagnosis, in view of the new light they have brought to bear on this case, than its various predecessors, notably that of manic depressive psychosis following either sexual or political frustration.

The Society thoroughly enjoyed Dr. Hunter's fine lecture, and a warm vote of thanks was proposed by Dr. A. M. Dawson.

R.C.N.W.

*On this occasion the king was so moved by the reception he received on his first public appearance that he declared it almost made his illness worthwhile.

Thursday, 1st December.

Professor Francis Camps, M.D., M.R.C.P.

"Jack the Ripper"

There was not an empty seat to be seen in the Physiology Lecture Theatre at this last meeting of the term. Professor Camps delighted the large audience with his fascinating detective work, and salacious details of the revolting crimes of the 'Ripper'.

Professor Camps explained how his technician had discovered original plans and drawings in the London Hospital basement relating to the murder of Catherine Eddowes. He brought these originals along with him, together with some slides of the letters of Jack the Ripper. The Professor gave us a brief resumé of the earlier murders of Nichols, Chapman, Stride and Kelly. All the bodies had been grossly mutilated, and the surgical fervour with which this had been done led to speculation about the skills of the assailant. None of the victims was heard to cry out in objection, and as their faces were said to be congested, Professor Camps suggested that they may have been strangled before the mutilation, a common pattern in such sexual crimes. It was the case of Catherine Eddowes which had had new light thrown on it by the drawings, amongst which were a beautiful sketch done at the scene of the crime, and others of the body at the mortuary. The former showed the lady's entrails in a considerable state of disarray, some hanging over her shoulder and portions detached on the ground.

Due to rivalry between the City and Metropolitan Police Forces, and incompetence at the mortuary, less was learned by the pathologist than might have been. It was noticed that the attacker had performed a left nephrectomy (probably in five minutes flat!). Shortly afterwards a Mr. Lusk, Chairman of the Whitechapel Vigilance Society, received in his morning mail, a box containing a portion of human kidney, and an accompanying letter from the Ripper saying that he had fried and enjoyed the remainder of the kidney. The Pathological Curator at the London Hospital examined the kidney, and considered it to have belonged to Miss Eddowes.

We hoped that Professor Camps might then be able to shed some light on the identity of the Ripper, but alas, he said that despite the new finds a solution was no nearer. He thought the theory that he was a surgeon unlikely, but that perhaps he was a butcher or mortuary attendant with a modicum of anatomical knowledge. It was doubtful whether the Ripper would have been caught even with today's modern aids to detection.

Dr. Donald Teare thanked the Professor for giving up an evening by the fireside to come and tell us about this fascinating case, with its wealth of forensic material.

The retiring President thanked the Committee for their untiring work, and wished success and enjoyment to the newly elected committee. They are:—

President: M. E. Setchell
Secretary: G. W. Libby
Treasurer: I. Corrall
Committee: P. M. Quinn
P. B. Wood
Charterhouse Rep.: D. K. Moynagh

JANUARY MEETING.

Sir Derrick Dunlop, Chairman of the Drug Safety Committee, will speak on 'The Drug Problem' on Thursday, 26th January.

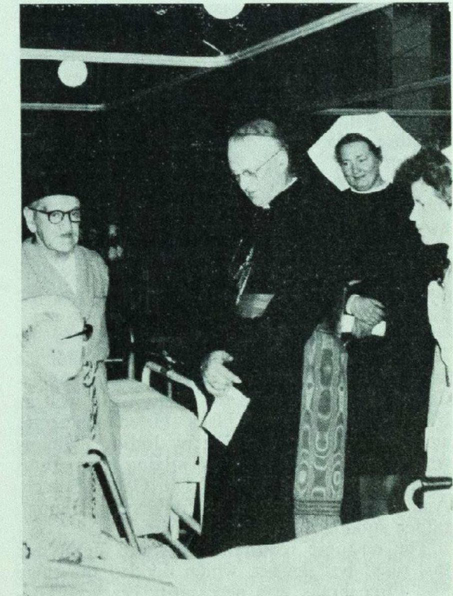
M.E.S.

Cardinal Heenan at The Royal Hospital

The visit of Cardinal Heenan on Tuesday, 15th November was the first visit by a Cardinal in the history of the hospital. Cardinal Heenan came to visit Bart's in his capacity as Bishop of Westminster—it is his episcopal duty to visit the parishes and institutions of the diocese, Bart's being in the parish of St. Mary Moorfields.

Arriving at 2 p.m. on a dismal wet afternoon, Cardinal Heenan was welcomed at the door of the Great Hall by officials of the Hospital, and then conducted on a short tour of some of the wards of the hospital. He visited Fleet Street, Harmsworth, Dalziel, Annie Zunz, Bowlby and Radcliffe wards, chatting to the patients in an unexpectedly calm and gay fashion.

An assembled crowd of about two hundred catholics greeted him in the Great Hall, where the Cardinal endeavoured to meet every one of those present. In a short address before tea, he expressed his thanks to Matron, the Clerk and Chairman of the Governors for "their delicate thought" in arranging for him to visit the hospital. He remarked that "to look after the sick, was closest to the priesthood". During tea, he talked quite informally to the various groups gathered there. His departure at about 4.45 p.m. was sudden, quiet and without demonstration—a short, but most appreciated visit.



The Cardinal in Dalziel Ward

NURSERY PRODUCTIONS

Tricolour Suite
Before the Flood

Before the Flood—Family Council

It was encouraging to see a large new cast of enthusiastic actors in this year's Nursery Productions. The two plays they chose were a great success, insofar as the audience enjoyed themselves as much as the actors.

The first play—Tricolour Suite—by Peter S. Preston, set in postwar Paris, with its cast of inefficient politicians, gendarmes, and a French waiter, provided good scope for character acting. The hero André Garnier—a suave young Frenchman, who tries to get into power by back door, or perhaps bedroom door methods—was played admirably by Pedro Vieyra whose confident acting held the play together. His mannerisms and accent were delightfully French, and his confidence smoothed over the awkward moments—and there were a few—where the co-ordination went awry. My only criticism might be that his gestures aside to the audience were too frequent. By his conspiracy with us he became remote from the other actors, and detached from the play itself.

The part of Athalie was well played by Jacqueline Hall, who gained more confidence later on, in an amusing portrayal of a sophisticated diplomat's wife. Jo Skelton did well as Mme. Lenoir—a dour black-skirted concièrge; and there was good acting by Judith Williams who wisely steered clear of mixing her natural Welsh accent with Pays De Galle French. Ann Sandford played a convincing, though rather subdued American tourist.

The costume requirements were simple for this play; but the set, which divided the stage into three areas was necessarily cramped, because of the unhelpful shape of the Gloucester Hall stage. Duncan Jack had a busy time producing a large variety of sound effects, but it was a pity that they did not always correspond to what was going on upon the stage. Electric bells rang before they were pressed and at one point the actors had to compete with music so loud that their words were lost. This was a difficult play to produce because of these hazards, and Benita Wylie did well to co-ordinate the large cast.

The second play—Before the Flood by A. A. Milne—was less ambitious in its requirements; but it provided more acting of a dramatic situation, rather than character sketches; and on the whole it left more room for imaginative production. The costumes and set were very ingenious, and showed imaginative use of a few materials. I particularly liked the specially shaped table—an attempt to introduce more depth into the shallow stage.

This play went smoothly in contrast to the first. George Lodge as Noah, played an old man convincingly, though sometimes he lacked authority. Hannah (Jill Levitt) tended to overact, and appeared rigid in her acting, without the freedom and ease that Ham (John Shepherd) had. I liked Jo Winner and Barbara Appleby as Meribal and Japheth—they played the part of the two lovebirds with great gusto. Julie Gould gave an excellent and refreshing interpretation of Tirzah; and Suzanne Pablot (Ayesha) provided us with her usual high standard of acting.

Despite the unaccountable modesty of the players in not appearing for a curtain call, it was a successful and enjoyable evening, with promise of some very good acting in the productions this year.

A. J. Barrett.

CATARACT SURGERY—
its History and Evolution

by H. B. Stallard

Blindness, the boredom of a pink grey world, the inevitable humiliating loss of independence and the severe limitations in the choice of useful work to do in the world, is about the most tragic of human afflictions. Every year thousands become temporarily blind in old age from cataract in Western countries, and in the East the number is millions. However, of all serious eye diseases cataract, uncomplicated by any other intra-ocular disease, has an excellent prognosis in the hands of a competent eye surgeon. Cataract is indeed almost exceptional in being a disorder in which after complete loss of a function, surgery effects complete restoration, the patient is blind and after operation sees.

Nevertheless patients suffering from cataract are still to-day exploited by charlatans, humbugs, quacks and other scurvy knaves, who battening on the sufferer's fear of blindness and dread of operation, treat them to no good effect with exercises, injections, drops, neck-twisting, pseudo-electrotherapy and other futile antics.

History

Susruta (generally placed about 1000 B.C.) is accredited with the earliest written account of cataract surgery in a voluminous ancient medical work entitled "Susruta Samhita". From the Indian translations it seems likely that Susruta performed couching (reclination) and discission (needling) of the cataractous lens. It is likely that the techniques of these operations were seen by the medical men who accompanied the eastern expedition of Alexander the Great and so ultimately brought them to the Mediterranean countries.

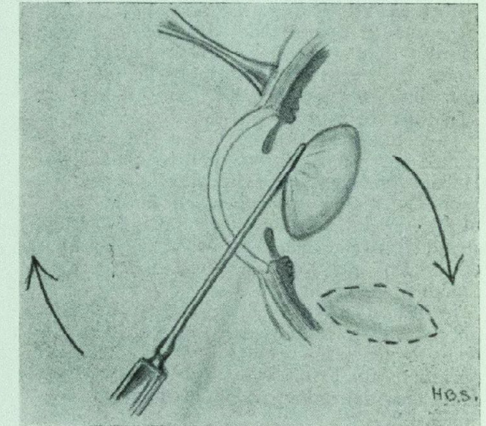


Fig. 1.—Diagram. Section of anterior part of eye to show reclination (couching) of the lens. The instrument inserted into the anterior chamber presses the opaque lens posteriorly and downwards into the vitreous humour.

So slow and even static was the practice of surgery for about 2,700 years that the displacement of the opaque lens posteriorly and downwards into the vitreous humour (Fig. 1) was practised till 1745 when Daviel (France) was the first to extract cataract through a limbal incision. Indeed couching is still practised to-day by itinerant quacks in India, and among primitive peoples (Fig. 2). Its immediate hazard is infection from the inadequately sterilized instrument passed into the eye to displace the lens, and its late complications are iridocyclitis and complicated glaucoma. Probably the only

and very rare justification for its practice to-day is for an aged blind maniac, who might by his antics do irreparable damage to the operated eye. For younger maniacs with the prospect of some years of life, general anaesthesia, careful and close suturing of the limbal incision and covering the operated eye with a plaster of Paris bandage for 2-3 weeks may be done.

In the days of ancient Babylon, eye surgeons received the highest professional reward for successful restoration of sight and the direst penalties for failure, their hands were cut off and they were blinded by hot irons. A possession of greatest value must have been a world-record breaking racing camel. Fig. 3 shows Eric Gill's relief of the healing of blind Bartimaeus which is over an entrance at Moorfields Eye Hospital. It is possible that digital pressure on the eyes directed downwards from above ruptured the pathologically friable suspensory ligament of hypermature cataract and displaced the lens into the lower part of the vitreous humour for when Bartimaeus opened his eyes his observation that he "saw men as trees walking" is suggestive of aphakic vision.

Even the great Vesalius in the 16th century copied uncritically the 9th century textbook of Hunain ibn Ishaq which showed on the authority of Galen (2nd century) the lens in the centre of the eyeball. It was not till 1600 that Fabricius ab Aquapendente demonstrated the true position of the lens and Kepler in 1604 described its function.

In 1612 the status of eye surgery fell low for the Statutes of Avignon "permitted everybody to practice couching, stone-cutting and operations for hernia without examination because these operations simply need nothing but practice".

Early in the 18th century Chevalier Taylor, a notorious, pompous, itinerant charlatan, surgeon-oculist to Queen Anne toured Europe in a gilded coach and performed the couching operation. Like others of his kind he was careful to be many miles away by the time serious intra-ocular complications were likely to occur.

Mr. John Gooddy reminded me that Norman Moore attributed the founding of the Eye Department at Bart's to John Freke. The Journal entry of 1st June, 1727 states—"Through the tender regard for the deplorable state of blind people, the governors appointed Mr. John Freke to couch and take care of diseases of the eye".

It was not till 1745 that cataract extraction was attempted, when Daviel made a limbal section in the lower half of the eye with a

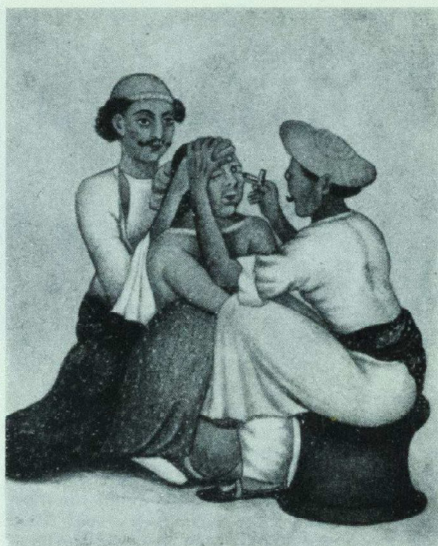


Fig. 2.—An Indian coucher seated before his patient. The assistant holds the head steady.

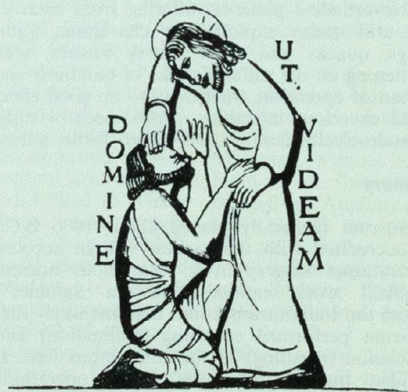


Fig. 3.—The healing of blind Bartimaeus. (Eric Gill's relief over an entrance to Moorfields Eye Hospital).

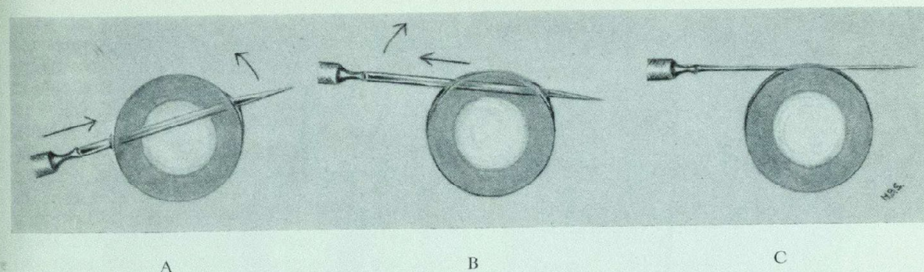


Fig. 4.—Cataract section (incision) made with von Graefe's knife. Diagram to show the manoeuvres of the cataract knife in making a corneal section. *Right eye.* The straight arrow indicates the direction of the knife's passage and the curved arrow its sweep upwards around the periphery of the cornea. A; After the counter puncture the back of the knife is held down against the lower margin of its entry puncture, the blade is passed towards the nasal side and at the same time it is swept upwards around the periphery of the cornea in the upper nasal quadrant. B; The blade is withdrawn to the temporal side and swept up through the periphery of the upper temporal quadrant. C; To complete the section the blade is brought horizontal. (The conjunctival flap and corneo-scleral suture have been omitted for the sake of clarity).

triangular knife and enlarged this incision either with scissors or a blunt-ended knife. The corneal flap was lifted, the anterior lens capsule incised and the opaque lens, impaled on a lance was lifted out of the eye. The risk of post-operative infection was a deterrent to the practice of Daviel's operation until the Listerian epoch when von Graefe in 1865 made a number of technical improvements which form some of the basis of the modern cataract operation.

Cataract Section (Incision)

Von Graefe's chief contribution was the exquisitely made knife to which his name is attached, and its use to make a peripheral incision around nearly half of the upper circumference of the corneo-scleral junction (Fig. 4). This incision is the most difficult and the most skilled in the whole field of surgery. It requires unique precision in its plane and in its timing in order to avoid rapid loss of aqueous humour and the folding of the iris over the advancing edge of the knife. A famous French surgeon's observation "La cataract extraction est la section" is almost true for after a perfect section (incision) the rest of the operation generally goes smoothly, but a bad section is followed by several immediate and remote troubles, sometimes disasters. Ambidexterity in making this incision, the right hand for the patient's right eye and the left for his left eye, when the surgeon is either seated or standing behind the patient's head is the hall-mark of an accomplished surgeon. Because of the difficulties in making a cataract section with von Graefe's knife, there has been for some years a trend for young surgeons and for the infrequent operator in an outpost of our dwindling colonial empire to open the anterior chamber by incising the limbus with either a No. 15. Bard Parker knife or a fragment of razor-blade fixed in a special holder (Fig. 5). The anterior chamber is entered at one end of the incision for a few millimetres and aqueous escapes. Into this opening is introduced one blade of a pair of corneal scissors and the incision is completed (Fig. 5). Another alternative, less satisfactory, and dangerous for the infrequent operator, is to pass a keratome through the limbus into the eye and to complete the length of this limited incision with corneal scissors.

In the modern cataract operation extra skill is necessary to make the section between presection placed corneo-scleral sutures (Fig. 6). Until the last two decades very few surgeons used corneo-scleral sutures to close the section. Various patterns of suturing have been designed by Liegard (1913) Stallard (1933 and 1948) Lindner (1936) and McLean (1940).

Extracapsular or intracapsular extraction?

Until the second or third decade of the 20th century extraction of the cataractous lens complete in its capsule was regarded as too hazardous by most eye surgeons to be accepted as

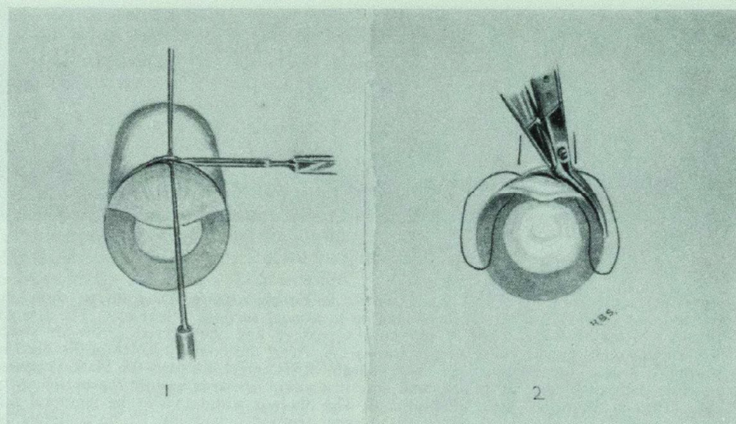


Fig. 5.—Limbal incision made ab externo. (1) Conjunctival flap reflected over cornea. The edges of the limbal incision are retracted by fine scleral hooks. (2) Two corneo-scleral sutures have been inserted and the anterior chamber entered at one end of the limbal incision. Completion of incision with corneal scissors.

a routine. The appalling sequence of troubles, particularly blindness from sympathetic ophthalmitis after vitreous loss was the main deterrent to attempting this operation, which is tidier than the extracapsular extraction. After the latter the posterior lens capsule and soft lens matter are left in the eye. The posterior capsule generally requires a second operation—

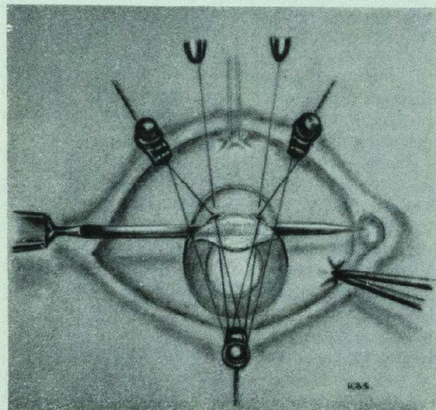


Fig. 6.—Cataract section made between the retracted arms of a double 'bridle' corneo-scleral suture (Stallard's).

capsulotomy—and the soft lens matter may irritate the iris and ciliary body, sometimes severely, when a patient is allergic to his lens proteins.

The first surgeon to achieve intracapsular cataract extraction was an Englishman, Sharp, in 1773 by the somewhat crude technique of thumb pressure after the incision. Over 100 years passed before it was attempted again by Pagenstecher (Germany), who in 1877 indented the cornea in front of the limbus below with fixation forceps, and depressed the scleral edge of the incision above so as to introduce a spatula behind the lens. Again the risk of vitreous loss from this somewhat rough procedure made its practice unacceptable. In 1910 "Jelunda" Smith of the Indian Medical Service described his expression technique of intracapsular extraction which he had done on 20,000 Indian patients. It seemed evident that the Indians' vitreous could stand operative pressure without its escape from the eye better than Europeans' on whom this technique too frequently resulted in severe vitreous loss. In India occurred the historical advent of cataract surgery and so it was fitting that about 2,900 years later came Smith's stimulus to extract the cataractous lens complete in its capsule thus dispensing with the necessity for Indian village people to make another long journey, often financially impossible, for a capsulotomy operation before they could see.

In the years that followed Smith's operation the dangers of the intracapsular operation were much reduced by such masters as Elschnig (1924) in Prague, Arruga in Spain and Verhoeff and Kirby in the U.S.A. In the late twenties Sinclair and Traquair in Edinburgh were exponents of this operation but no surgeon in London attempted it till the mid-thirties, and even then it was done with the profound disapproval of the more senior surgeons at Moorfields. Several advances particularly over the last two decades have reduced to only one per cent, in the hands of a skilled surgeon, the dreaded complication of vitreous loss and even this can be checked and controlled by the timely closure of the incision by drawing on pre-section sutures.

The lens capsule and suspensory ligament

Considerable technical skill was required to seize the anterior lens capsule with special forceps just in front of the equator of the lens, either in the 12 o'clock or 6 o'clock meridian, and by careful to and fro rotation of the lens with increasing excursions (Fig. 7) and counter point pressure, to break by degrees the suspensory ligament of the lens, and when this was achieved to lift the lens forward through the pupil and then up and through the section (limbal incision).

These manoeuvres on patients between 25-55 years of age are sometimes embarrassed by the suspensory ligament being tougher than in the elderly so that the lens capsule ruptures beneath the forceps grip. If this mishap occurs at an early stage in the manoeuvre the operation is converted into an extracapsular extraction, if late and during the delivery through the pupil it is possible to extract the lens and the ruptured capsule after it. An embarrassing situation is when the capsule breaks after partial rupture of the suspensory ligament, for vitreous is forward and the lens has not come through the pupil. To effect a wider and more even distribution of the grip on the lens capsule and so to reduce the risk of capsule rupture Professor Barraquer (Barcelona) designed a suction cup attached by a tube to a motor. This technique has the disadvantage of introducing into the anterior chamber the somewhat cumbersome cup and particularly serious was the aspiration of vitreous in some cases. Gentler suction is effected by a small hand suction bulb. This suction technique is quite justifiable in the case of hypermature cataract in which the capsule is so tense, a state the French so aptly call 'gonflé', that a forceps grip is impossible,

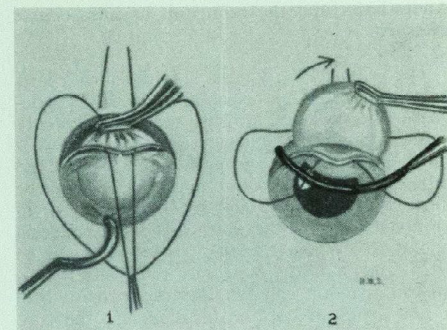


Fig. 7.—Intracapsular cataract extraction. (1) the capsule is gripped with forceps in front of the equator at 12 o'clock. Point pressure is made with an expressor at 6 o'clock. (2) Delivery of the cataract through the section. The 'bridle' corneo-scleral suture is drawn up to close the section immediately the cataract is clear of the eye.

and in fact simulates glissading on the surface of ice.

In 1959 J. Barraquer, the second son of the Spanish Professor, made by accident an important discovery whilst attempting to treat vitreous opacities with α-chymotrypsin (a proteolytic enzyme) when he noticed the lens sinking back into the vitreous and realized that α-chymotrypsin had dissolved the suspensory ligament. As Pasteur once remarked "chance favours the prepared mind". Barraquer realised that this discovery would ease the delivery of the cataractous lens in intracapsular extraction, and remove the traction risks of a strong suspensory ligament in young and middle aged patients which causes rupture of the capsule during excursions of the capsule forceps. This discovery has taken much of the manual skill out of the intracapsular extraction by forceps.

In 1961 Professor Krwacwicz (Poland) described the cryoextractor, a hollow pencil containing liquid nitrogen at –79° with a curved nickel plated copper ball tip. On application of the tip of this instrument the cataractous lens adheres to it by a frozen area over 2 mm. in diameter. It is particularly useful in extracting a dislocated lens and one that is hypermature. Its dangers for routine use are the risk of damage to the iris despite the use of a traction guard, and the necessity to bend the cornea back in order to avoid contact with the point of the cryoextractor.

Anaesthesia and the reduction of intra-ocular pressure

The value of akinesia of the orbicularis muscle and the extra-ocular muscles by adequate injection of a local anaesthetic, supplemented more frequently these days by skilfully administered general anaesthesia and tubo-curarine has done much to reduce the intra-ocular pressure and so lessen the risk of vitreous loss in the intracapsular extraction operation. When I was a House-surgeon in 1927 and indeed for some years after this, anaesthesia for cataract surgery consisted in a few drops of cocaine instilled into the conjunctival sac. As there was no akinesia of the superior rectus muscle and no traction suture placed in this muscle the patient used to be implored, sometimes testily, to look down, a feat which some found as impossible as it was for the surgeon to procede with the operation. In those days pressure on the eyeball from the contractions of the orbicularis muscle, the weight of the speculum separating the eyelids, and the movements of the eyeball raised the intra-ocular pressure often quite dangerously so that disasters which could have been avoided by modern technique were more common than today and it is little wonder that the better intracapsular operation, attempted without such proper precautions, fell into disrepute among the senior surgeons of that time.

Today the branches of the upper division of the facial nerve are blocked by an injection of xylocaine 2 per cent as these traverse the zygomatic and maxilla, a retro-ocular injection is given into the muscle cone to block the post-ganglionic fibres of the ciliary ganglion, and the superior rectus muscle belly is also injected with xylocaine. Amethocaine drops are instilled for surface anaesthesia of the conjunctiva and cornea. In addition to this local anaesthesia and akinesia it is well to give pentothal and curare to nervous patients, to those whose co-operation under local anaesthesia is in doubt, to deaf patients, foreigners, doctors and nurses whose knowledge may increase their apprehension and so raise their intra-ocular pressure, and to the mentally unstable whose behaviour would be unpredictable under local anaesthesia. In the past, the eye surgeon dreaded the performance of the anaesthetist who induced vascular congestion of the eye at the time of operation, for during post-operative retching, coughing and vomiting, the cataract section opened with prolapse of the iris and sometimes vitreous loss. Today these unpleasant effects are generally prevented by combined local and general anaesthesia with pentothal and the careful suturing of the cataract section reduces the risk of post-operative prolapse of intra-ocular contents and haemorrhage.

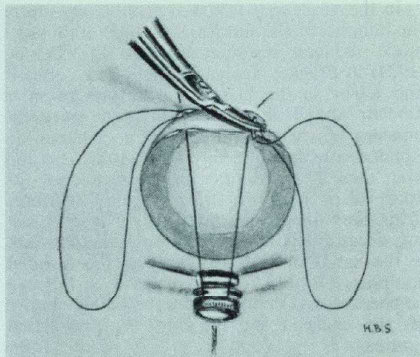


Fig. 8.—Insertion of double ('bridle') corneo-scleral suture (Stallard's) before cataract section.

Corneo-scleral sutures

An accepted and most important step in the modern operation of intracapsular extraction is the better security against disaster afforded during operation and in post-operative convalescence by accurately placed corneo-scleral sutures which traverse the line of the section. I have found it preferable to insert two of these through small incisions about 2 mm. long and 0.5 mm. deep at the 11 and 1 o'clock meridia at the corneo-scleral junction before the section is made (Fig. 8). The arms of this suture are festooned over lid screw-clamps which retract the lids, are drawn taut and clamped to the head towel with bulldog clips (Fig. 6).

After the section is completed the loops of the suture are taken off the screw-clamps and are drawn up so as to leave loops on either side of the section and of sufficient length to allow the delivery of the cataract through the section. The assistant surgeon holds the two scleral arms of this double corneo-scleral suture and as the equator of the cataractous lens enters the incision he draws on the suture gradually so that as the lens leaves the eye the incision is closed. Division of the corneal arm of the suture converts it into two and these are then tied separately.

In cases of glaucoma where the section has been brought deliberately through the cornea below a filtration bleb a third suture in the 12 o'clock meridian is necessary. Rarely, when there is some bulging of the anterior part of the eye one or two more extra corneo-scleral sutures are necessary.

The conjunctival flap is replaced and sutured with a continuous key pattern suture. To effect immediate miosis sterile pilocarpine is injected into the anterior chamber through a cannula and as a last surgical event sterile air is injected into the anterior chamber through a fine cannula to press back the hyaloid face of the vitreous and the iris and to reform the anterior chamber.

Administration

With increasing longevity in the civilized world the incidence of cataract is increasing, and in countries such as India where the nutrition of the village people is below physiological standards and they become senile prematurely the numbers blinded by cataract is immense.

It is tragic enough in England that patients have had to wait blind for one or two years, often when few years of life remain, and indeed some have died before a bed has been available. A common idea in general hospitals is that as the human eye is only 1/75th of the body surface the in-patient accommodation available should be proportionately small. In the large Continental Clinics in the capital cities and large provincial towns, the eye in-patient accommodation is between 100-200 beds. In England the special hospital devoted to eye diseases is an inevitable and a necessary safety valve to deal with large numbers of eye patients whom the general hospitals cannot accommodate. The disadvantage of the special hospital is its isolation from general medical and ancillary services so necessary in the practice of modern ophthalmology. Even in these hospitals the waiting lists for admission are immense, sometimes up to 2,000.

This is of course, little compared with the tragedy of India and the Far East, where tens of thousands cannot reach surgical help and the field teams have insufficient trained surgeons and available time to contend with the vast numbers requiring operation. In such a situation it is impossible to spend 40 minutes or more in performing intracapsular cataract extraction with the safety precautions afforded by careful corneo-scleral suturing and other features of western technique. One Indian surgeon at the age of 80 did 481 cataract extractions in one day in December 1965—about one a minute! A critical result is not expected for so long as the peasant can see the silhouette of his family, a cow and a haystack at a few yards range he is thankful. So it would seem justifiable in such circumstances to operate on as many patients as possible in the shortest possible time and to hope that the number benefited may offset the inevitably high incidence of post-operative complications.

Retrospect

One of the very rare pleasantries of growing old is to look back over a panorama of surgical progress which has been particularly exciting during the last two or three decades.

About 15 years ago on a visit to my old Chief, a superb surgical craftsman, he said to me "I hope you are not doing that dreadful operation, intracapsular cataract extraction". I had to admit that this operation was my preference but that the 'dreadful' features of it had been almost entirely removed by improvements in akinesia, anaesthesia (local and general) and by expedite closure of the incision with corneo-scleral sutures mounted on exquisitely made needles unavailable at the time of his zenith.

"Things done well,
and with a care exempt themselves from fear".

Henry VIII. 1.ii.

TWILLINGATE HOSPITAL NEWFOUNDLAND—

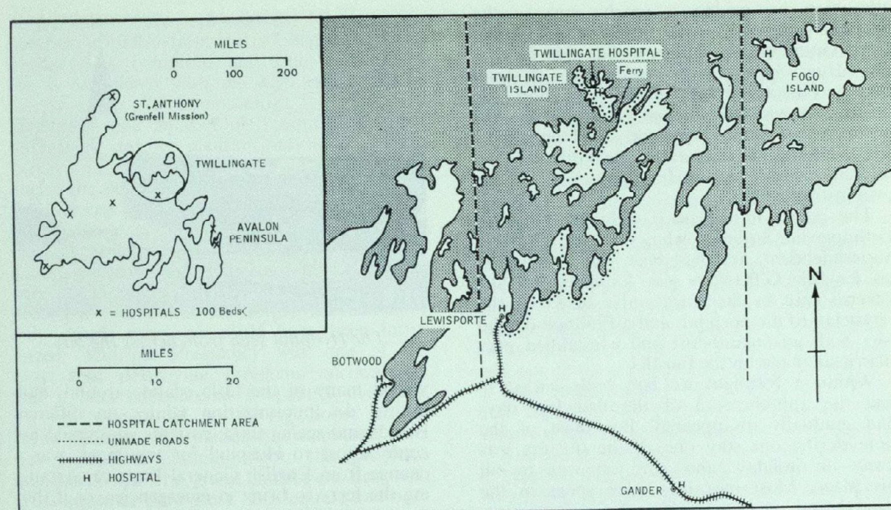
A SUMMER VISIT

by M. R. B. Keighley

It was a grey morning, the mists lay heavy on the sea, the foghorn at the lighthouse announced yet another damp, cold day—so typical at that time of year in the change from winter to summer. I looked out of my window and could just see the cliffs across the bay and a mass of little boats bouncing on top of the Atlantic swell. Behind me was the hospital with its 120 beds shrouded in mist. What a strange place to be spending a summer!

There was an American student with me, who had arrived a few days before—he quickly assured me that we were in for a primitive summer, and after our breakfast of cod (with which we were soon to become very accustomed) he showed me round the hospital. The first thing that struck me was the apparent utter confusion of bed arrangement. Surgical and medical problems all thrown together, with a few obstetric beds to ring the changes. There was a large male and female ward, a small nursery, two large geriatic wards, two supposedly obstetric wards which were for ever encroached upon when the bed situation became desperate, and four smaller wards, the composition of which was very variable. The paediatric ward divided into the cots and beds was a hive of activity, there seemed to be kids everywhere. The operating theatre was small and inadequate but I was assured they managed. Anaesthetics were given in the theatre—and I was surprised and pleased to see a Boyles machine. Downstairs was the out-patient department with three examination rooms, a large waiting room and the doctors' office. The X-ray machine looked old and clumsy, but I was told it was very adequate and that before long I would be expected to handle it and develop my own films. The laboratory was small, but I was delighted when I found that most of the investigations needed could be done there. When I look back, I wonder how the hospital would have managed without our two lab. boys who were as cheerful at mid-day as they were cross-matching blood at 3.00 a.m. I soon learnt that my much forgotten bacteriology and pathology would have to be revised very rapidly; when faced in the middle of the night with a problem, one was expected to have done the haemoglobin, white count, urea and blood sugar, and if necessary, to have spun down the urine and plated out organisms for culture and sensitivity before rousing one's colleagues. The last place that I visited in my tour of the hospital was the dental department. When I realised I had not met a dentist, and the suggestion had been tactfully put to me that I might as well learn there and then how to pull teeth, my heart sank, and I first began to appreciate what would 3½ months in Twillingate involve.

Twillingate is a little fishing town with rather less than 1,000 inhabitants; it is the main community on Twillingate Island which boasts a population of 3,000 as a whole. The island is the last of a series of little islands between itself and the Eastern shores of the mainland. On a fine day when walking up the hill behind the Hospital one can see practically the whole of the Hospital's catchment area—a mass of



Twillingate Hospital the catchment area.

tiny islands, stretching as far as the eye can see. Some are thickly forested with fir and maple, others are barren apart from a few copses; a mass of rock and heath with a coastline of little bays and craggy cliffs. Between the islands the bright blue Atlantic is topped with spray and fleets of fishing boats—the villages, each with its white-timbered church, nestle between the rugged shores. Out on the horizon is the mainland stretching round in a huge curve forming the shores of Notre Dame Bay. In the ocean, barren rocks topped with grass stick proud of the water, inhabited only by sea birds and the occasional pack of seals. In the early summer icebergs drift down into the bay from the pack ice, forming a majestic picture of weird shapes and glowing fires in the evening light, with the whales blowing amongst them.

It is hard to imagine the same place in the winter with the sea frozen solid so that the ice becomes the only means of communication as the roads are deep in snow. For four months the land is white, the temperature down to −30°F, every day the sky a bright blue. The dog sleighs are rarely used now but 10 years ago they were a common sight. When the mists between winter and summer are over the weather remains fine for most of the months. As summer begins the fishing starts, lobster pots mended in the winter are hauled up every evening, the cod traps are laid, and it is a morning's work bringing up the cod. Nets for sea salmon are next to be laid, and as the summer progresses so do the fish; from herring to mackerel, and finally the squid season brings an end to the fishermen's season. The winter months provide time for mending nets, boats and tackle, and so the cycle their forefathers adopted is passed on from one generation to the next.

The staff were led by Dr. Olds, an American surgeon who had been out in Twillingate for 34 years—he was regarded by the locals as the Albert Schweitzer of Twillingate, his name had spread throughout Newfoundland, and we had, on occasions, patients travelling hundreds of miles in order to have his medical attention. When he arrived, he and Grenfell (of the Labrador Medical Mission) were the only people qualified to deal with the medical problems of the whole of Newfoundland apart from the Avalon Peninsula. In those days all he could offer was surgery—and as a result even now people are very surgically orientated. He started a scheme amongst the poor fishing communities whereby they could receive free medical attention and hospital

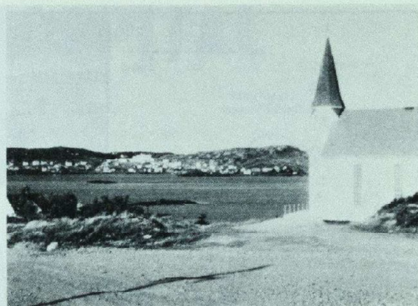
admission by paying a yearly sum to the hospital funds, and with this, and a Government Grant he was able to offer this service, but drugs have to be paid for. It soon became obvious to me that the "Old Man", as he was known, was not just a surgeon; he was a superb mechanic, he would build prostheses for the limbs he amputated, he built his own bronchoscopes, and made many more of his own instruments.

The others in the team included a British Orthopaedic Surgeon who was the Hospital Superintendent, and had been there 10 years; an English G.P. who was looking after the general care in the wards, also acted as the physician to the hospital; and a Philippino, who was both an anaesthetist and a qualified paediatrician made up the fourth.

Within a fortnight we had both settled in and the apprehension of the first few days had gradually disappeared. For most of the time during our stay one of the doctors was away on holiday, and our job was to fill his place. Most mornings were spent in the theatre and we would either be giving anaesthetics or assisting whoever was operating. Between cases, there was an opportunity to check up on the patients that we had admitted the night before in the wards, and to keep an eye on the expectant mothers. There were usually three or four patients for theatre every day, and during our time there we saw a most varied selection of operations. By the afternoon a group of people had usually gathered at the Dental clinic for tooth extractions which usually constituted an hours work. The rest of the afternoon would be spent in seeing patients in the out-patient department, doing the occasional house call, or keeping an eye on the wards, but it was probably the night work that was the most interesting of all. After the evening round with the others we were left to take every other night "on call." To begin with we found we were calling for advice on every issue, but as time went on we were expected to cope with more and more of the problems, both in the wards and from casualty.

Frequently two or three of us from the hospital would "take off" and go fishing with some of the locals, either for trout and salmon, which were most prolific in the rivers, or for squid and cod in the sea.

In the last month of my stay, the American student had gone and a dentist had arrived. I had become well acquainted with many of the local fishermen and their families, and had visited many of the little islands around. Sailing to do immunization clinics on different islands and seeing those patients who could not come across to Hospital for treatment, was a change from English General Practice. Arranging the ferry to bring in emergencies, or if they were too sick, to go myself, was another task that kept me busy. In the end it was a question of taking X-rays, doing what lab. work was necessary, and preparing the theatre staff if necessary—before disturbing the doctors. Before leaving I had been allowed to do some operating, and I had been left to get on with most of the hospital procedures but always with one of the others keeping a distant eye on what was being done.



The Hospital seen from across the bay

I cannot possibly enumerate all I saw and did, but amongst the humdrum of routine admissions one would come across the odd diagnostic problem that aroused our interest and discussion. Open Pulmonary Tuberculosis was not uncommon, and two of the nephrectomy specimens were found to be tuberculous on histology. The results of old meningeal involvement in several people was not uncommon, and one Potts spine with a cold abscess was admitted during my stay. Evidence of old tuberculous peritonitis was seen at one or two laporotomies. Renal disease and Hypertension were common. The psychiatric work, oddly enough, was quite a common cause for hospital admission in women, possibly due to the long absence of husbands away fishing in the summer months. Anaemia was common in women who had borne large families, but surprisingly the obstetric problems were few. One or two families had Christmas disease, and the children were for ever coming in with bleeding cuts. Orthopaedic procedures in the lumber-men were responsible for a large number of admissions too. Congenital heart disease was common, and one wonders if this is associated with the high rate of intermarriage in the communities. A case of Diphtheria and another of Tetanus were seen during my stay, to mention only a few of the varied and interesting problems that presented during the three months at Twillingate.

Quite one of the most striking things about the medicine amongst people in these remote parts of Newfoundland was the need for education in Preventive Medicine. Time after time one would come forcably face to face with problems that could be simply eradicated, if only simple measures could have been introduced. Multiple Pregnancy was one of the most soul destroying problems encountered, and it was encountered frequently everyday. To see women of 30 having borne six or seven children with inadequate ante-natal care, was indeed a pathetic sight; the problems associated with the grand multi-para and with gross anaemia were great. Inadequate and non-existent contraceptive measures were the direct cause of gross ill health and psychological stress. This is a measure, not only of the patients' failure to seek advice, but also of the complete lack of education on the subject. It was amazing to see the change in outlook and the relief of stress in those women, who having had one or two children had been started on oral contraceptives. On taking a careful history from most mothers it was evident that a large proportion had had urinary infections in pregnancy, which through an inability of the patient to attend ante-natal clinics, or a failure to appreciate their importance, had never been adequately treated.

No wonder there was a high incidence of hypertension in women of over 40 years. Adequate antenatal care was often impossible simply because patients would not appreciate its importance, especially when it took a whole day to get up to the doctor at a cost of 15 dollars. One of the biggest problems apart from anaemia was the early decay of teeth in young children, and every effort was made to give the mothers an adequate intake of fluoride in the last three months of pregnancy.

The incidence of Infective Hepatitis was staggeringly high and occurred in epidemic proportions; on detailed inquiry it was quite apparent that this was the direct result of a faecal oral route of inoculation, because the simple code of hygiene after defaecation was never observed. Simple education of the population on such simple hygienic methods is hardly the job of a busy cottage hospital, yet the number of beds occupied by people from diseases directly related to lack of hygiene assumed enormous proportions. One feels this is due to a basic lack of education of the population that could be achieved in schools, over the radio, by newspapers, and to patients whilst temporary residents in hospital. This equally applies to dental hygiene and the incidence of dental caries. Scabies, and typhoid were common diseases which could be totally eradicated if public health measures could be enforced.

Tuberculosis, as I have indicated previously, is still a common disease in Newfoundland, but in this field active measures are being taken to screen every person on the island. People will not go up to hospital for Chest X-rays, but a boat fitted with a Mass Miniature X-ray, and facilities for performing Mantoux tests visits the fishing communities every three years.

Routine immunization in outlying islands is a practice that is only just catching on; it is only when one sees cases of tetanus and diphtheria that the importance is fully appreciated. Diet is a huge problem, with obesity and diabetes in the women. A high salt diet, from the salting of all the fish that is eaten, as well as a high proportion of salted beef and pork is a possible aetiological factor in the prevalence of hypertension. Vitamin deficiencies which have been dietary in origin have only recently been eradicated. One of the most tragic losses of life in these fisherfolk is from drowning, well over half the people working on the sea cannot swim. What right have we to be giving Gamma Globulins to people in contact with Infective Hepatitis before teaching those at risk on the sea to swim?

The summer soon passed and recollections of many interesting hours in the hospital, amongst the doctors, and on the sea, with the local fishermen, filled my mind as for the last time I chugged across on the ferry, amongst the little islands with their rocky shores, between the fleets of fishing boats, and watched the sea birds curling madly around the stern.

Post script:—

I should like to thank the Canadian Government for making this trip possible. If anyone is interested in repeating this visit during their final year, there is a Canadian Scholarship that covers the travel expenses and pays your keep in Newfoundland. Arrangements are being made to make this an annual event from Bart's and a notice will be going up to this effect if this can be arranged.

Milk for Water

A Case of Chyluria

by C. S. B. Roch-Berry

Chyluria, the passage of a chyle or lymph fluid in the urine, is an uncommon clinical entity. Chylous urine is rich in albumin, fat, and fibrin. There have been approximately 400 cases[1] of chyluria reported in the literature. The first recordings date back to the writings of Hippocrates, who mentioned several cases, including one of a woman who voided oily urine for several days after childbirth. The nature of chyluria was still obscure in 1644 when Peu[2] of Paris stated that these patients were excreting milk in their urine. In 1651, Pequet[3] discovered the circulation of lymph and recognised the fact that the milkiness of the urine was produced by chyle. In 1670, Moellenbrogii postulated an abnormal connection between the urinary and lymphatic systems.

When chyluria presents in the female it is often associated with pregnancy[1, 5].

The following case report is of a female patient, who was referred to Bart's with chyluria in October 1965.

CASE REPORT

The patient was a housewife, 28 years of age, who presented with passing milky urine, loss of weight, and amenorrhoea.

In 1963 she gave birth to a little girl. The first stage of labour was lengthy but otherwise the pregnancy and labour were perfectly normal, with no instrumental or operative intervention. She did not breast feed the child because of congenitally inverted nipples. Lactation was suppressed by taking Stilboestrol tablets.

One day after the birth she started to pass milky urine. This was not associated with any pain, discomfort, or haematuria. She thought no more of it, expecting it to clear up of its own accord.

Two months later she went to her G.P. who made a tentative diagnosis of an urinary infection. Various antibiotics were tried without success and she was referred to the Clatterbridge Hospital, Cheshire, as an Out-Patient.

Various investigations were carried out, including a cystoscopy and an I.V.P. but nothing abnormal was found. At this time her B.P. was 135 mm. Hg. During this time she felt quite well although she had lost nearly two stone in weight. Her periods had returned after the birth but were scanty and irregular.

In March 1965 her periods stopped but pregnancy tests proved negative.

In August 1965 she was feeling continually tired and had no energy to do her housework. If she went for more than a few hours without food, she felt faint. She was then readmitted to the Clatterbridge Hospital as an In Patient under Mr. P. L. Robinson.

Numerous tests were carried out, the only ones of note being

B.P. $\frac{70}{55}$ mm. Hg.

Urine. A true chylous fluid.

Drip infusion pyelogram. Appeared normal. No communication between the urinary tract and the lymphatic system was demonstrated.

Stools. No ovae or pus.

Blood urea. Slightly raised at 50 mgm. %.

She was referred to Bart's and was admitted as an In-Patient under Professor Taylor for further investigations and treatment.

The patient had never visited the tropics and there was no evidence of oedema in the legs or labia. Some of the investigations carried out at Bart's which shed fresh light on the condition were:—

B.P. $\frac{90}{70}$ mm. Hg.

Blood urea. Slightly raised at 55mgms %.

Serum electrolytes. Raised potassium at 7.0 mEq./1 a low sodium at 124 mEq./1 and a low chloride at 85 mEq./1.

Cystoscopy. Showed that the chyle was effluxing from the left ureter.

Pyelography Retrograde pyelography with cine recording revealed a pyelo-lymphatic leak in the upper pole of the left kidney.

Red cell and plasma volume. Both were significantly reduced at 1.1 and 1.4 litres resp.

Renal function. Showed diminution of renal function on both sides.

The patient was placed on a high sodium diet with improvement in her electrolyte balance.

On the 9th Dec. exploration of the left kidney was undertaken by Professor Taylor.

At operation a left oblique (Morris) incision was used to gain access to the left kidney.

In the retroperitoneal space around the left kidney prior to opening the renal fascia, a number of dilated lymphatics were found. One of these was injected with hypaque; the resulting picture was not of much help.

The kidney was then exposed, rid of its capsule and drawn into the wound.

The renal artery, vein and ureter were carefully cleaned of all interstitial fibrous tissue. Near the upper pole of the kidney, a number of particularly large lymphatics were ligatured. During the course of the operation mannitol had been administered to the patient i/v and continuous urine collection from the bladder was maintained. Towards the end of the operation an unequivocal clearing of the urine had taken place. Direct aspiration of the renal pelvis provided a clear specimen of urine.

The wound was then closed in layers with drainage.

An E.C.G. monitor was set up and continuous recordings were made throughout the operation. This was done because of the still slightly high serum potassium level. No significant recordings were seen except a few extra-systoles when the bladder was washed out.

The patient made an uneventful recovery from the operation. In the next two weeks she gained a stone in weight, her blood urea and serum electrolytes became normal.

Unfortunately on the night of the 19th December the chyluria recurred spontaneously, but to a lesser extent. The urine remained like this and the patient was discharged three days later.

On follow up in **February, 1966** the patient was still passing whitish urine, although it had lessened since its recurrence in December, 1965. She had maintained her weight increase and her periods had returned since January and were normal. The following investigations were carried out:—

Blood urea. 28 mgm. %

Urine. Cloudy yellow with some protein but no glucose.

Serum electrolytes. Normal.

B.P. 118/88 mm. Hg.

It was decided that at this time no further surgical intervention was necessary. The patient was discharged without further treatment. However it has been arranged that the patient is carefully followed up so that any change in her condition can be noted and the required treatment given.

There are several theories as to the aetiology of chyluria. The one proposed by Ackerman and Van Dyke Carter[4] in 1863 has received the greatest support. They assumed that a mechanical obstruction is present in the lymphatics between the intestine and the thoracic duct, resulting in lymph stasis and ectasia of the lymphatics distal to the duct. The chyle then passes from the lacteals of the intestine in a retrograde fashion towards the urinary tract. The lymphatic valves dilate and lymphatic varices are formed. Rupture of a lymphatic varix may occur, resulting in a lymphatico-urinary fistula with flow of lymph into the renal pelvis, ureter or bladder. Pregnancy may be an exciting cause of chyluria due to the increased intra-abdominal pressure [1,5,6]. Chyluria may also be a direct result of surgical damage to the renal, vesical or prostatic lymphatics. Nonparasitic chyluria can further be seen in conjunction with lymphatic aneurysm, trauma, tuberculosis, abscess or neoplasm[7]. Parasitic chyluria due to fibrosis of lymph channels can be secondary to filariasis, echinococcosis, ascariasis and cysticercosis.

Chyluria may be of varied duration and is frequently associated with remissions and ex-

acerbations [1,8]. The only constant symptom is the passage of milky urine. This may also be pink due to the presence of blood and may be thickened as a result of fibrin clot formation[1]. This haematuria is assumed to be secondary to rupture of minute blood vessels adjacent to the site of the fistula[9].

Biochemical analysis of the urine is of diagnostic importance. The urine is rich in albumin, fat, and fibrin with an associated haematuria. A simple test for confirmation of chyluria is to administer Sudan red 111 on heavily buttered toast. In the ensuing urine samples the urine will be bright orange and the fat particles will be stained with the Sudan red 111. Other lipidurias which give a positive Sudan red 111 test are nephritis, diabetes, eclampsia, degenerating kidney tumours and nephrotoxins such as phosphorus. Sudan red 111 does not appear in the urine of normal individuals.

Chyluria may be confused grossly with lipiduria pyuria, and pseudochyluria[11]. In the lipiduria there is an absence of fibrin, and the fat is in droplet form. Microscopic analysis of the urine will rule out pyuria. Pseudochylurous urine has a low S.G. and solid content, whereas chyle has not. Chylous urine on standing will become alkaline, whereas it is acid when voided[12].

If investigations of parasitosis prove negative, as they usually do, this does not exclude filariasis as obstruction can occur long after the parasites have succumbed[13].

Cystoscopy and retrograde pyelography has been used to isolate the lymphatico-urinary fistula.

Yamauchi[5] from observations on his series of 45 cases of chyluria, stated that 65 attacks occurred in 24 female patients and were related to pregnancy on 31 occasions; 23 attacks occurred during pregnancy and eight within three months postpartum period.

Therapy for chyluria as a rule has been unsatisfactory. Antifilarial drugs have no place in its management except during the acute phase of filariasis[1].

Lazarus[10] considered nephrectomy unwarranted and Yamauchi[5] believed decapsulation and removal of the perirenal lymph channels unnecessary. However Blaloch[14] has treated chyluria successfully with resection. Recently several authors have described the use of increased intra-abdominal pressure in the treatment of chyluria[12].

Systemic changes when present should be actively treated. Logan[15] stated that undernourishment due to loss of fat in the urine can be treated by the use of high calory, high protein diet.

Many reports have shown that the increase in the amount of chyle in the urine is directly related to fatty meals, and that the degree of chyluria is directly proportional to the amount of fat in the diet [17, 18, 19]. Hashim [16] has treated patients with synthetic triglycerides with a resulting diminution and in some cases cure of the chyluria and also stabilisation of weight.

From the forgone discussion it can be seen that the case reported showed a number of the characteristics of a nonparasitic chyluria. However the low blood pressure and amenorrhoea were slightly atypical. The patient recorded by Sall[1] also showed hypotension. This was unexplained but may have been due to the loss of protein and fat in the urine.

Amenorrhoea was not recorded in any of the literature on chyluria. Secondary amenorrhoea is a constant finding in anorexia nervosa before malnutrition is established. Malnutrition can cause amenorrhoea as was seen in some P.O.W. camps in the last war.

Acknowledgements

I would like to thank Professor Taylor for his permission to record this case.

REFERENCES

1. Sall, S.: *Am. J. Obst. & Gynec.*, **83**, 521, 1962.
2. Peu, R.: Cited by Lazarus and Marks (10).
3. Pecquet, J.: Cited by Johnston (9).
4. Ackerman, T., and Carter, V. D.: Cited by Yamauchi (5).
5. Yamauchi, S.: *J. Urol.*, **54**, 318, 1945.
6. Lowgren, E.: *Acta Med. Scandinav.*, **144**, 375, 1953.
7. Cookson, H. A., and Pallar, T. H.: *Arch. Int. Med.*, **53**, 878, 1934.
8. Swanson, G. E.: *Rd.*, **81**, 473, 1963.
9. Johnston, D. W.: *Ann. Int. Med.*, **42**, 931, 1955.
10. Lazarus, J. A., and Marks, M. S.: *J. Urol.*, **56**, 246, 1965.
11. Cazerta, S. J.: *New Eng. J. Med.*, **255**, 1239, 1956.
12. Bloomstrand, R., Thorn, W. A., and Abrens, E. H.: *Am. J. Med.*, **24**, 958, 1958.
13. Manson, P. H.: Manson's Tropical Diseases, ed. 14, London, 1954, Cassal & Co., Ltd.
14. Blaloch, A.: *Surg.*, **54**, 536, 1963.
15. Logan, A. H., Smith, L. H., and Pool, T. L.: *Am. J. Med. Sc.*, **216**, 389, 1948.
16. Hashim, S. A., Roholt, H. B., Babayan, U. K., and Van Itallie, T. B.: *New Eng. J. Med.*, **270**, 756, 1964.
17. Hertz, A. F.: *Lancet*, **16**, 733, 1907.
18. Burman, H. R.: *J. Clin. Invest.*, **32**, 637, 1953.
19. Fernandes, J., Van de Kamer, J. H., and Weijers, H. A.: *J. Clin. Invest.*, **34**, 1026, 1955.

More than meets the eye

Some less frequently encountered aspects of medicine

2. FORENSIC MEDICINE by R. D. Teare

Consultant Pathologist and Reader in Forensic Medicine at St. George's Hospital.

Of the various specialties which may be included in the broad scope of Forensic Medicine that of Forensic Pathology attracts the most recruits and it is the subject that I wish to describe as a career or discipline.

Being such a small sub-specialty, its student appeal is not great and aspirants are unaware of its possibilities and demands, whilst unsure of its discipline and rewards.

Most full time forensic pathology is conducted through the staff of Medical School Departments, although a large amount of the more routine work may be done by hospital consultant pathologists. The training of a forensic pathologist is therefore initially that of a pathologist, and in particular a morbid anatomist. Full registration must be completed, choosing jobs with the widest possible range of experience, rather than for instance, assisting at partial gastrectomies for six months. Following this, I would recommend a year or two in clinical medicine (largely perhaps because I did this myself), then specialisation in pathology starting as a trainee in a large department where experience can be gained in all the branches of this subject. Many jobs are geared to rotate the trainee for six months in each department and this should be aimed at. After this, specialising in morbid anatomy is indicated, at the same time retaining contact with chemical pathology and haematology as far as possible.

It is at this point, somewhere between registrar and senior registrar grades, that the budding forensic pathologist may opt for total commitment to this discipline by searching for a junior post in a forensic department. Such jobs are few. It is now that the applicant should understand that much of the more mundane forensic pathology is often done by hospital consultant pathologists and may thus direct his (or her) road towards this end. In this way a career in minor forensic pathology may be achieved without burning one's boats and entering the field too soon.

Higher qualifications will be required, i.e. examinations will continue to rear their ugly heads. The Diploma of Medical Jurisprudence offered by the Society of Apothecaries is particularly specialised while the Membership of the College of Pathologists, much wider in range, is fast becoming an essential qualification for any pathologist. The final examination of the College can be taken with what is described as a "forensic slant".

It would be appropriate to describe the type of work that comes to the forensic pathologist. The majority of the work consists of autopsies performed on behalf of coroners. I shall have a word of description later about these officials. Such autopsies are on persons dying suddenly and for whom no doctor is in a position to sign a death certificate. Most of these are natural deaths and once this has been ascertained there is no further legal procedure, the coroner signing the death certificate and burial proceeding accordingly. The remaining cases are those when death is unnatural and includes suicides, road and factory accidents, industrial disease, and violent deaths including murder. These deaths are always the subject of a coroner's inquest and may also involve legal proceedings in the criminal courts. Here the pathologist will be required to give evidence—frequently of a formal nature though occasionally controversial if any interested parties wish to superimpose their own idea of "how, when, where and by what means". It is appropriate to mention that the cases which find space in the National Press form a very small proportion of the forensic pathologist's work. In murder cases it is usual for a senior member of an academic department to be called in by the County police rather than a

local hospital pathologist—who often has no wish himself, to become involved in lengthy criminal investigations and multiple court appearances. Such cases often involve travelling long distances, even abroad at times, and meanwhile one's routine work must either wait or be done by others.

Coroners are officials appointed to inquire into the manner by which a person came by their death. Ideally they are both medically and legally qualified but this ideal is seldom attained, especially in less populated parts of England. (The system in Scotland differs in many minor respects from the practice in England and Wales, with the coroner being replaced by the *Procurator Fiscal*). They are appointed to cover an area—there are, for instance, five full-time coroners for London but in less densely populated parts they may hold jurisdiction over much larger areas. The disposition of coroners' autopsies is by gift from the coroner to a pathologist, and so it is essential for the forensic pathologist to know a coroner. Many coroners use the hospital pathologist for straightforward cases and call in a member of an academic forensic department for difficult cases upon the recommendation of the Chief Constable. Coroners have one or more policemen to conduct their enquiries into the cases which are reported to them, and these policemen are known as the Coroner's Officers. The forensic pathologist has much to do with these officers, who conduct the questioning of relatives and witnesses to obtain the "history".

Remuneration can be by salary in the junior and middle academic grades, with part time readers and professors generally augmenting their meagre salaries by coroner's fees, which are paid for each autopsy, together with a further fee for attendance at their own or any other court. Hospital pathologists generally have part time contracts with their employing authority to enable them to do coroner's work, though these fees do not have to be handed back to the Regional Hospital Board. Occasionally the forensic pathologist will be employed by the defence to conduct a separate post mortem or other examination.

Forensic pathology necessitates a knowledge of toxicology, obviously with particular reference to the interpretation of levels of alcohol, barbiturate and other poisons. In the increasingly complex world of biochemistry the forensic pathologist does not need to be a practising analyst and all academic departments rely upon their biochemists for analyses. Similarly, a hospital pathologist practising any forensic pathology will need the support of a well staffed biochemistry department for these investigations.

I will try and give you some idea of the life of a forensic pathologist. Monday mornings are invariably spent doing autopsies for the coroners, on cases that have been reported to him over the weekend. It might be fair to say that about 60% of the cases will be natural deaths from heart disease, pneumonia and many assorted acute organic catastrophes and complications. Hence the need for a broadly based medical knowledge in order to understand—perhaps superficially in abstruse diseases—the complete spectra of human ailments. Anything may be awaiting on the forensic pathologist's "list"—neurological, cardiological, obstetric, psychiatric, pulmonary, general medical and even sometimes dermatological cases. Depending on the season, winter being the busiest time, Monday afternoon will probably be spent in the same way, delivering specimens for analysis and histology back to the laboratory, later on.

The rest of the week will be spent attending coroners' courts for inquests and driving around the metropolis attending magistrates courts and local mortuaries for further autopsies. Perhaps the most useful attributes of a forensic pathologist are punctuality and the driving "ability" and street knowledge of a taxi driver.

Research work in forensic medicine is wide open. Most academic departments are understaffed in this respect due to lack of public interest, and consequently, funds from interested bodies. This lack of public interest is also reflected in the state of many county and council mortuaries where, since votes are not won here, minimal and primitive facilities only are maintained.

In between the above, come all the attendant duties of a specialist doctor: reviewing books and occasionally writing them, publishing cases, writing articles and preparing lectures. The public (and private) reputation of a forensic pathologist is that of deep involvement in salacious crime and other activities of the underworld. This reputation is hard to shake off but the compensations (if any) are that—assuming one likes lecturing—requests to speak will be frequent and the audience can be guaranteed to fill the hall in the hope of being made privy to the otherwise unpublished secrets of Scotland Yard.

Also, it is not uncommon for forensic pathologists to specialise inside the discipline itself, such as into cases of rape and sexual assault

or into blood grouping and disputed paternity. Often it behoves the senior forensic pathologist, sitting midway between the professions of medicine and the law, to sit on committees and boards in which his specialised knowledge can marry the problems of either. It is also essential to be able to "talk medicine" but in laymen's language: the average doctor is often unaware of the difficulty and lack of understanding of medical terminology by the laity, and a "suborbital haematoma with contusions" is still a "black eye" in court.

Several learned societies deal with the specialist needs of the forensic pathologist. The Medico-Legal Society has members from the three fields that it serves and forms a broad base to acquaint each with their own problems by means of lectures and the *Medico-Legal Journal*. The Forensic Sciences Society is a more scientifically orientated body. There is the British Association of Forensic Medicine and also the British Academy of Forensic Sciences. In such a small specialty international co-operation is considerable with a world wide camaraderie.

Finally, a word on other branches that should be included in Forensic Medicine. Coroners have already been mentioned, and this may often be a part time duty of a doctor in a sparsely populated district. A more legally attuned mind is needed for the examination of witnesses and wide knowledge of the law in all fields, particularly relating to industry, motoring and, where applicable, farming and navigation. Coroners also deal with treasure troves—a relic of 12th century legislation. Some doctors of a more administrative turn of mind may turn to the Medical Defence and Protection Societies or positions in the General Medical Council. And if M.B., B.S., followed by specialist medical examinations are not your cup of tea, the acquisition of a legal degree may turn the more vocal doctors into lawyers with a useful advantage in court.

A forensic pathologist's life is a busy one but one compensation is that night calls are few and far between, though early mornings may often be necessary to cope with the volume of work. Frustrating time wasting at courts can often be usefully used in catching up with the volume of paper work that inundates any professional man in a position of responsibility.

The forensic pathologist must quickly learn that cross-examination in court is not a reflection upon his own ability, but an attempt to find the truth from a maze of medical opinion and non-medical half-truths or fictions.

I hope that this article will enlighten those who read it, and perhaps attract a few towards this interesting and rewarding specialty. As a final point to those few I should mention that it is *de rigeur* to wear a dark suit when appearing in court.

ANNUAL REPORT OF THE CHAIRMAN OF THE STUDENTS' UNION

Wine Committee

The activities of the Wine Committee have been numerous and entirely successful. Probably their chief success was the combined Barbecue and View Day Ball, at Charterhouse Square, which has been acclaimed by many as the best ball for ages. This will become a permanent annual event. All the usual trips, hops and divers activities sponsored by the Committee took place and the Committee has spent over £500 on subsidies over the year. With the new bar open in College Hall, (and with the departure of the Doctor) the work of the Wine Committee is likely to increase and I wish them continued success in the future.

College Hall

About 100 extra rooms have been opened at College Hall and all are filled. About 40 preclinicals live in. Car parking at Charterhouse has had to be restricted to residents and non-resident clinical students. This was a regrettable step but unfortunately necessary to avoid complete chaos. I welcome Mr. David Williams the new Warden and Mr. Nixon the new bursar, who seems to be running the financial side of College Hall very efficiently. Mr. Martin Birnstingl has retired from the Wardenship and I would like to thank him for his close co-operation with the Union and his interest in Student activities.

Pot Pourri

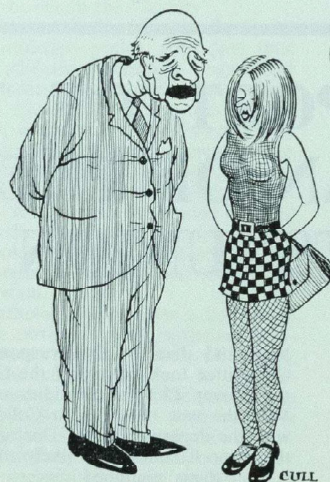
There were four nights of Pot Pourri this year (Christmas 1965) followed by a very successful New Years Eve party on the last night. Owing to licensing difficulties there will only be three nights this year (Christmas 1966) and the party will be on the last night (Dec. 30th). The magistrates will not grant a bar extension after 12.15 on a Saturday night. It is hoped to return to the four nights next year.

Clubs

Congratulations to the following who have been awarded their Honours Colours this year: J. Coltart, W. Garson, W. Goss, R. Nicholson, R. Stevens, R. Thompson, S. Thompson, P. Savage, and B. Scott. Quite a successful year for the Rugger Club, especially for the 'A' XV who won the 'A' cup for the first time for about 30 years and caused much celebration by the President and Vice-Presidents, not to mention the team itself. In the 100th season just beginning the centenary XV had a magnificent 19-8 victory over the United Hospitals side and I hope this is a good omen for this important season. The Boat Club has had a good year, winning a Junior Pennant in the Tideway Head of the River Race (which met an untimely death!). Congratulations again to C. Evans for his continuing success in the canoeing world, and in fact to all the clubs, games playing and non-games playing, for the hard work and enthusiasm that has been put into their activities.

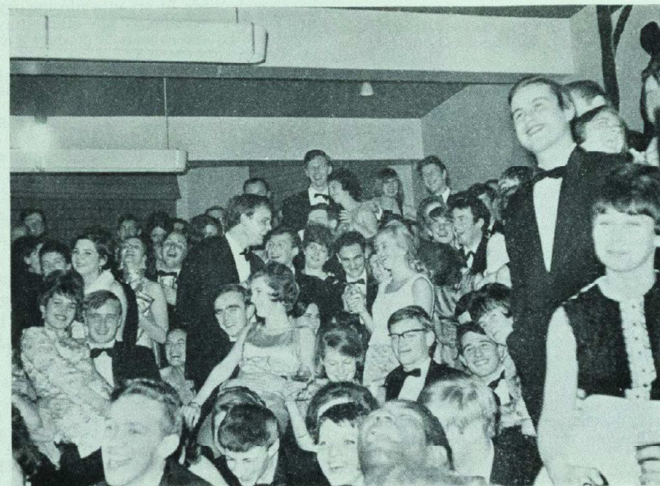
Finally I would like to thank all the people who have helped the Union with its activities this year, especially our retiring President, Mr. R. A. Bowen and the Senior Treasurers. Special thanks go to the Dean who has been exceedingly co-operative and generous to the Union, and who has represented us faithfully and fairly on the higher committees. I wish the next Council every success in their work next year.

A. R. BAILEY,
Chairman 1965/66.



" I LIKE TO IMPRESS ON ALL NEW MEMBERS OF STAFF THAT AT BART'S WE TRY TO THINK OF OURSELVES AS JUST ONE BIG HAPPY FAMILY "

THE RUGBY CLUB CENTENARY BALL



After three days of hard preparation the voice of organisation was silenced and parties were seen emerging from the local taverns converging on a 'westernised' Charterhouse for the Rugby Club's Centenary Year Ball.

The new bar, augmented by a small one in the A.R., was efficiently run by a team of able volunteers supervised by the Wine Committee. Music was provided throughout the evening by two bands—The Crusaders, a 10-piece steel band which proved to be very popular and provided excellent dancing music, and The Beachcombers, a more conventional group whose popularity was evident from the ever-crowded dance floor.

The only two breaks in the dancing were for the meal and the Cabaret. The meal was simple, but very palatable, and those responsible must be congratulated for their sterling efforts to provide food for the '5,000'. It seems a pity that each year a couple of pints is enough to make some of the guests incapable of distinguishing between harmless bread missiles and messy cream ones—this always causes unnecessary upset to the unfortunate ladies who have their dresses ruined.

The meal over, all adjourned expectantly to the Recreation Room to see whether this year's cabaret would outdo the stripper of last year. The audience was as usual demanding and critical, voicing its opinions mainly through the medium of one of the more paralytic barmen who was a cabaret himself up to a point . . .

Two acts were provided, the first making hard work of a few (sometimes funny) jokes, and sporting a guitar on which he seemed loath to demonstrate his skill. He escaped to allow a 'female impersonator' to follow, he/she went from bad to worse and eventually refused to continue the act in the face of such a lively (if not appreciative) audience. It was with mixed feelings that everyone returned to the dancing, but it was not long before the Ball was again in full swing.

At two o'clock the bars closed, but festivities were kept up right until the official end at half-past, when tired yet contented, all departed to sleep themselves back to sobriety.

In retrospect it must be said that it was a most enjoyable evening, and a great deal of thanks is owed to Peter Bradley-Watson, whose inexhaustible energy and resourcefulness was the organising power behind the Ball.

MEDICAL BOOKS

Biochemistry

The Thread of Life, by John Kendrew. G. Bell & Sons, 1966. 21s.

This little book is based on a B.B.C. Television Series of the same title by the author, an eminent Nobel prize winner. It describes the fundamental and exciting modern concepts of the three dimensional configurations of proteins and nucleic acids, the genetic code and the means by which nucleic acids control protein synthesis. Although written primarily for the layman, there is no doubt that those with some scientific knowledge will get most benefit from the book. Every point is clearly explained and illustrated, using, so far as possible, examples from everyday life. For example, printing errors and the Morse code are used to demonstrate possible origins of mutations, but despite the use of these simple analogues, the information, as one might expect from the stature of the author, is right up to date. At the end of the book there are many excellent photographs of molecular models and electromicrographs which greatly help towards an understanding of the subject.

All interested in Biology and all students of medicine should read this little book which will surely help to clarify their ideas and which may stimulate their enthusiasm for the basic biochemical facts of life.

E. D. Wills.

Man's Haemoglobins. Including the Haemoglobinopathies and their Investigation, by H. Lehmann and R. G. Huntsman. Published by North-Holland Publishing Co. Price 70s.

Special note must be made of this new book because the authors are both past members of this Medical College and Hospital. Dr. Lehmann is well known for his distinguished contribution to the new knowledge of the haemoglobinopathies and this book will be specially welcome to those who wish to understand more about the overlapping field of biochemistry and haematology.

Quite apart from the comprehensive treatment of the abnormal haemoglobins there are chapters on glucose-6-phosphate dehydrogenase deficiency and iron metabolism. There is a particularly detailed and useful section on laboratory methods which will be invaluable to those who need to investigate and identify abnormal haemoglobins.

To many authors a written record must be presented at the altar of science with due regard to accepted ritual, but such writing often makes dull reading. In the present work the authors have adopted a light-hearted and informal style which is particularly refreshing and occasional anecdotes serve to enliven the text. The discussion is not confined rigidly to the subject of haemoglobin but ranges over primitive tribal customs to modern space travel. There are numerous illustrations and here too an occasional diversion is made to art or anthropology. It may be thought that the authors too often stray from their object but the real effect is to produce a most readable text book.

The standard of the general lay-out, printing and illustrations is high but unfortunately it is yet another example of high quality foreign goods.

J. C. B. Fenton.

Genetics

Genetics in Medicine, by A. Smith. Published by E. & S. Livingstone Ltd. Price 6s.

This booklet has been written specifically for postgraduate medical students of public health and social medicine who are preparing for the diploma in public health. The author begins by pointing out that the D.P.H. is the only medical curriculum containing a requirement of genetics. This is taken as the justification for devoting the first 54 pages to a brief account of elementary genetics of 'A' level standard. The topics covered are: (1) mitosis and meiosis, but here the description of chromosome morphology and behaviour is out of date; (2) single-genic traits, including a very thin account of blood group genetics; (3) the concepts of genotype and phenotype; (4) an extremely brief account of abnormal human karyotypes and (5) continuous variation, but the treatment of this is so incomplete and vague as to be almost useless. He also perpetuates the myth that sexual cross-fertilising organisms are genetically homozygous at most loci. These topics have been suitably modified to avoid more than a passing reference to Mendel's peas and to *Drosophila*, subjects which are reputed to bore medical students. It is only in the last two chapters, on genetic research in medicine and on the importance of heredity in determining the health and diseases of human communities, which includes some sensible comments about Eugenics, that the author gets to the point of his booklet, but he has not written in enough depth to achieve his aims.

Medical graduates may know more genetics than the author realises. Those who remember their biochemistry will know what is wrong with the following quotation about DNA: "The desoxy-nucleic acid molecule consists of alternate molecular sub-groups in which minor variations may occur in the composition of short side-chains" (p. 27). The author is apparently unaware of the advances made in molecular sub-groups of the DNA molecule to specific observable effects in the individual (p. 27). I cannot recommend this booklet while there are so many excellent elementary genetics texts, including paperbacks and student editions, available to the interested reader.

M. Hollingsworth

SPORTS NEWS

SPORTS' EDITORIAL

Christmas past, the winter season is now in its second and most important phase. The Clubs, which have until now, been sifting through the talent at their disposal, must now turn their minds seriously to the task of producing good cup sides. The next three months should provide plenty of excitement as there is no lack of talent and enthusiasm on the part of the players, and with dedication to training all the clubs could do well this year. This season is particularly important for the Rugby club, and they are fortunate to be in the apparently easier half of the draw. Provided all goes well, they could find themselves playing Guy's in the final, where, if they put up a performance similar to that of the Centenary game they might give the 'Cassius Clays' of Hospitals' Rugby a surprise.

On the more social side, this is the time of the year when the Skiing parties set off for the icy slopes, the sun, and the wine, women and song of après-ski. There is, hardly surprisingly, a great attraction to this ever increasingly popular 'sport', which year after year brings back bronzed faces and broken limbs.

It only remains to wish you all a prosperous New Year and to hope that Christmas did not sap too much of your sporting vigour.

RUGBY CLUB

Unfortunately we have received no reports from the Secretary for the last two months. We hope to have some news in the next issue of the Journal.

GOLF CLUB

October 27th. **Hospitals' Cup semi-final v. St. Thomas's Hospital. Won 4-1.**

Chislehurst was very wet, making it quite a formidable course playing off the competition tees.

M. Bowen led the team and had a close game until the fifteenth when he was one up. Faultless play over the next two holes gave him victory by 3 and 2.

J. Sadler had an exciting duel in a round which included several birdies, but in spite of his gallant efforts he lost one down.

A. Hoppe and D. Grieve were in dazzling form and crushed their opponents by 7 and 5 and 6 and 5 respectively.

R. Begent won by 3 and 2 in a less spectacular game.

R. Begent.

November 30th. **Hospitals' Cup Final v. Guy's,** at The Berkshire G.C.. **Lost 3½-1½.**

For the second year running we met **Guy's** at the tough 6,400 yd. Red course of the Berkshire. The course was sodden after the previous night's downpour and a stinging gale called for the greatest skill from every player.

We took the field in great anticipation of reversing the previous year's defeat and were encouraged by a small, but enthusiastic gallery of supporters.

The team in order of play was: David Grieve, Jon Sadler, Angus Hoppe, Mike Bowen (capt.), and Richard Begent.

David Grieve although playing dynamic golf and tussling hard with a mighty wind, turned for home 3 down to the brilliant play of the Guy's captain. The latter was so powerful in

this first nine that even into the gale, holes of 480 yd. were within his range in 2. In the second nine however, Grieve made a dramatic comeback, and by the fifteenth green had squared the match. Unfortunately, the persistent par scoring of his opponent proved too much, and the 16th and 17th holes were lost to clinch the match 2 and 1.

Jon Sadler's opponent must be classed amongst the best in the university; even so Sadler held him well until the turn. Thereafter he was unable to stave off the constant scoring to a near professional standard and lost 6 and 4.

Angus Hoppe had a very close match and, although successively 2 down with 4 to play and 1 down with 2 to play managed to draw level on the 17th with a cast iron par. The tension of the match showed itself on the last hole, when this straightforward par 3 was halved in 5 leaving the match square.

Mike Bowen came up against an extremely steady opponent and consequently, standing on the 10th tee was in the unhealthy position of being 3 down. The seriousness of the situation now spurred him on to make a magnificent comeback, to take six out of the following 8 holes and to win the match 3 and 1.

Richard Begent, after a very tense 15 holes found himself on the 16th tee 2 down with three holes to play. His opponent's drive on this 230 yd. hole was safely on the fairway but short of the green. Begent's drive had to hit the green. The ball flew sweetly from the clubface but creamed into the trees on the left. All was lost, by exactly 3 and 2.

A. Hoppe.

MOTOR CLUB

Annual Report, 1966

The last year has seen a greater amount of outdoor activity, with less emphasis on films and talks.

During the summer, monthly visits to the Ealing skid-pan were arranged, and several members regularly attended. We were all rather slow with our reactions at first, but improved with experience.

A number of trips were made to race meetings, including the Le Mans 24-hour race. We set out from London on Friday, 17th June, and after a night journey through France and a very expensive breakfast we reached Le Mans, where we quenched our raging thirsts with draught Bass. After watching the first few hours of the race we revisited the bar and retired to the coach for some sleep. Later some of us were able to slip through the police cordon round the Mulsanne straight to get close to the cars doing over 200 m.p.h. Towards the end, when the Ford victory was certain, we started to move off, only to have a most tiresome return journey fraught with delays.

Other races visited were the Monaco Grand Prix, the British Grand Prix and the special stages of the Monte Carlo rally.

We now supply a copy of 'Auto News' to each A.R. and also have Bart's car badges in stock.

I. McLellan.

CROSS-COUNTRY CLUB

Although Bart's have run as a team in only one race this month, there have been several U.H. fixtures in which we have been well represented. Brooks, Messelden, Williams, Tunstall-Pedoe and Thompson are rarely out of the leading eight U.H. places and this prominence is in no small way due to the valuable training along the Embankment on Monday and Thursday evenings. We are indebted to Dan Tunstall-Pedoe for his experience and judgement of pace. Members of any other clubs are welcome to join us for these sessions. This month we should like to welcome Trevor Doouss to the club: we hope to get him fit as soon as possible.

League Div. 1, at Twickenham, November 2nd

1.	Burton (*Kings*)	28 min. 50 sec.
24.	Messelden	31 min. 37 sec.
28.	Thompson	32 min. 01 sec.
50.	Brooks	33 min. 29 sec.
60.	Down	34 min. 17 sec.
78.	Markham	37 min. 46 sec.

League Div. 2, at Petersham, November 2nd

1.	Fisher (*Borough Road*)	28 min. 40 sec.
44.	Sanders	32 min. 37 sec.
48.	Davies	32 min. 57 sec.
57.	Wood	33 min. 44 sec.
90.	Doouss	39 min. 34 sec.

R. Thompson.

THE MEDICAL PROTECTION SOCIETY

FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Senior Medical Secretary
Herbert Constable
MRCS, LRCP

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Dental Secretary
Frank Allott,
LDS

SOCCER CLUB

Since the last report was published, the soccer club has enjoyed mixed success. Ten games have been played, of which five have been won, four lost and one drawn.

The team is now in the second round of the cup, having beaten K.C.H. 5-0. The team played well and this was an encouraging result but the test will come against The London Hospital in the next round.

The School of Pharmacy have been played twice in the University League but with conflicting results. At Chislehurst Bart's won 4-1 with the aid of two goals from Weir. However in the return game the team gave a disappointing performance to lose 1-5.

Our cup success was followed by a 5-0 victory over the Westminster Hospital. The forward line moved well in this game and the goals were equally shared between them. Once again we could not maintain our form for two games in a row and the next game was lost 0-5 to the U.H. President's XI.

At the time of writing the club has just returned from a three day tour of Cambridge. The team started in fine style by beating Christ's College, the current Cambridge league champions, by 7-2. All the forward line scored, though special mention should be made of two goals from Weir and a fine chip shot by Woodrow.

Even before the start of our second game, against St. John's, it was apparent that the previous day's exertions had affected the team. When, after twenty minutes, Bart's were four goals down, total disaster threatened. However the second half saw a defensive revival led by Mumford at centre-half and only two more goals were conceded. By the third day, the pace was, if anything, slower. Luckily our opponents Trinity Hall were the weakest of the three teams we played. Layton-Smith and Weir scored twice each for Bart's to give us a comfortable lead, but towards the end defensive lapses allowed the opposition to score twice.

The following have represented the club this season:—Sutton, Thew, Dorrett, Mumford, Turner, Ellis, Farrow, Raine, Weir, McGechie, Woodrow, Leech, Hall, Bowen-Roberts, Hill, Tommey, White, Wall, Davis, Rutherford, Wright, Layton-Smith.

C. M. Sutton.

BOAT CLUB

The United Hospitals' Winter Regatta. Wednesday, 16th November.

To take three cups to Chiswick and to return with none (we did in fact win one final, the Double Sculls, but the cup for this event has long been missing)—would seem to be a bad omen for the club. However, the gales that swept the country during the week were blowing just as strongly at Chiswick, and the waves were such that some boats on reaching the start had to be emptied before they could make the return journey. But, most damning to our chances, was the fact that in the afternoon when the wind was against the tide, the course had to be shortened to half the usual length, because the umpire's launch itself would not risk going below Chiswick bridge.

Senior Fours: two crews entered this, a scratch IV, and a rather more serious IV. The former contained three trialists and Matthew Stallard who has had to give up a long and fine rowing career to learn a little medicine. Their opponents in the first round scratched, but they met St. Thomas's, the eventual winners, in the second round and lost by 1½ lengths. The other IV had been going out for six weeks and had been coached by John Gordon, Peter Brass, and recently, Matthew Stallard. All four members had rowed in the VIII last year. The first race against Guy's was with the wind and tide, and was won comfortably by 1½ lengths. The semi-final was rowed in the afternoon and although we gained half a length at the start, the lead was not made good and hitting some bad water it was lost.

Junior VIII: after teething troubles the crew was settled and showed some promise, coached by John Currie and Brian Ayers. Their first race was rowed in the afternoon over the shortened course, and again this was not the length of race, for which they had been training. They started down but were pulling back and could not quite make it in time, at the finish.

Pairs: Three were entered for this event, but it was found that two would have to race against each other in the semi-finals, their opponents having scratched, so we decided to scratch one and let Gilchrist and Featherstone row the final. D. Parr and R. Anderson lost by three lengths to London, who met and defeated M. Stallard and Hugh Whitfield in the final.

Novice IVs: won their first race with little trouble to reach the semi-finals, where they were beaten by the Royal Vets.

Senior Sculls: Crispin Cobb has been doing a good deal of sculling during the autumn in Walton colours, and a comfortable win in the first race brought him to the final, where he was beaten by Crooks of Thomas's, a sculler he had previously beaten in better conditions.

Double Sculls: Cobb again, and Barry Grimaldi, late of the successful Emanuel School VIII, beat Mary's twice in the semi-final (a second start in mid-course was ordered after a clash) but this was not enough for Mary's who demanded to row in the final which also included St. Thomas's, and Bart's won this handsomely by three lengths.

Junior Sculls: M. Castleden won his first round but lost the semi-final owing to a misunderstanding. Grimaldi won his semi-final to find that he had to turn round immediately to scull in the final, where he was beaten by a fresh Thomas's man by one length.

The Rugger IV: a crew of wide experience in many fields, including some in rowing. They got in some practice on the way to the start, but had the misfortune to meet the eventual winners in their first race. They lost by 1½ lengths.

Crews: 'A' Senior IV—Bow, B. G. M. Lamberty, P. A. B. Cheetham, B. D. Cutler, J. D. C. Martin.

'B' Senior IV—Bow, H. N. Whitfield, M. C. Stallard, N. Snell, K. Webb.

Junior VIII—Bow, J. Shaw, D. A. Stringer, M. Williams, R. E. Franks, C. Forrester-Wood, J. Jarvis, A. Wingfield, P. Houlton, Cox, P. Smyth.

Pairs—H. N. Whitfield, M. C. Stallard.
—C. R. S. Anderson, D. C. Parr.

Double Sculls—B. Grimaldi, P. C. Cobb.

Senior Sculls—P. C. Cobb.

Junior Sculls—M. Castleden, B. Grimaldi.

Novice IV—Bow, J. Dearlove, R. N. Wilmshurst-Smith, A. Moynagh, R. Packham, Cox, M. Martin-Smith.

Rugger IV—Bow, C. Davidson, J. A. Sills, J. W. D. Baugh, T. O'Carroll, Cox, S. T. Ringpuller.

WHAT DOES

STAND FOR?

IT STANDS FOR **security and peace of mind from the day you qualify—until the day you retire—and after.**

IT STANDS FOR **the provision of advice on all your professional problems . . . . for legal assistance in any difficulty or proceedings of a professional nature . . . . for unlimited indemnity in respect of damages and costs in the event of an adverse verdict or a settlement out of Court.**

IT STANDS FOR THE MEDICAL DEFENCE UNION **the oldest and largest organisation of its kind in the world. Further particulars can be obtained from**

THE MEDICAL DEFENCE UNION

Tavistock House South Tavistock Square London W C 1

Secretary Dr. Philip H. Addison

Dental Secretary: A. H. R. Rowe, M.D.S., F.D.S.

ELEGANT HAIR STYLES at
JOSEPHINE
of REGENT STREET

CITY BRANCH

ST. BARTHOLOMEW'S HOSPITAL
VOUCHER FOR
20% DISCOUNT AT
JOSEPHINE
TEL: CLE 0464-3
MONDAY—THURSDAY incl.
30 Goswell Road, E.C.1.
Valid for January 1967

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL BARTS STAFF
ON OUR OWN MANUFACTURED GOODS

DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings.
GOLD & SILVER - Cigarette cases.
Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. - Teasets & Plate.

10%-20% DISCOUNT TO ALL BARTS STAFF

on all Branded Goods—ALL SWISS WATCHES, Clocks, Cutlery, Pens and Lighters and on Second-hand Jewellery.

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St only)
88/90 HATTON GARDEN, E.C.1
HOL 0700 or 6431
OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00
Special attention to orders by post or phone

May and Baker Cup: Saturday, 26th November.

The crew included five of last year's VIII. We had one outing, coached by Ben Moore, in which to prepare ourselves to race a Guy's VIII —which had been together for three weeks. This proved ample time for we won by two lengths, coxed by Jo Winner who caused much demoralisation amongst the Guy's crew.

The World Medicine Shield:

Had the Junior VIII kept together, we might well have won this but our second VIII was newly formed, and although it had plenty of go and gained half a length at the start, Guy's, their Junior VIII at the Winter Regatta, pulled back slowly to win by half a length.

Crews: 1st VIII—Bow, N. Snell, J. N. G. Gilchrist, P. I. Featherstone, P. A. B. Cheetham, B. D. Cutler, P. C. Cobb, B. G. M. Lamberty, J. D. C. Martin, Cox, J. Winner.

Second VIII—Bow, R. Packham, R. N. Wilmshurst-Smith, A. Wingfield, I. B. M. Stephen, C. Forrester-Wood, D. A. Stringer, C. M. Castleden, R. E. Franks, Cox, M. Martin-Smith.

J. D. C. Martin.

HOCKEY CLUB

Tour of Cambridge 1966. 19th-22nd October

The trip to Cambridge, although so early in the season, always seems to be the highlight of the year's hockey; the games producing both skilful and enjoyable hockey.

The first match was against **Jesus College** and having drawn against them for the last two years, the anticipated keenness of the game was in fact realised and we managed to win by just one goal scored by our captain Andy Barclay from a short corner. The traditional alcoholic hospitality of Jesus College was maintained and ensured us of a very lively (though hazy and short-lived for some) evening's activity.

A revival of that Old English drinking game Clap-Clap met with some local opposition, so that after scoring a convincing 2-0 win over **Selwyn College** on Friday afternoon a new outlet for the more active members' energy was sought. This resulted in a re-enactment of the Civil War (English), under flood-light with soccer rules (and without much else). Since this was a rather revolutionary performance—it again "met with some local opposition"!

Saturday was the most active day of the tour and we played two matches.

In the morning match, **Fitzwilliam College** proved to be the most formidable side we had encountered for several years at Cambridge, and it was a severely chastened Bart's side that left the field after losing 5-2.

We fared rather better in the afternoon against **Pembroke College** and won by one goal to nil in a closely fought game—a satisfying end to a successful though exhausting tour.

Members on tour. A Barclay (Capt.), P. Jordan, G. Benke, M. Rymer, C. Yates, J. Thompson, W. Goss, D. Edmonson, W. Castleden, D. Robinson, C. Hunt, R. Barclay, P. Curry, N. Houghton.

Summary of Results

v Jesus College	Won	1-0
v Selwyn College	Won	2-0
v Fitzwilliam College	Lost	2-5
v Pembroke College	Won	1-0

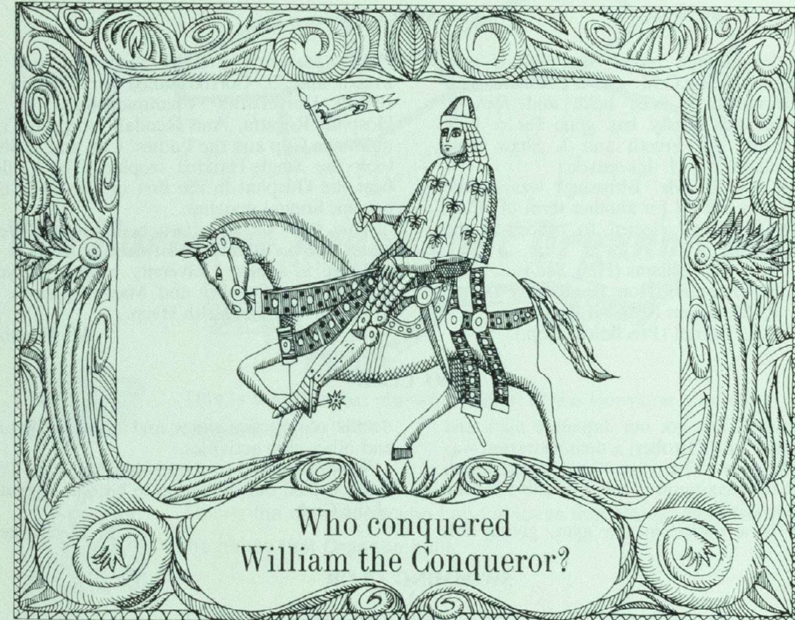
Cup Hockey

We have entered two cup competitions so far this year. The University of London Cup and the United Hospitals Senior Cup. In the preliminary round of the University Cup we scored a resounding 8-0 win over the **Royal Holloway College.**

We were also successful in the 1st round of the United Hospitals Cup, but not by such a comfortable margin. Our 1-0 win against **Charing Cross** was not very inspiring. It is to be hoped that we can do far better in later rounds.

Results to date	P	W	D	L	GF	GA
Bart's I	12	6	3	3	22	16
Bart's II	6	3	0	3	12	19

P. R. Jordan.



No one.
But he still worried a lot.
About his acne.
It was unconquerable too.

Today, William's plight is still shared by many adolescents.
But now Neo-Medrone Acne Lotion
– the modern comprehensive acne control agent –
removes the frustration of uncontrolled acne.

Whenever you need a staunch ally
against acne, signify

Neo-Medrone Acne Lotion

Supplied: 25 cc. plastic squeeze bottles. **Upjohn** UPJOHN LIMITED • CRAWLEY • SUSSEX
REGISTERED TRADEMARK: NEO-MEDRONE GB 3855.1

SAILING CLUB

After the summer recess, the club is now active again—the A.G.M. and a Freshers' sailing afternoon have been held, and *Rahere*, our 14-year-old Firefly has gone for a long overdue refit. M. Freeth and J. Shaw have already sailed for U.H. this season.

At the A.G.M. Mr. Birnstingl was in the chair and was elected for another term of office. The following were elected to offices in the Club:—

M. J. H. Williams (Hon. Sec.)
R. Chapman (Hon. Brent Sec.)
R. Markham (Clinical Rep.)
B. O'Farrell (Preclinical Rep.)

Last season was fairly successful, and M. Freeth and D. Gorrod sailed for U.H. in the British Universities' Championships. In the Hospital Regatta, Ann Rendall won the Commodore's Cup and the Ladies' Cup and J. Shaw took the Single-Handed trophy. The College beat the Hospital in the first of what will now become annual matches.

This year we have two boats at the Welsh Harp, and an Enterprise at Burnham.

There is a new University ruling this year, that between October and May lifejackets are to be worn on the Welsh Harp.

M. Freeth.

JUDO CLUB

We have at last got our Japanese mats and on Monday, 24th October, a demonstration was held in the gym. There are 40 members, which is almost the maximum number possible for the mat area available.

There is a notice in the gym. giving full details of practice times and a list of fixtures and other club activities.

We are pleased to report that Mr. I. P. Todd has accepted our invitation to become President of the Club.

P. D. Clarke.

SWIMMING CLUB

The most extensive tour in recent years began on Friday, 28th October, when we left Charterhouse in four cars bound for the West Country to compete in six matches in four days. The freshers Sheira, Weir, Huston, Pepper and Ridmead were soon to prove their worth, and veterans Knight, Coburn, Davies, Weller and Quinn made up the party. On the Saturday, J. Britton and D. Hanley (both qualified) appeared for a spectacular one day performance. It was unfortunate that Stan Clark, the ex-British 100 yards record holder, could not swim for us. The apparently poor results neither reflected the spirit and enjoyment of the matches nor the potentiality of our inexperienced team.

In spite of our heavy programme we managed to visit a remarkable number of interesting places, including the Swindon Accident Hospital.

Results
(C=Combined team).

Date	Opponents	Polo	Swimming
28th Oct.	Swindon Dolphins	C	L
29th Oct.	Bristol	L	L
	Southampton U.	C	W
31st Oct.	Exeter U.	C	W
	St. Lukes	L	L
1st Nov.	Yeovil S.C.	C	L

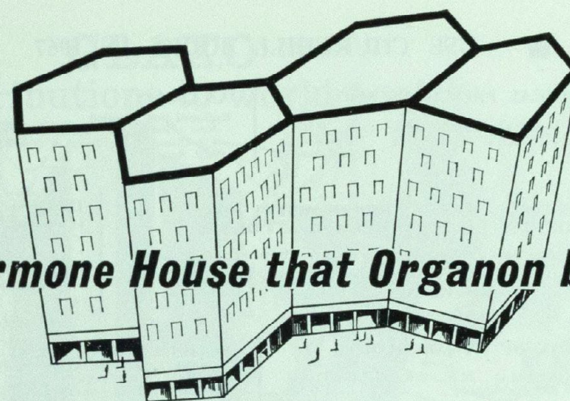
We would like to thank M. Knight for organising the tour, and also the many kind people who entertained us.

P. M. Quinn.

LADIES' HOCKEY

It is with great regret that we have to report that so far this season no matches have been played. On one occasion this was due to weather, but apart from that we have been forced to cancel our matches due to lack of players, disappointing both our opponents and our own keen members. We badly need more players and we are sure that there are many women students who are capable of turning out for us, even if they are not always available every week. Those interested should contact Sue Kotting as soon as possible.

S. Kotting.

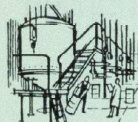


The Hormone House that Organon built

This is the idea that started the plan of the Hormone house that Organon built.

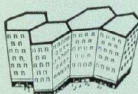
This is the researcher who had the ideas that started the plan of the house that Organon built.

This is the rat that was there at the start, as well as the cows, the sows and rabbits that enabled the researchers to probe the secrets of the hormones which built the house of Organon.

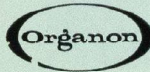


These are the workers who mixed the chemicals that joined up the molecules to make the bricks of the house that Organon built.

This is the doctor who found that the hormones helped his patients and prescribed the products of the house that Organon built.



The Hormone House



ORGANON LABORATORIES LIMITED
CROWN HOUSE LONDON ROAD MORDEN SURREY ENGLAND

USE CHURCHILL BOOKS IN 1967

PHARMACOLOGICAL PRINCIPLES AND PRACTICE
A New Book. By W. D. M. PATON, M.A., D.M., F.R.S., and J. P. PAYNE, M.B., Ch.B., D.A., F.F.A.R.C.S.
Illustrated. *Ready shortly.*

ANATOMY
Regional and Applied
New (Fourth) Edition. By R. J. LAST, M.B., B.S., F.R.C.S.
438 Illustrations (many in colour).
Just Ready. **130s.**

ANAESTHETICS FOR MEDICAL STUDENTS
New (Sixth) Edition.
By G. S. OSTLERE, M.A., M.B., F.F.A.R.C.S., and ROGER BRYCE-SMITH, M.A., D.M., F.F.A.R.C.S.
(Paperback) **14s**

BIOCHEMISTRY FOR MEDICAL STUDENTS
By W. V. THORPE, M.A., Ph.D., H. B. BRAY, Ph.D., D.Sc., and SYBIL P. JAMES, Ph.D., D.Sc.
Eighth Edition. 58 Illustrations. **36s.**

DISEASES OF THE EYE (Parsons)
Fourteenth Edition.
By Sir STEWART DUKE-ELDER, *G.C.V.O.*, F.R.S., M.D., F.R.C.S.
21 Col. Plates and 450 Text-figures.
60s.

Shaw's TEXTBOOK OF GYNAECOLOGY
Eighth Edition.
By JOHN HOWKINS, M.D., M.S., F.R.C.S., F.R.C.O.G.
4 colour plates and 451 text-figures. **40s.**

Holland & Brew: MANUAL OF OBSTETRICS
Twelfth Edition. By ALAN BREWS, M.D., F.R.C.P., M.S., F.R.C.S., F.R.C.O.G.
61 Plates (12 col.) and 388 Text-figures. **90s.**

Pocket Books

GYNAECOLOGY
By S. G. CLAYTON, M.D., M.S., F.R.C.S.
Fifth Edition.
17 Illustrations. **12s. 6d.**

MEDICINE
By G. E. BEAUMONT, M.A., D.M., F.R.C.P., D.P.H.
New (Fifth) Edition. **20s.**

OBSTETRICS
By Sir ARTHUR BELL, M.B., F.R.C.S., F.R.C.O.G.
Fifth Edition.
15 Illustrations. **12s. 6d.**

J. & A. CHURCHILL LTD., 104 GLOUCESTER PLACE, LONDON, W.1.

Charterhouse Grill & Restaurant

Fully Licensed

—

Ample parking facilities opposite

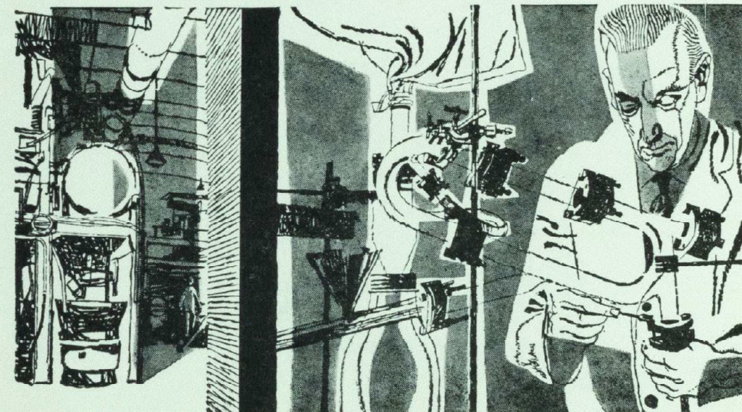
Monarch 7392

—

Private cocktail and Dinner parties catered for

33-35 Charterhouse Square London E.C.1

GLAXO
contributions to world health



corticosteroids

The latest Glaxo topical corticosteroid development is betamethasone 17-valerate, Betnovate. This entirely new steroid ester has been tested in the laboratory against more than 50 compounds and clinically in a number of British dermatological centres. The results of these and other trials show Betnovate to be outstanding in the speed and intensity of its action against psoriasis and other steroid responsive dermatoses.

Betnovate is, moreover, considerably lower in price than most of the newer topical steroid preparations. Because it achieves swifter and more decisive responses, it gives a new economy in price and performance.

The first announcement of the clinical value of cortisone was made in 1949. This started an intensive world-wide search for vegetable steroids that could be used as starting material for the economic synthesis of the hormone. In the United Kingdom, Glaxo pioneered a British process utilising hecogenin derived from East African sisal waste. Intensive development of this basic method has enabled Glaxo not only to produce a range of corticosteroids for all types of treatment but also progressively to reduce their prices.

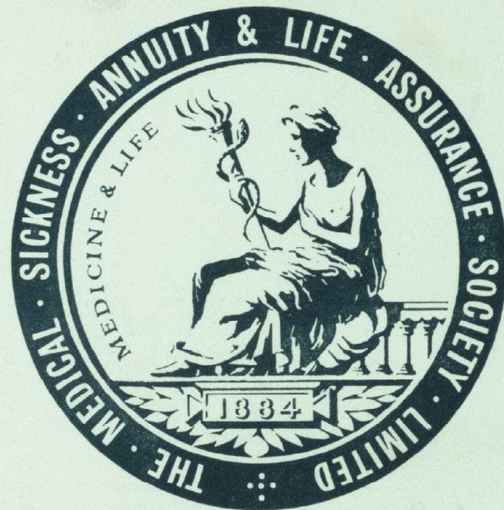
The recent introduction of betamethasone was a major advance in this work. Because it is safer and more effective than other cortisone derivatives, betamethasone offers a fresh start in corticosteroid therapy.

Furthermore, it was the first new corticosteroid, with advantages over available compounds, to be introduced at a price lower than that of existing preparations.

So far, development has taken about 300 man-years of complex scientific effort at a cost of £1,250,000. The result is, however, that Glaxo produce safe, effective and economic corticosteroids that are entirely British made.

The name Betnovate is a trade mark of Glaxo Laboratories Limited

GLAXO LABORATORIES LIMITED · GREENFORD · MIDDLESEX



The Doctors and Dentists own Insurance Company

Sickness and Accident Insurance
Permanent Policies to meet the special needs of the Medical and Dental Professions.

Family Provision Assurance
A tax free income for your family in the event of death.

Life Assurance
Capital for retirement and security for dependants in the event of death.

The Combined Policy
Three Policies in one—Permanent Sickness and Accident Insurance, Life Assurance and Family Provision Assurance.

Foundation Policy
A foundation on which students and newly qualified Doctors and Dentists can build to obtain a combined policy. Cover against incapacity and death at very low cost with the right to convert to a normal policy later.

The Medical Sickness Annuity and Life Assurance Society Limited

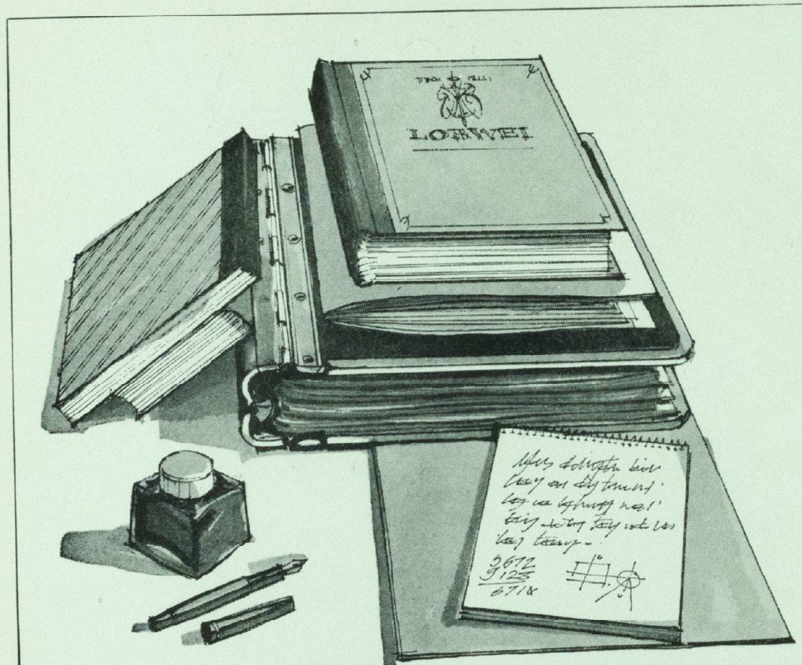
P.O. Box 449, 7-10 Chandos Street, Cavendish Square, London W1. Tel: Museum 1686

Printed by The Studio Press (Chelsea) Ltd., 37 Petergate, London, S.W.11.

Pot-Pourri, Clinical Pharmacology

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

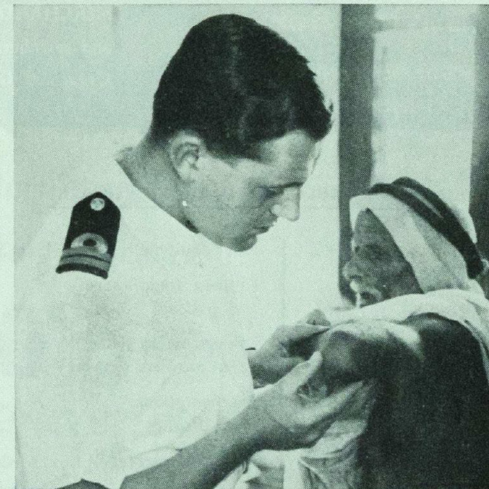
VOL. LXXI No. 2 FEBRUARY 1st, 1967



When you've plenty to think about a bank account makes life easier

You want your grant or allowance to go as far as possible, but you don't want to spend too much time worrying about it. And you needn't. A Lloyds Bank account helps you keep an eye on your spending – you plan your payments when you pay by cheque. You don't need to carry unnecessary amounts of cash around with you. And you have regular statements of account so you always know where you stand. Call at your local branch today.

Let Lloyds Bank help you to plan



How you can see the world and gain valuable medical experience

(before you settle into general practice)

Would you like to see the Far East, the Mediterranean, or the West Indies? Study the new sciences of aviation, underwater or nuclear medicine? Have complete clinical freedom, modern medical equipment and the opportunity to practise a very wide and varied field of medicine? Lead an active, exciting outdoor life against a world-wide backcloth?

These are some of the opportunities open to you as a Medical Officer in today's modern and expanding Royal Navy. During a 5-year Short Service Commission you can gain valuable, practical medical experience, treating both Royal Navy personnel and civilian families.

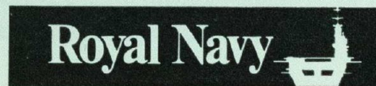
And you'll see something of the world—before you settle into the routine of general practice. You will be well paid, with a starting salary higher than that of a civilian hospital registrar. Marriage and other allowances can add considerably to your income. And, if you wish, you can apply for a Permanent Commission after 1 year's service. Later, you can study (with financial backing) for higher degrees, and you could aim for consultant status.

3 Ways of Entry.

1. As a fully registered doctor; civilian experience counts towards your seniority.
2. During your pre-registration year.
3. As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General
of the Navy, Dept. 26FR7,
Empress State Building, London, S.W.6.



The Business Houses' Discount Buying Service

49 BOW LANE, CHEAPSIDE, LONDON, E.C.4.
Telephone: CENtral 7225

Authorised Suppliers of BRANDED MERCHANDISE to Staff Associations and members of Approved Organised Groups.

DISCOUNTS AVAILABLE LISTED ALPHABETICALLY

Item		Discount
Batteries (car)	UP TO	17½%
Bicycles	,, ,,	17½%
Branded Shirts	,, ,,	20%
Beds	,, ,,	17½%
Bedding (sheets, blankets, b/spreads)	,, ,,	17½%
Bathroom fittings	,, ,,	17½%
Blankets (electric)	,, ,,	17½%
BRANDED CARPETS	,, ,,	30%
Cars	,, ,,	10%
Car radios	,, ,,	17½%
Camping equipment	,, ,,	17½%
Car accessories	,, ,,	17½%
Clocks	,, ,,	17½%
Cookers (large)	,, ,,	10%
Cookers (small)	,, ,,	15%
Curtain fittings	,, ,,	17½%
Cutlery	,, ,,	33⅓%
Dressing table sets	,, ,,	30%
Electrical appliances	,, ,,	17½%
Furniture		
Bedroom	,, ,,	17½%
Kitchen	,, ,,	17½%
Lounge	,, ,,	17½%
Office (re-conditioned)	,, ,,	HALF PRICE
Fridges	,, ,,	12½%
Gardening and General tools	,, ,,	17½%
Glassware	,, ,,	20%
Hi-Fi equipment	,, ,,	20%
Kitchen equipment and gadgets	,, ,,	17½%
Lawn mowers (hand)	,, ,,	17½%
Lawn mowers (power)	,, ,,	12½%
Leather goods	,, ,,	20%
Light fittings	,, ,,	17½%
Nylons (assorted)	,, ,,	30%
PHOTOGRAPHIC EQUIPMENT INCLUDING FILMS	,, ,,	17½%
Pen sets	,, ,,	10%
Perfume (French)	,, ,,	20%
Radios	,, ,,	17½%
Radiograms	,, ,,	20%
Record players	,, ,,	20%
Suitcases	,, ,,	17½%
Tape recorders	,, ,,	20%
Television sets	,, ,,	20%
Table lamps	,, ,,	17½%
Tyres (FITTED FREE)	,, ,,	17½%
Tools (POWER) and accessories	,, ,,	17½%
Typewriters	,, ,,	12½%
Towels	,, ,,	17½%
Venetian blinds	,, ,,	20%
Watches	,, ,,	17½%

This list is intended only as a guide to the range of merchandise we are able to offer. In addition to items listed, there are many others available at comparable discounts. The company reserves the right to amend prices and discounts without notification.

A DIVISION OF
THE RYAMS ORGANISATION (Southern) LTD

R. E. F.
PHOTO SERVICE

Wedding Specialists
Covering England

10% Discount

TO ALL HOSPITAL STAFF

Enquiries, full details:
13 HORNSEY RISE GARDENS,
N.19.

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL BARTS STAFF
ON OUR OWN MANUFACTURED GOODS

DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings,
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. - Teasets & Plate.

10%-20% DISCOUNT TO ALL BARTS STAFF

on all Branded Goods — ALL SWISS WATCHES, Clocks, Cutlery, Pens and Lighters and on Second-hand Jewellery.

GEORGES & CO.
of HATTON GARDEN

(Entrance in Greville St only)
88/90 HATTON GARDEN, E.C.1
HOL 0700 or 6431
OPEN WEEKDAYS 9.00 6.00 SATURDAYS 9.00–12.00

Special attention to orders by post or phone

UNIVERSITY EXAMINATION POSTAL INSTITUTION

G. E. OATES, M.D., M.R.C.P., London

POSTAL COACHING FOR ALL MEDICAL EXAMINATIONS

Carefully designed courses under the supervision of specialist tutors. Advice on reading, guidance notes to each lesson and solutions to all test papers are provided.

PROSPECTUS AND LIST OF TUTORS on application to

Dr. G. E. OATES,
17 Red Lion Square, London, W.C.1
Telephone: HOLborn 6313

SAVE up to 7/6 in the £

off the basic price on all your purchases

Almost anything can be supplied at most favourable discounts and delivery can be arranged anywhere in the country.

Furniture, Carpets, Watches 25%. Cutlery, Venetian Blinds 20½%. Tape Recorders, Projectors 20%. Record Players, Binoculars 20%. Radio, TV, Sewing Machines 20%. Screens, Lenses, Enlargers, etc. 20% Electrical Goods, Oil Heaters, Washing Machines, Spin Driers, Razors, Heaters, Food Mixers, etc. 17½% to 15%. Refrigerators, Mowers, Power Tools 12½% to 15%. Gas Appliances 12½%. Cars 10%

All goods supplied are brand new and fully guaranteed

Reading Warehouses Ltd.

(Dept. BM)
TADLEY, HANTS.
Phone: TADLEY 3704

You-nursing overseas with the Royal Navy

A stretcher case arrives by boat. As a Nursing Sister in the Queen Alexandra's Royal Naval Nursing Service you deal with all types of surgical and medical emergency. You are concerned with health and fitness of officers and men of the Royal Navy.

The nursing care of their families is also part of your duties. And you attend to an increasing number of National Health patients.

Midwifery and district nursing may also be part of your work. And in the Q.A.R.N.N.S. you have officer status— but are not subject to saluting, marching or naval discipline.

Within 12 months of your first appointment you can be overseas. Here you are sailing off Malta in your spare time, enjoying that Mediterranean sunshine!

You have a friendly, active social life. Your accommodation is free. And you are given 42 days' holiday a year.

HERE is a nursing career that gives full scope to your nursing skill. Offers a wide variety of valuable nursing experience. Gives you modern facilities to work with. And encourages you to take a wide measure of responsibility.

Good pay and Gratuities. You enter initially for a 4-year short service commission. But this can be extended to 6-8 years—with a gratuity of over £680 after 4 years; over £1,000 after 6 years and over £1,300 after 8 years. Nursing Sisters can earn over £821 per annum, rising to over £967 after 3 years: Senior Nursing Sisters up to £1,204 p.a. And there are opportunities for a permanent pensionable commission where salaries can rise to £1,780 p.a. and beyond.

If you are a qualified State Registered Nurse with at least one year's post graduate experience, write for further details to:

Matron-in-Chief, Q.A.R.N.N.S., Dept. 26MZ1, Empress State Building, London, S.W.6.

GAMAGES

NEW BUDGET ACCOUNTS

THE FAIREST OF ALL CREDIT SCHEMES

OUTSTANDING PAYMENTS CANCELLED IN EVENT OF DEATH

A Gamage Budget Account enables you to buy one or a variety of articles from the many thousands in the Store just when you want them. You buy at CASH PRICES fixed in the face of the FIERCEST COMPETITION, plus 1/3d. in the £ to cover the clerical expenses involved. You simply agree to pay a fixed sum monthly (minimum 15/-). As soon as your application is accepted you are entitled to purchase goods up to EIGHT TIMES the value of your credit, provided their total cost does not exceed your credit ceiling.

Ask for explanatory leaflet and proposal form, Enquiry Office— Ground Floor.

MEN'S HAIRDRESSING

Expert Service for busy men in modern and comfortable surroundings. Modern sterilising system. Also manicure. Lower Ground Floor.

TELEPHONE ENQUIRIES

When the Store is closed, including Saturday afternoons and Sundays, our ANSAFONE will record all your enquiries and messages at HOLborn 8128. It's quicker and cheaper to 'phone in the evenings!

"CRYSTAL DOME" Self-Service Restaurant. A widely varied Luncheon Menu available from 11.30 a.m. — 3.30 p.m. The "Crystal Dome" adjoins the Cocktail Bar on the 3rd Floor and is served by three direct lifts.

GAMAGES, HOLBORN, E.C.1. HOLborn 8484 Open Thursdays, 7 p.m.

If you have taken your 2nd M.B.-

or equivalent; or are just about to take it—

you can apply for an R.A.F. cadetship worth over £1,000 a year

A cadetship is a straightforward and very fair bargain between the medical student and the Royal Air Force—

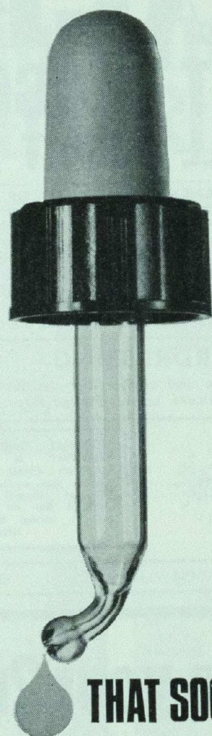
You agree to practise medicine for 5 years as a Royal Air Force Medical Officer as soon as you are fully registered.

The R.A.F., in return, pays all your tuition expenses and fees, and gives you a respectable cash income until you qualify. There is a substantial cash gratuity if you leave at the end of 5 years. If you are interested in a Permanent Commission—that is, in making your career in the R.A.F.—you will have the opportunity to apply for it after one year's full-time service in an R.A.F. practice.

How the scheme works If you apply for a cadetship, and are accepted, you are commissioned as a Pilot Officer, and receive the appropriate pay and allowances. Apart from this, you live and work like any other medical student. When you start your pre-Registration year, you are promoted to Flying Officer; and when you take up your first R.A.F. appointment you do so in the rank of Flight Lieutenant, as a doctor on an R.A.F. station with opportunities to go abroad.

Entry to Cadetships is by application and interview.

For more information please write, giving your age, nationality, and details of medical training, including expected date of graduation, to Squadron Leader M. A. Pallister, B.A., M.B., B.Chir., M.R.C.S., L.R.C.P., D.T.M.& H., D.P.H., D.I.H., R.A.F., Ministry of Defence, 1-6 Tavistock Square (26EB3), London, WC1.



THE DROP THAT SOOTHES THE INFECTED EAR

'Otosporin' rapidly destroys virtually *all* bacteria commonly found in ear infections, reduces irritation, inflammation and pain.
'Otosporin' brand Drops contain polymyxin B sulphate, neomycin sulphate and hydrocortisone in a bland suspension designed to facilitate penetration. Issued in bottles of 5 ml.

'OTOSPORIN'

CONTENTS

Vol. LXXI No. 2 — 1st February, 1967

A New Era? ... 42
Letters to the Editor ... 43
News ... 44
Examination Results ... 45
Obituary; C. E. Kindersley, F.R.C.S. ... 46
Clinical Pharmacology by P. Turner ... 47
Medical Practice Abroad, No. 5, Rhodesia; by J. W. G. Evans ... 50
Medicine in Literature ... 53
Cartoon by Cull ... 53
The Wine Committee's Fourth Annual Smoker ... 55
Ward Shows '66 ... 56
Pot Pourri ... 58
Matron's Ball ... 61
Old Prints of St. Bartholomew's Hospital by Roger Clayton ... 62
The Tall Ships Race 1966 by P. Smyth and R. Williams ... 65
London Markets, No. 2; Street Markets by Paul Swain ... 69
Prospect ... 71
Bart's Choral Society; Dido and Aeneas ... 71
Penguin Reviews ... 72
Medical Book Reviews ... 76

THE JOURNAL STAFF

Editor: **J. A. Sills**
News Sub-Editor: **Miss E. A. Macdonald**
Reviews Sub-Editor: **I. D. Fraser**
Social Sub-Editor: **R. C. D. Staughton**
Sports Sub-Editor: **P. A. Ashby**
Photographic Sub-Editor: **C. G. Fagg**

Manager: **J. P. D. Reckless**
Assistant Managers: **C. S. B. Roch-Berry**, **N. T. Goodchild**, **M. Castleden**
Charterhouse Representatives: **P. Swain**, **Miss J. Hall**
Nurses' Representatives: **Miss E. Ferreira**, **Miss P. M. Kilshaw**

A NEW ERA?

To announce a breakthrough in treatment knowing that the chances of success in the particular case are at the most even, takes courage. How easy it would have been to have kept the procedure unpublicised and released details in the event of success only. But the team which carried out the intra-uterine transfusion of the unborn baby in heart failure from the effects of the Haemolytic anaemia of Haemolytic Disease of the Newborn (HDN), chose to announce the operation after its completion, thus allowing us all to share the post-operative progress, and Fleet Street to go to town on the 'Human Interest' story. The subsequent still-birth of the child was disappointing to all and must have been a blow to the team and to the mother. All sympathy is due to the team and one admires in particular the courage of the mother; Medical History is made not only by brave treatment, but also by brave patients.

This intra-uterine transfusion, which was carried out first in Puerto Rico is the latest advance in the progress of HDN. For years the clinical pictures of Icterus Gravis, Hydrops Foetalis, and Haemolytic Anaemia of the Newborn were considered as separate conditions, but in 1941 Levine suggested that these conditions were all due to destruction of foetal red blood cells by maternal antibodies. Since that time advances in the diagnosis, treatment and prophylaxis of the disease has been remarkable.

Maternal predisposition to HDN is obtained from the history and blood grouping tests, sensitisation is detected by the anti-globulin test, which shows the presence of 'incomplete' 7s globulins directed against foetal red cell antigens.

Treatment aimed at the prevention of Kernicterus (the deposition of Bilirubin in the Basal Ganglia) is by exchange transfusion of fresh compatible blood after birth. Labour may be induced after 32 weeks gestation, depending upon the condition of the foetus and the maternal antibody levels, the foetal blood chemistry being studied by amniocentesis for haemoglobin and bilirubin levels.

More recently the technique developed in New Zealand of injecting compatible red cells into the foetal abdominal cavity in utero under radiological control, has become the definitive early treatment in many centres for foetal anaemia and distress, and encouraging decreases in mortality have been reported.

The work of Clarke's group in Liverpool which indicates that foetal D+ red cells circulating in the maternal blood stream during the puerperium may be destroyed by injections of high-titre anti-D serum gives great hopes for the prophylaxis of the condition.

Besides the direct application of intra-uterine procedures in HDN, the general implications of this technique must be considered. The uses of the procedure may be limitless, control of foetal metabolism in eclamptic and diabetic conditions, early detection and more precise diagnosis of congenital heart disease and surgical treatment of hydrocephalus spring to mind. But who can predict the applications of a new technique? Who could have predicted that early 'open heart' operations would lead to the simultaneous replacement of three heart valves by prostheses?

However, should intra-uterine procedures become routine, we hope the precedent set in this first operation in Britain in maintaining the secrecy of the sex, will become accepted. The mystery and suspense over the sex of the foetus is surely an integral part of pregnancy, and while the Profession is bound to try to reduce foetal mortality, it must not step beyond its brief and destroy this mystique.

LETTERS TO THE EDITOR

WARD SHOW LUNCHES

Sir,—Last year those who participated in the ward shows had the unenviable pleasure of munching cold pork pies and apples in a chilly Abernethian Room before presenting themselves upon the wards in a jolly manner. Surely Sir, it is unfortunate that those who entertain at Christmas for the enjoyment, not only of themselves, but also the patients and nursing staff should be rewarded thus. Gone it seems are the days when the pre-Ward Show lunches were traditional fare of turkey, Christmas pud, certain well matured carols and 'Rule Britannia' in R.S.Q. and the Nurses' Dining Room. It is rumoured, and I remind you Sir, there is no smoke without fire, that this is the first of the snubs to the merry Christmas entertainers at Bart's that will lead to the end of shows on the wards. Why is it that traditions are so easily brushed aside with an 'enlightened' austerity, under the guise of progress?

Bart's, I believe, is the only London hospital still presenting shows on the wards at Christmas —is not this reason for supporting such enterprise and goodwill? Bart's with so many traditions to be proud of, should set an example by preserving its character in this insane world. Then could the ward shows together with the West Wing, linger on to be savoured by future generations otherwise brought up in an atmosphere of mediocrity.

Yours sincerely,
ROGER CLAYTON
College Hall,
Charterhouse Square,
E.C.1.
January 1st, 1967.

The following letter has been received. The large number of signatures (too many to print as a full list) indicates that the sentiments expressed are fairly widely held among those taking part in the Christmas 1966 Ward Shows.

Sir,—One of the traditional features of Christmas at Bart's has been the annual pilgrimage to the Nurses' Dining Room for the Christmas fare for those in the Ward Shows.

It is with regret that we noted the lapsing of this custom. We are grateful for the apples, and the veal and ham pie off greaseproof paper, but we hope in future years for a return to the traditional pre-Ward Shows fare.

Yours faithfully,
....
Abernethian Room,
St. Bartholomew's Hospital.
28th December.

SNAKE-BITES AGAIN

Sir,—I feel obliged to comment on the treatment of snake-bite as proposed in the July 1966 *St. B.H.J.*, by J. Reckless. I shall comment upon his points singly:—

1) While it is of the greatest importance to recognise and identify the snake, surely it could be dangerous to attempt pursuit and capture oneself?

2) One should *never* apply a ligature after an adder bite, for it will aggravate the oedema, and will tend to increase tissue damage. A tourniquet may be of use in the treatment of the bite of an Elapid (mamba, cobra, etc.), as venom spread is not largely by blood vessels. The ligature must not be too tight; the pulse should be weakly discernible distal to it. Antivenom must be injected as soon as possible.

3) Bathing the wound in water would seem to be of doubtful value. It will serve to remove *none* of the venom injected, while "wiping away from the wound" as recommended can only help to increase the spread of venom through the tissues.

4) Incision (or worse still, excision) has no place in the first-aid treatment of snake-bite. Very great dangers: anatomical, physiological and psychological are inherent in the technique in the hands of anyone but a trained surgeon (who is unlikely to be present). Incision may be needed in hospital, for example, to prevent oedema producing rupture of the wound site. Suction without incision, and relying on the puncture holes only, for drainage, is unlikely to have much effect.

5) Tea or coffee, not particularly commonly available near where the encounter has occurred, may be of some benefit to the morale of both the patient and the person supplying the beverage. Codeine or pethidine may be needed to control the pain.

6) Reassurance is of course very important. One should not be too sanguine, though. Not many people are likely to survive the bite of, for example, a Gabon Viper, without efficient and prompt medical treatment, and very prompt injection of antivenom.

Another treatment often recommended, is the application of Potassium Permanganate. This practice is to be utterly condemned. While Potassium Permanganate can destroy the toxic properties of some venoms when the two are in direct contact, such conditions do *not* occur in snake-bite. The use of permanganate may well cause necrosis and gangrene.

Possibly the most up-to-date and reliable authority on the subject is John Visser: Poisonous Snakes of Southern Africa and the Treatment of Snake-bite. Howard Timmins, 1966.

Yours, etc.,

M. A. SIMPSON,

Pretoria,
South Africa.

12th December.

Sir,—Until quite recently the treatment of snake-bite was not in any way clearcut; and many steps of little use, and some of positive use were still recommended.

Thoughts on the treatment appear to be becoming more rational and scientific. I would concur with Dr. Simpson in the points he made.

In 1961 the British Red Cross Society asked the Royal Society of Tropical Medicine and Hygiene for advice on the First Aid treatment of snake-bite in the United Kingdom and overseas, and a committee was set up to draw up simple and precise recommendations. These are very much on the lines suggested, differing from Dr. Simpson's comments in small details only. (Transactions of the Royal Society of Tropical Medicine and Hygiene, Vol. 56, No. 1, pp. 93-94, 1962).

Yours faithfully,

J. RECKLESS,

96, Hodford Road,
London, N.W.11.

16th January.

Engagements

EDELSTEN-ALLEN—The engagement is announced between Dr. Anthony David Edelsten and Miss Nicola Jane Allen.

ROLFE-SMETHURST—The engagement is announced between Dr. Michael Rolfe and Miss Lynne Smethurst.

ROWSELL-LINDSEY—The engagement is announced between Anthony R. Rowsell and Miss Frankie M. Lindsey.

Marriage

STRANACK-FOOT—On September 10, K. S. Stranack to Dr. Caroline R. Foot.

Births

BARRETT—On December 13, to Trudy (née Bell) and Dr. Richard Barrett a daughter (Catherine Jane), sister for Andrew.

MILLER—On December 19, to Jane (née Evans) and Dr. Richard Miller a daughter (Sophie Jane).

SHARP—On September 26, to Jill (née Collins) and Dr. Guy Sharp a son (Matthew Guy) brother for Amanda.

Deaths

DAY—On November 2, Dr. George Day, M.B., B.S., aged 72. Qualified 1916.

L'ETANG—On December 15, Dr. Joseph George L'Etang, M.R.C.S., L.R.C.P., aged 80. Qualified 1914.

ROYDEN—On December 10, Dr. Thomas William Eardley Royden, B.A., M.R.C.S., L.R.C.P., aged 67. Qualified 1925.

New Years Honour

Knight Bachelor

Mr. Michael Willcox Perrin, C.B.E., F.R.I.C., Chairman (Treasurer), Board of Governors, St. Bartholomew's Hospital, London; Chairman, the Wellcome Foundation.

Honours

University of London

Readership in human metabolism has been conferred on Dr. R. W. E. Watts.

University of Cambridge

M.Chir. Mr. R. L. Rothwell-Jackson.

Royal College of Physicians, London

Dr. A. W. Franklin has been elected to the Council.

Appointments

Professor D. J. Boullin as Associate Professor of Pharmacology to the University of Vermont as from July 1st, 1967.

Mr. Richard I. Myall, F.I.M.T.A., F.H.A., Treasurer to Salford Hospital Management Committee, has been appointed Chief Financial Officer of St. Bartholomew's Hospital. He will take up his position in March and will succeed Mr. R. Brinley Codd, who is to take up a new position as Treasurer to the South East Metropolitan Hospital Board.

The 3rd Horder Memorial Travelling Fellowship

The Trustees of the Horder Memorial Trust announce that the Horder Memorial Travelling Fellowship for 1967 has been awarded to Professor Douglas A. K. Black, M.D., F.R.C.P., Professor of Medicine of the University of Manchester and President of the Renal Association, in order to travel to South Africa.

Professor Black hopes to visit South Africa with his wife in the summer of 1967, and it is hoped will give the Horder Memorial Lecture at St. Bartholomew's Hospital, London, in the autumn.

The Horder Memorial Trust was formed as the result of an appeal by the late Lord Horder's former house physicians and the Royal College of Physicians, London. The objects of the Trust are to allow senior men in the medical profession to travel, particularly to visit the Commonwealth countries and by so doing to cement international relationships.

February Duty Calendar

Sat. & Sun., 4th & 5th
Mr. Tuckwell
Dr. Oswald
Mr. Aston
Dr. Cole
Mr. Dowie

Sat. & Sun., 11th & 12th
Mr. Hunt
Sir Ronald Bodley Scott
Mr. Aston
Dr. Bowen
Mr. Cope

Sat. & Sun., 18th & 19th
Mr. Ellison Nash
Dr. Black
Mr. Manning
Mr. Ellis
Mr. McNab Jones

Sat. & Sun., 25th & 26th
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Ballantine
Mr. Dowie

Physician Accoucheur for February is Mr. D. Fraser.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD SECOND B.M. EXAMINATION MICHAELMAS TERM 1966

Pass

Blackburne, J. S.
Moon, J. R. A.
Crowther, A. N.
Moon, J. A.
Turner, J. M. M.

UNIVERSITY OF CAMBRIDGE FINAL M.B. EXAMINATION MICHAELMAS TERM 1966

Pass

Kersley, H. J.
Wood, T. A.
Purcell, J.

Supplementary Pass List Part I. Pathology and Pharmacology

Barrington-Ward, E. J.
Dymond, J. P.
Graham, W. B.
Ireland, N. J.
Scotchman, F. G. V.
Milne, I. S.
Setchell, M. E.
Tucker, N. H.
Casson, J. H.
Goss, W. H.
Trowell, J. E.
Wood, P. B.
Buckley, M. R.
Gordon, J. F.
Gray, A. G.
Hollingshead, J. F.
Raine, P. A. M.
Thompson, J. B.
Williamson, R. C. N.

Obituary

Charles Edward Kindersley, F.R.C.S.

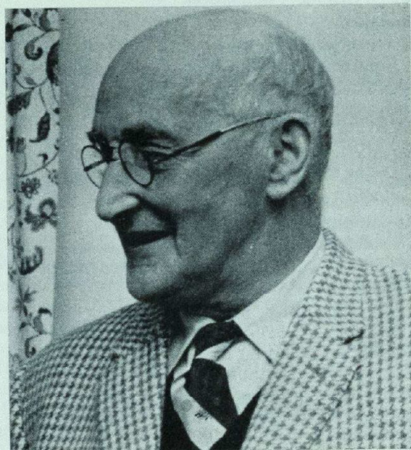
With the recent death of Charles Kindersley (20th November, 1966) Bart's has lost one of her most loyal and distinguished alumni.

Charles Kindersley was born on 5th May, 1890, the third child in a typical Victorian family of six. His family background and early training undoubtedly gave him the solid foundation on which his career was built. His grandfather was Vicar of Brampford Speke, near Exeter. His father, who had been a Rowing Blue, Rugby Blue and International, was assistant master at Eton, and his influence on his son was very great. Charles was sent to Sedbergh, where he played rugby and captained the school shooting team. From there he went to Magdalene College, Cambridge, where, he used to admit, sport dominated his interests. He continued to excel at rugby and rowing, and managed his examinations sufficiently well to take up a place at Bart's in January 1913. There he started as a dresser to Sir Anthony Bowlby. Sport continued to be a dominant interest, and he played for Bart's 1st XV, for United Hospitals, Middlesex, and Harlequins. He also rowed for the hospital with C. W. B. Littlejohn.

In 1914 when war broke out, Kindersley enlisted as a Surgeon Probationer R.N.V.R. At the end of 1915 he was sent back to Bart's to qualify, and he obtained the Conjoint Diploma in 1916 and returned to the Navy.

In 1918 he married Miss Peggy Carlisle, and transferred to the R.A.F. After demobilisation in 1919 he returned to Bart's as House Physician to Dr. Tooth, and then came to the old Royal United Hospital, Bath, as House Surgeon to Mr. Forbes Fraser. After completing his job in Bath, Kindersley settled in general practice in Warminster, where he was actively associated with the local cottage hospital, and where he kept alive his interest in surgery. In 1928 he made a very brave move by selling his practice, and returning to Bart's, where he demonstrated anatomy and worked for the F.R.C.S., which he passed in 1930.

Returning to Bath, he put up for a vacancy as Consultant Surgeon, and was appointed against a strong field. At this time Bath, like many provincial hospitals, was staffed largely by people still doing general practice. Charles Kindersley and his medical colleague, the late Dr. R. G. Gordon, set out to alter this and to establish a hospital staffed with people doing



consultant work only. The years between 1930 and 1939 were productive years for Kindersley. He visited clinics abroad, and was particularly impressed by Bohler's fracture service in Vienna. On his return he started and built up a fracture service at the Royal United Hospital, which in time he handed over to the late John Bastow, and which has become the main part of the orthopaedic service. He also started a plaster and orthopaedic service at the Royal National Hospital for Rheumatic Diseases. At this time, too, he started his association with the surrounding small cottage hospitals, an association which continued during the war years, and was to lead later to the formation of an extremely well integrated Clinical Area.

In 1939, at the threat of war, Kindersley volunteered again, and was appointed Major R.A.M.C. in charge of the Surgical Division of the local Military Hospital, but was invalided out about a year later. Following the war he was drawn into medico-political activities, and in the next few years served on a multitude of committees, including those which gave birth to the Central Consultants and Specialists Committee, and later on the Joint Committee and Whitley Council. He was a dominant member of all local medical committees and of the Hospital Management Committee. When he

retired from active clinical surgery in 1955, the Regional Hospital Board appointed him Emeritus Consulting Surgeon. In 1957 he was appointed Chairman of the Hospital Management Committee and held that post until his 75th birthday. At that age he was still the most alert quick thinking member of the committee.

Charles Kindersley was a great man who would have made his mark in any walk of life, but chose to devote his great energy and inexhaustible enthusiasm to building up in Bath and its Clinical Area an efficient well run friendly hospital service. While on the active staff he maintained a close connection with Bart's and particularly with Sir James Patterson Ross, a connection which led to the sending of a steady flow of junior staff to work with him both before and after the war. At least three of his housemen have ended up with University Chairs and many have become distinguished in surgery. Their letters of appreciation written at his death show how great was his influence on them.

He maintained close links with Bart's graduates in and around Bath. He was a founder member of the Wessex Rahere Club and an assiduous attender at the annual gathering, at one time holding the post of chairman.

Charles Kindersley will be missed by all, especially his second wife and his son who survive him and to whom we extend our sympathy.

S.G.

Clinical Pharmacology

by P. Turner

Many people, even within our own profession, regard Clinical Pharmacology as *"pharmacology taught to clinical students."* Nothing could be further from the truth. It is the study of the response of human beings and human tissues to drugs, and often this may be very different from results in animals. This has been recognised for a long time. Purkinje, in 1829, wrote "Normally we should simply think of making use of animals . . . but the most reliable results may be obtained only by experimenting with one's own body, provided the experiments are performed with adequate care." Nevertheless, it is only in recent years that its importance has been generally appreciated, and this is reflected in the comparative lack of Clinical Pharmacology departments in this country, although there are several such centres in the United States.

In the *Clinical Pharmacology Division* of the Medical Professorial Unit in this Hospital, studies are taking place along two broad lines. Firstly, the study of drugs in normal subjects, and secondly their evaluation in diseased states. Thus we might say that human pharmacology and therapeutics find a common meeting place in this department. While it is of evident importance that such studies should be under the supervision of a medically-qualified and experienced person, the actual observations and analysis of results do not need to be, and indeed graduates from other disciplines such as physiology and pharmacology may well be better fitted to do this work than medical graduates without a scientific training. The results obtained in such studies require careful statistical evaluation, and it is imperative that a Department of Clinical Pharmacology should have the services of a statistician and, if possible, access to a computer as the analytical methods required are often time consuming. We have been very fortunate to have the assistance of Mr. J. V. Smart, statistician to Smith Kline and French Lab. Ltd., who has been closely associated with many of our research projects, both in their planning and evaluation.

Purkinje, in the quotation already referred to, emphasised the importance of "adequate care" in human drug testing, and the first task of a clinical pharmacologist is to develop methods of investigation which are both safe and acceptable to his subjects. It is often surprising to many people how safe and acceptable such procedures can be, for example, in the cardiovascular field where in recent years much has been learnt about responses of the

heart and circulation to various agents by means of catheterization of different parts, in normal subjects (and not only with prisoners and mental hospital patients as volunteers!).

A subject of particular interest in this department has been the study of the effects of drugs on the brain. Ever since the introduction of drugs such as the barbiturates which depress, and amphetamine which stimulates the central nervous system, tests of central function have been sought which will reflect these actions. The first purpose of such tests is to screen new compounds for central activity to decide which deserve further study. The second purpose is to suggest a focus of activity in the brain and the mode of action of the substances concerned. Thirdly, a study of changes within the central nervous system induced by drugs may lead to a better understanding of the physiology and pharmacology of the nervous system and their disturbances in diseases of that system. Many such tests have been devised, behavioural, motor, electrophysiological and sensory, and it is with the latter which we have chiefly been concerned.

The sense of smell can be measured quantitatively by releasing into the nose increasing quantities of odourised air under standard conditions until the subject perceives an odour to be present. There are, however, so many variable factors, particularly the state of the olfactory mucosa, that this test is not sufficiently accurate to show drug effects in therapeutic doses.

The critical flicker fusion frequency (c.f.f.) is a test of visual discrimination, measuring the rate of intermittency of a light when it no longer appears to be flickering but fused or steady. It is sufficiently sensitive to show dose-response effects with many drugs in therapeutic doses. For example, central stimulant drugs such as amphetamine, phenmetrazine and diethylpropion produce an increase in c.f.f. while central depressant drugs such as chlorpromazine and amylobarbitone cause a decrease. The time course of a drug can also be studied under different conditions. In a useful collaborative study with the School of Pharmacy, Chelsea College, we found that the excretion rate of dexamphetamine sulphate was markedly dependent on urine pH, and that whereas about 50% of a dose was excreted in 16 hours with an acid urine (pH 5), only 3% was excreted in an alkaline urine (pH 8). It was then possible to show with c.f.f. that the stimulant action of amphetamine on the central nervous system was both increased and prolonged if the subject's urine was alkaline in contrast to the effect with an acid urine. One can also study drug interaction on c.f.f. For example, whereas amphetamine raises c.f.f. and amylobarbitone depresses it, a combination of both in the ratio found in Drinamyl ("Purple hearts") is not significantly different from an identical placebo. At the same time as studying the effects of drugs on c.f.f., interesting neurophysiological and psychophysiological factors emerge which deserve further attention, and we have therefore been able to analyse some of the things which determine c.f.f. under different conditions, quite apart from the pharmacological aspect. It is of interest that Dr. G. M. Besser has shown similar drug effects on the auditory flutter-fusion threshold, which is the equivalent of the c.f.f. in the auditory pathway.

Co-operation between departments and colleges is always desirable, provided that there is full mutual collaboration and respect. Such a study was carried out with the Department of Ophthalmic Optics, Northampton College of Advanced Technology (now the City University), in which the effects of promethazine hydrochloride (Phenergan) on visuo-motor co-ordination were studied. Students there designed an apparatus which simulated to some extent a driving machine, with a steering wheel to guide an electric contact along a tortuous path of holes in a rotating drum. In a double-blind procedure comparing promethazine hydrochloride 50 mg. with a placebo it was possible to demonstrate a marked impairment of visuo-motor co-ordination, which obviously has important implications for driving and other complex tasks.

A subject of great contemporary interest to clinical pharmacologists is the rôle of the autonomic nervous system in many disease states, and the introduction of specific neurone- and receptor-blocking drugs has facilitated its study. About a year ago we were able to show that propranolol, the β-adrenergic receptor blocking drug, when given intravenously abolished the tachycardia of patients with thyrotoxicosis and anxiety states, and that the responses of these two groups were not significantly different. Propranolol, in an oral dose of 20 mg. q.d.s. was then shown to be effective in the routine management of patients with anxiety, reducing autonomic manifestations such as palpitations and dizziness. Some years ago it was shown that intra-muscular reserpine and oral guanethidine could reduce the lid-retraction of thyrotoxicosis, but the introduction of guanethidine and propranolol eye-drops made possible a closer study of this effect. Guanethidine eye-drops can produce spectacular effects in the eyes of thyrotoxic patients by abolishing lid-retraction, and even reducing sympathetically-mediated proptosis, although it does not appear to influence established exophthalmos with organic changes in the orbits. Propranolol eye-drops had little effect on the eyelids and it therefore appears that while the cardiovascular manifestations of thyrotoxicosis are β-receptor adrenergically mediated, the lid-retraction is probably an α-receptor effect. Unfortunately there is as yet no satisfactory α-blocking drug for topical use in the eye, with which this might be proved. Not only have these studies proved fruitful from the point of view of thyroid-sympathetic relationships, but they are allowing a study of the interactions of sympathomimetic amines with guanethidine and propranolol in the eye, which provides a useful and readily visible model for such an investigation.

There is still considerable controversy over the rôle of thyroid hormones in producing the manifestations of thyrotoxicosis, and a critical investigation which we must carry out in the future is their effect on the pharmacologically denervated heart. This requires considerable preparatory work, however, for we do not yet know what is the true atropinising dose to block all vagal cardiac tone, and the dose of propranolol necessary to protect the heart completely from sympathetic tone. We are at present investigating these factors with Dr. Douglas Chamberlain in the Cardiology Department. In all these studies we are very grateful to the students who have so willingly volunteered as subjects for our studies.

A clinical pharmacology department must study not only responses to drugs but also the way in which they are handled by the body. For example, at the moment we are investigating a new drug which is claimed to possess anti-depressant properties, and at the same time as observing its effects in psychiatric patients we are studying its excretory products in urine in the hope that we may be able to determine its metabolic pathway. It is always possible that a metabolite rather than the drug itself is the therapeutically active substance, and it is only by such studies that this can be determined. This, of course, requires full collaboration with the drug manufacturer for the identification of metabolites which have been isolated is difficult and necessitates the synthesis of many different compounds for comparison with the unknown. Nevertheless, it is obviously in the interests of the company as well as ourselves, for this information to be provided. In the past, relations between drug manufacturers and the medical profession have not been cordial because of suspicion on the part of doctors generally that the firms' primary interests are commercial and profit-making, and that these considerations outweigh those of the patients' best good and safety. Dollery wrote in the *Lancet* recently "No-one can deny that some of the problems facing clinical pharmacology can be traced to the ambivalent relationship between pharmaceutical companies and the medical profession. Each needs the other, but the relationship is a curious mixture of admiration and distaste. On the one hand, there is the private industrial enterprise which must make a profit, and on the other the hospital doctor paid a salary, often with an altruistic-streak that makes him look down on the profit motive." While this may be true in part, most drug research in this country is financed by pharmaceutical firms, and there is a genuine desire on the part of many of them to co-operate closely with the medical profession in order to develop products which will be of the greatest therapeutic benefit. The strict requirements of the Dunlop Committee for the Safety of Drugs have increased the need for such close co-operation, and we are trying in our unit to develop good relations with the pharmaceutical industry. At present we are testing several new preparations in normal human volunteers and patients for their pharmacological and therapeutic effects and also for any toxic actions. This means, of course, finding not only suitable patients but designing accurate tests to give objective data susceptible to statistical analysis. Clinical impression alone is not enough, and in almost every instance, comparison of the new preparation with another established agent or with a placebo is necessary. It is to be hoped that such mutual co-operation and enterprise will increase in the future, not only in our own department but throughout the hospital and profession generally.

There is no doubt that the importance and scope of clinical pharmacology will increase in the next few years, and this subject will offer attractive prospects to those contemplating an academic career in medicine, and who have special interests in human physiology and pharmacology.

Medical Practice Abroad

5. RHODESIA

by J. W. G. Evans Obstetrician & Gynaecologist

Your editor has asked me to produce an article for the Journal on medicine out here. I have been in the country barely eight years, and in one centre only, Salisbury, during this period. I therefore lay no claim for authority on the subject, nor on this land-locked country itself. However, I hope these personal impressions of a recent Rhodesian will be of interest, especially about a country which has hit the world news of late.

I have enjoyed the articles by Bart's men about other countries abroad; I have often wondered about the authors' background and the reason for their emigration.

After a house job "on the sector" at Bart's in 1942, I spent four years in the R.N.V.R., I found a years Resident Casualty job after this period invaluable. A spell in General Practice before and after the *National Health Act* was an education. The obstetrics I did at this time emphasised the dangers of not possessing a basic working knowledge of this subject. Fortunately I was able to get out of general practice, and start the long trail to the "membership" of the *Royal College of Obstetricians and Gynaecologists*. Four years at, and associated with, the Jessop Hospital for women, Sheffield, laid the foundation for this. In 1956 and 1957 Senior Registrar jobs were hard to come by, and it was at this impasse that I came out to Rhodesia in November, 1958. For the two years prior to emigration, I acquired much practical experience in Senior Registrar and Consultant grades in a locum capacity, all over England. This state of affairs had no foreseeable ending and gave no satisfaction to a wife and three young children!

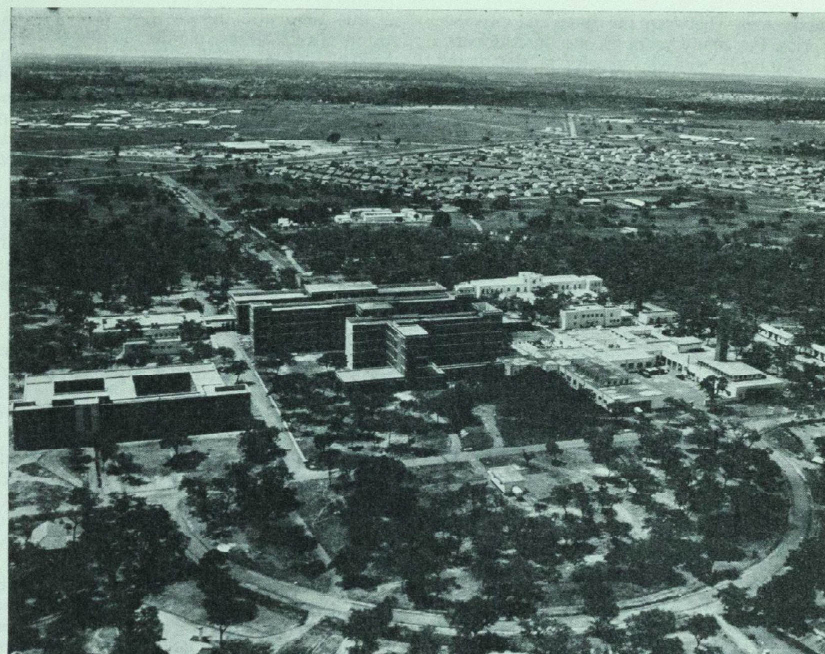
The practice I joined in Salisbury was founded by a competent Gynaecologist, the late Baillie-Higginson. It is private practice in its fullest sense. I perform my own obstetrics and gynaecology, which amounts probably, to half the total work. It is my experience that pursuing the intricacies of general practice in no way detracts from the performance of one's speciality. The surgical technique acquired over the years changes little, but knowing the patient's back-ground, her family obligations, and her likely response to treatment are of equal import. Also, every item of care from beginning to end is one's own responsibility.

The history of medicine in Central Africa is fascinating, and as is the case of all "backward" countries, presents a challenge for the future. Professor Michael Gelfand of Salisbury, an authority on this subject, has produced many publications. I bring to your notice two books by him well worth reading. "Tropical Victory—An account of the Influence of Medicine on the History of Southern Rhodesia. 1890-1923". *Published 1953,* and "Proud Record." *Published 1960.*

Much ignorance still prevails on the geography of this country. Letters frequently arrive addressed "Salisbury, South Africa!" *The Federation of Northern Rhodesia, Nyasaland and Southern Rhodesia* disbanded in 1963. The component Countries are now *Zambia, Malawi* and *Rhodesia* respectively, and all have independent status.

Rhodesia has territorial provinces—Salisbury is the centre for Mashonaland, Bulawayo for Matabeleland, Umtali for Manicaland and Gwelo for the Midlands. Salisbury is the largest city in Rhodesia and has a greater European population of over 85,000. It is aptly called "The City of Trees." Many of its wide avenues and streets are lined by flowering trees, particularly *Jacarandas* and *Flamboyants*, which in their seasons produce a blaze of colour. Another feature of Salisbury is the number of tall buildings, which from distant approach, silhouette the sky line. As Professor D. V. Hubble, on a recent visit here, re-iterated . . . " a beautiful city, a magnificent city."

Farming is the life blood of Rhodesia. Tobacco is the established money earner. Beef is making rapid strides for the export market. Lately there has been a big drive on the diversification of crops. Enormous areas in the Low Veld have been irrigated. Sugar production is already high there, and thousands of acres grow citrus fruit and cotton. This recent scheme mentioned is only one of several to develop the national resources of the country, to make it self-sufficient and have a surplus to export. The mineral wealth of the country is yet untapped. Copper, tin, asbestos, chrome, gold and precious stones, to mention a few metals and minerals already mined, contribute to the national economy. The Wankie Colliery is one of the world's largest coal producers. Also world famous is Risco,near Que Que, which has vast iron and steel foundries. Recent surveys forecast richer strata of most of the substances mentioned and also the presence of other metals and minerals required by the atomic age.



An aerial view of Harari African Hospital and Maternity Home.

The taming of the Zambesi River at Kariba has produced a hydro-electric scheme of great magnitude, and also one of the world's largest man-made lakes. At Livingstone the glories of the Victoria Falls must be seen to be believed.

The seasons in Rhodesia are interesting. September ushers in the warm weather. The following five months are hot, temperatures range from 80 to 90 degrees. These are the rainy months. Showers are usually short and sharp; frequently over one inch falls in the hour. Of latter years the average rainfall has been about 36 inches, which doesn't differ much from that at Old Trafford! From April to September one expects coldish, dry but sunny days. However, this year there were heavy thunder storms in June and July!

Rhodesians are sport minded. There are few doctors who do not make use of the excellent facilities for golf, cricket, tennis, bowls and fishing. Rugby football could be considered the national sport, but the hard grounds and high altitudes influence earlier retiring age than in the United Kingdom.

There are over 150 doctors practising in Salisbury and district. Probably nearly 40 of this number are full time or part time Government Medical Officers. The Government Health Service is the foundation of medicine out here, for all hospitals are Government controlled and private practitioners have the privilege of their use. This does not imply that there is a Government controlled health scheme in any way.

Harmony exists between the state and private enterprise. For many years private practitioners have voluntarily staffed Casualty at the main Government hospital in Salisbury from 6 p.m. to 8 a.m. the next day. Dr. George Gardos, a Bart's man who was here, covered a great deal of the medical set-up in an excellent article in your Journal two years ago.*

The *Lady Chancellor Maternity Hospital* in Salisbury is of high standard. It is for Europeans, Indians and Coloureds. Just about 2,000 confinements take place there yearly. Its counterpart in Bulawayo is the *Lady Rodwell Maternity Hospital*. There are large general hospitals in the main centres for European and Coloured races. Also, in smaller centres and in the bush, there are hospitals which give valuable service to all races and afford enormous practical experience to isolated practioners.

The African population is catered for by perhaps the largest and best equipped hospitals in Africa. These are the *Harari Hospital* in Salisbury, and the *Mpilo Hospital* in Bulawayo. Too much cannot be said for the high standard and for the prolific work performed at these institutions. African general practitioners are few and far between. It is hoped that soon the new Medical School in Salisbury will be producing doctors to answer this need, and thereby relieve the strain on the main hospitals' Out-patient Departments.

It is my experience that general medicine differs little from any other part of the world I have encountered. Bilharzia is the scourge of all races. In the European, it is easy to suspect but difficult to diagnose. The comparatively recent fluorescent antibody test has helped considerably in the diagnosis, but the isolation of ova from the intestinal and/or renal tract on which certainty of diagnosis depends can be perpetually elusive. Over the years, I have been suspicious of the efficacy of intravenous antimony preparations; perhaps the recently produced Ambilhar oral preparation of Ciba will be the answer to bilharzial treatment.

Malaria, rarely contracted by the European in Salisbury, can be easily missed, with serious consequences. The common sources of contact are the Zambesi Valley and the holiday resorts in Portuguese East Africa.

Upper respiratory tract infections are common, and can be difficult to treat. In winter particularly, when the warm sun sets, the very cold evenings and nights can be treacherous; at this time also, absence of rain creates a surfeit of dust. Many mothers are wage earners through choice or necessity; so large crèches abound, where their infants are parked for the day. Happy and well run places though they may be, cross infection abounds, and it is my opinion that this factor is responsible for the too-high rate of upper respiratory tract infections in children. Also on the subject of children, I have been impressed by the cases of acute appendicitis which have shown the minimum physical signs and constitutional disturbance, yet have been fulminating at operation. Again, not infrequently, acute appendicitis can be masked by the common symptoms of gastro-enteritis.

In spite of the altitude of nearly 5,000 feet, the hypertensive and heart cases do well. Although fibrositis and "backs" abound, the established arthritic likes this comparatively dry climate.

The elderly are well catered for medically, which costs them nothing if they are in benefit. The main European population contributes to individual *Medical Aid* schemes which are essentially satisfactory to both patient and doctor.

An earning of £300 a month for a single handed practice is considered a poor turn-over. Perhaps £600 to £800 a month is an average figure, but this figure entails much hard work. Practice expenses are high. Consulting room rents, the salaries of sisters, book-keepers and messengers, all have to be met before one's own monthly cheque is drawn. There are, of course, much higher salaries earned than those mentioned.

Rhodesia is a great country. The longer one lives here, the more one appreciates the vast racial problems confronting the responsible Government. One fact is certain. A Prime Minister has emerged who has the respect and backing of most Europeans and many more Africans than the world press portrays. The political events of the past year have, so far, had little impact on the normal tempo of life, and particularly of medical practice. As I have implied earlier, the whole continent north of the Limpopo cries out for more doctors. The wealth of clinical material and the opportunity for practical experience is incalculable. A most significant observation is that of the several, who for various reasons leave this country, a high percentage return.

Photograph courtesy of Rhodesian Ministry of Information.

*St. B.H.J., *December,* 1964; Vol. LXVIII No. 12 p.495.

Medicine in Literature

an extract from

TENDER IS THE NIGHT

by

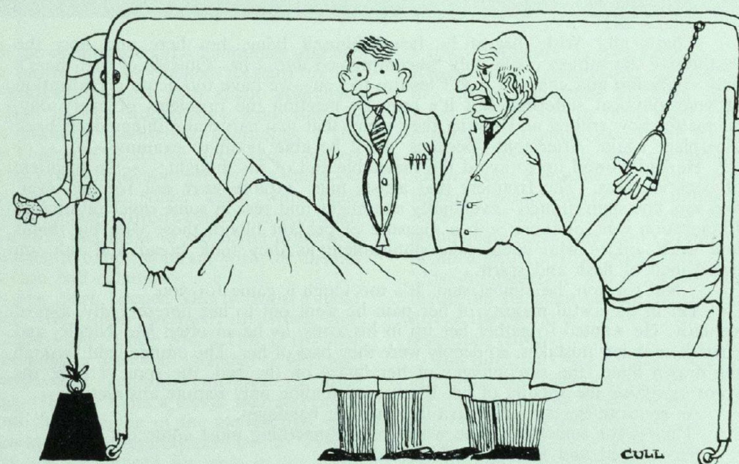
F. Scott Fitzgerald

His most interesting case was in the main building. The patient was a woman of thirty who had been in the clinic six months; she was an American painter who had lived long in Paris. They had no very satisfactory history of her. A cousin had happened upon her all mad and gone, and after an unsatisfactory interlude at one of the whoopee cures that fringed the city, dedicated largely to tourist victims of drugs and drink, he had managed to get her to Switzerland. On her admittance she had been exceptionally pretty—now she was a living, agonizing sore. All blood tests had failed to give a positive reaction, and the trouble was unsatisfactorily catalogued as nervous eczema. For two months she had lain under it, as if imprisoned in the Iron Maiden. She was coherent, even brilliant, within the limits of her special hallucinations . . .

The woman could not see him when he came in—the area about her eyes was too tightly swollen. She spoke in a strong, rich, deep, thrilling voice.

'How long will this last? Is it going to be for ever?'

'It's not going to be very long now. Doctor Lladislau tells me that there are whole areas cleared up.'



" HAS IT NOT OCCURRED TO YOU, EVEN AS A REMOTE POSSIBILITY, THAT YOU MIGHT BE APPLYING A TOUCH TOO MUCH TRACTION ".

'If I knew what I had done to deserve this I could accept it with equanimity.'

'It isn't wise to be mystical about it—we recognize it as a nervous phenomenon. It's related to the blush—when you were a girl, did you blush easily?'

She lay with her face turned to the ceiling.

'I have found nothing to blush for since I cut my wisdom teeth.'

'Haven't you committed your share of petty sins and mistakes?'

'I have nothing to reproach myself with.'

'You're very fortunate.'

The woman thought a moment; her voice came up through her bandaged face afflicted with subterranean melodies:

'I'm sharing the fate of the women of my time who challenged men to battle.'

'To your vast surprise it was just like all battles,' he answered, adopting her formal diction.

'Just like all battles.' She thought this over. 'You pick a set-up, or else win a Pyrrhic victory, or you're wrecked and ruined—you're a ghostly echo from a broken wall.'

'You are neither wrecked nor ruined,' he told her. 'Are you quite sure you've been in a real battle?'

'Look at me!' she cried furiously.

'You've suffered, but many women suffered before they mistook themselves for men.' It was becoming an argument and he retreated. 'In any case you mustn't confuse a single failure with a final defeat.'

She sneered, 'Beautiful words,' and the phrase transpiring up through the crust of pain humbled him.

'We would like to go into the true reasons that brought you here—' he began, but she interrupted.

'I am here as a symbol of something. I thought perhaps you would know what it was.'

'You are sick,' he said mechanically.

'Then what was it I had almost found?'

'A greater sickness.'

'That's all?'

'That's all.' With disgust he heard himself lying, but here and now the vastness of the subject could only be compressed into a lie. 'Outside of that there's only confusion and chaos. I won't lecture to you—we have too acute a realization of your physical suffering. But it's only by meeting the problems of every day, no matter how trifling and boring they seem, that you can make things drop back into place again. After that—perhaps you'll be able again to examine—'

He had slowed up to avoid the inevitable end of his thought: '—the frontiers of consciousness.' The frontiers that artists must explore were not for her, ever. She was fine-spun, inbred—eventually she might find rest in some quiet mysticism. Exploration was for those with a measure of peasant blood, those with big thighs and thick ankles who could take punishment as they took bread and salt, on every inch of flesh and spirit.

—Not for you, he almost said. It's too tough a game for you.

Yet in the awful majesty of her pain he went out to her unreservedly, almost sexually. He wanted to gather her up in his arms, as he so often had Nicole, and cherish even her mistakes, so deeply were they part of her. The orange light through the drawn blind, the sarcophagus of her figure on the bed, the spot of face, the voice searching the vacuity of her illness and finding only remote abstractions.

As he arose the tears fled lava-like into her bandages.

'That is for something,' she whispered. 'Something must come out of it.'

He stooped and kissed her forehead.

'We must all try to be good,' he said.

The WINE COMMITTEE'S Fourth Annual **SMOKER**

With the qualification and temporary absence of the satire king we looked forward to the latest smoking concert with slight apprehension. But it was unnecessary and the six artistes aquitted themselves admirably. "The Purple Umbrella Removal Van Inc." turned out to be a most enjoyable evening. It was good to get one's hands sticky again with Wine Committee punch, a little sweeter this year than usual, and it was good to see revue done well by students, a happy contrast with the dismal rugger club ball cabaret.

The first part opened slowly with a cold audience who soon warmed up when Sue Macdonald sung "Little Me." This is the first time the smoker cast has included a girl, and her performance certainly enlivened the proceedings. "Taped" was a clever and successful idea and the changing of the guards film with commentary was a masterpiece. By the end of the first act we realised we were in for more singing than usual. The songs were clever throughout, but had a mixed reception.

Things really began to happen in the second part; with the man from U.R.A.N.U.S. performed brilliantly by Brian Briggs, followed by Roger Rolls' exasperating attempts to remove his stethoscope from his ears, the audience were soon rolling in their seats. The act was amazing for the amount of filth concealed (and not concealed) in it and towards the end it seemed that even the all male audience were finding some of this type of humour too much. However it finished on a strong note with the home-made film "One Man's Spray" which told of an unusual aerosol spray, a kind of canned "love-in-idleness", which in the right hands made the recipient submit immediately to the lust of the operator, but in the wrong hands had disastrous effects!

The third part was of much the same standard as the first, the opening number "Tladitional (sic) Japanese Nit Play" being a little subtle for the, by then inebriated, audience. But most of the sketches were well received, especially "Ouzo" and Sue Macdonald's song "Naughty."

George Dunn gave the most outstanding performance of the evening showing great versatility. The rest of the cast was close behind him. The production could have been a little

more polished, somewhat slicker. One or two items were underrehearsed and careful alteration of the running order might have eliminated some of the rather clumsy twilight interludes between sketches. (It was a pity the Wine Committee didn't put candles around the auditorium which would have cast a little light on the stage during scene changes.)

One left the fourth annual smoker with a feeling that this is a tradition that must be continued; the talent is there and it should be a duty of the Wine Committee each year to seek it out and sponsor it.

A. R. Bailey.

Ward Shows '66

It is impossible to review the Ward Shows without firstly defining their purpose and secondly, deciding how far they went towards fulfilling the ideal. The purpose we all know: the Ward Shows are intended for the entertainment of the patients primarily, and one must resist the temptation to include the sort of "in" humour which is more suitable for Pot Pourri audiences—this is easier said than done!

It was very gratifying to see that the Ward Shows of 1966 succeeded in being on the whole, non-medical in their content, and that they served admirably to entertain the most ill and most miserable of patients. Of course the material was not always first class—no one should expect it to be. There were a number of rehashes of old ward show songs and sketches, a great deal of homosexual humour which was only good in parts, and few of the shows contained much that was original; but without exception the shows were performed with tremendous gusto and there were parts of every show which were good enough to deserve mention.

The Pre-Clinical show, "Any more for enema" gave the impression of being a little under rehearsed, but on the whole was quite a good show. The abstract set was effective. The main things that this show lacked, however, were good musical numbers, but the sketches made up for this to a great extent—in particular the Gastric Grand Prix and the excerpt from Peter Pan. What emerged most from this show is that there are a number of very talented people amongst the pre-clinical students, who will be well able to cope with the staging of ward shows in the following years.

The Clerks and Dressers "Beyond the syringe *or* Hold everything there's something in my eye", was a well produced show in which a large cast was used intelligently. The humour was old and in places frankly corny but it was performed in such a gay, tongue in cheek spirit that they got away with it and the show was funny. Characterisation was good especially that of the Barbarians, and Houseman and Robin. Two songs, namely "Say hey to them" sung by Harold and his men, and "Hoist the sail" by the Barbarians were very well performed. Perhaps the only criticism one can make is that the whole thing ran for too long and they would have done better to have omitted a lot of Harold's *campery* which tended to be overdone.

The Out-patients show, "What did you do in the Ward Daddy?" was one of the slickest, best produced shows that I have seen at Bart's. It displayed a wealth of talent both musical and comedy wise which was well used and as a show it was entertaining from beginning to end. The psalm, the abbreviations sketch and the bassoon playing were excellent and the majority of the rest of the show was of a high standard. The several times lift size "mod" models set painted by Mike Simmons deserves special mention.

The Kids show: "A grimm fairy tale" was one which I found particularly delightful. This was true pantomime, which captured that combination of slapstick, light comedy, charm and pathos which is so hard to define, but instantly recognisable when it is there and painfully obvious if it is absent. The production by Antony du Vivier was excellent and the superb costumes and make-up helped to create a beautiful overall effect. An asset to the show was the splendid selection and use of sound effects, which on the wards never missed a cue.

The music was appropriately chosen, particularly those few red hot seconds of seething trumpet playing which heralded the entrance of the largest and most buxom daughter. The main success of the show however lay in the casting. All the main characters were very good, and in particular Chris Garrard made an ideal pantomime hero.

The Specials show which was called "Nothing Special" turned out to be just the opposite. This was a small all male cast whose talents were used to the full. Despite no piano accompaniment (or perhaps because of it) they were best in their musical numbers. Every one of them sang well and in good harmony. Two things stand out in my mind, not because they were funny (it was not the sort of show to make one fall about with laughter) but because they succeeded in raising a small tear in many a female eye and some of the male ones too! They were of course the two songs "Message to Matron" and "Red blood corpuscle", each as charming as the other and each as beautifully performed. This was a good show excellently produced by Jon Lilleyman.

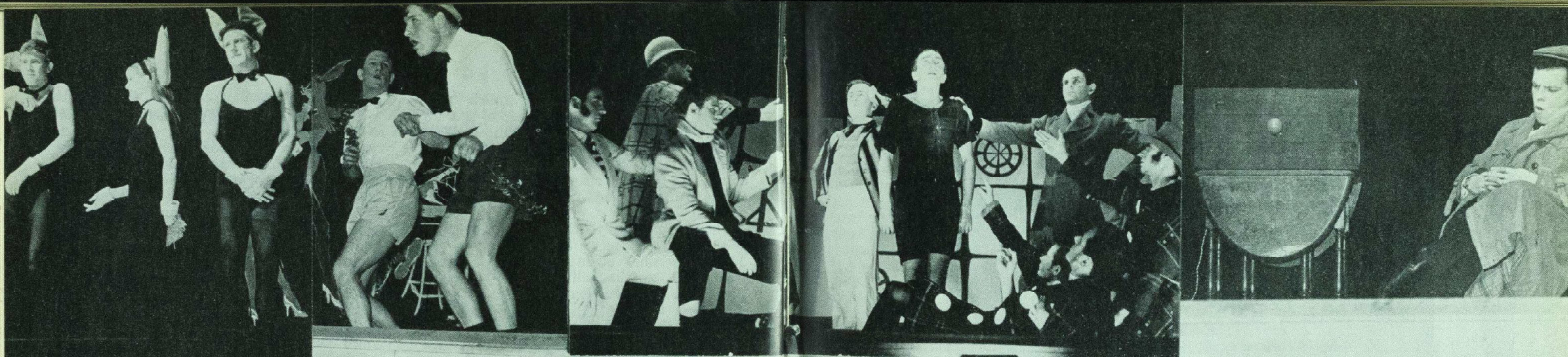
The Midder and Gynae show "Anything Goes" would not have been the best of shows had it not been for its two special items which tended to save the day a little. These were the musical sketch played by a heavily disguised *Rahere Ensemble*, and the *Egg and Sperm* dance routine. The remainder of the show was good in its musical numbers, particularly the Wormwood Scrubs song, but it rather fell down on its sketches. The final song based on Gilbert and Sullivan's "Captain in the Queen's Navy" was well done. The Rahere Ensemble gave five minutes of excellent entertainment consisting of four minutes of musical foolery, which requires incidentally a great deal of musical ability if it is not going to develop into a mess of unfunny dross; and a final minute of complete contrast in which they played a polished arrangement of Eleanor Rigby.

That a number of male medical students should go in front of an audience and perform a dance routine in all seriousness, sounds like the beginning of an incredible shaggy dog story. But contrary to many expectations, including my own I must admit, the dance routine was first class and full credit must go to Sandra Jack for not only teaching these men to dance, but for making them do it well enough not to be too overshadowed by her own superb performance. The idea was original and the music, Dave Brubeck's "Unsquare Dance" was an excellent choice.

The Finalists show "The Final Straw" was a slick, fast moving show with a talented and experienced cast of whom we have grown to expect great things. We were not disappointed. The Crowther-Savage singing team once again produced a memorable number in the form of the "Yellow ticket on your windscreen" which was performed with professional skill. The Bunny Club set was excellent and the appearance of Mary Newbold as a bunny girl was a sight that put the real thing in the shade. The remaining songs were good and well delivered as was the Radio Telescope sketch which incidentally, to my mind, contained the best bit of camp humour of all the shows. It is to be hoped that these capable performers will not be entirely lost to Bart's and that they will illuminate future House Shows.

The House Show; "The Housetrap or When did you last see your wife" was as always, a show the production of which is fraught with difficulties due to the large number in the cast, and their unavailability for rehearsal at any given time. Congratulations are therefore due to Mark Casewell for not only capably dealing with the unenviable task of producing the show, but also for his own splendid performances in the show. The House Show this year, although not containing too many numbers of exceptional merit succeeded in being well enough rehearsed to give an air of polish which prevented it from dragging in any part. The enormous cast was well disciplined to move within the very limited area of the wards without catastrophy. The opening song "Be Prepared" was a good example of this. The two outstanding numbers of this show were both songs. The first "Please don't alter the psalter anymore" was a fair and funny comment on *pointing* and was well performed by all four participants. The other, "I've got a ferret sticking up my nose" was one of the highlights of the ward shows. This was good enough to be included in any West End revue. The song was funny in itself and the arrangement of the Edwardian costumed tableau added favourably to the comedy. Mark Casewell sang well and the balance between solo voice and chorus was just right. It was a great shame that the women were not used more as they showed themselves to be both decorous and talented in their brief appearances.

To sum up I should say that the general standard of the Shows was high and that they went a long way towards creating a gay and



In the Martian Camp!

Ferrets don't explode you say—it happened nine times yesterday!

uplifting atmosphere for the patients this Christmas.

Finally may I take this opportunity to extend thanks to the sisters for their co-operation in staging the shows in their wards; to Bert Broe et al., who once again returned to tackle the monumental task of make-up with enviable patience; and to all the students and the House for the work that they obviously put into the Ward Shows which made them the success they undoubtedly were.

GEORGE DUNN

POT POURRI POT POURRI POT POURRI POT POURRI

Was it better or worse than last year or the year before that? I find it almost impossible to answer with any general statement of comparison, because the Pot Pourri is such a varied form of entertainment and yet, because it is also unique, the only thing to compare with one Pot Pourri is another. It is unique not only because of its content, but also because it has its own special "family" audience, an audience that is more than usually committed to enjoying itself. For me the Pot Pourri is at its best when the performers do not take the easy way out and make fun of the strictly parochial. It would be understandable if even the most committed and faithful audience was struck with bored déjà vu if, each year, all it saw was someone else's version of an impersonation of Dr. X or Sister Z.

This year's show was a little shorter of convulsively funny moments, but fortunately there were fewer embarrassing moments than last year, and the general standard was high. The cast usually seemed to know what they were doing and why, and performed numbers as though they had talent behind their confidence rather than beer. Another step forward was that there were fewer boring chorus lines than usual.

The Compère Team opened with an invented Japanese story mimed to a commentary. This was not one of my favourite moments but it was well received and so did its job.

The chorus line which opened the *Outpatients'* show, happily did not turn out to be a promise of many more to come. Apologies to the audience along the lines of "We may not be very good but join in our fun" make my flesh creep and only tend to make everyone expect the very worst. My flesh stopped creeping during the "Abbreviations" number which, ably performed by John Sills and Martin Savage, was well written and funny. The "set of rules for students" number made better use of a chorus and the line about not killing for your own amusement lifted it out of the ordinary. The pop song badly needed more than a distant piano for accompaniment. 'No cure for l'amour' was refreshing and pleasantly well sung. This was followed by a good 'quickie' from the compères.

The *Preclinicals* seemed to go all out for breaking the smut barrier, but nevertheless they showed a promising approach towards getting laughs. They managed to perform their alimentary script without too many of those half hidden sniggers that make embarrassment infectious.

It was a pity that in the next Compères sketch Peter Hill could not quite catch the character of the Squadron Leader as well as George Dunn and Brian Briggs had caught theirs, but the three of them eased some good quality laughs from the audience.

The *Kids* Show was certainly the best Kids Show that I have seen. Their use of overdone

Houseman greets Harold!

audience participation made it as appealing to an adult audience as I'm sure it was to the children. The *Finalists* were disappointing. I couldn't help feeling that I had seen it all before and better done by the same people.

Opening the second half the *Midder and Gynae* crowd spent a salutary amount of time above the waist. Willie Goss, Michael Spira, David Baker and Alan Gray earned their applause and their encore. It was a delight to find such musical expertise combined with an obvious talent for humour, the latter particularly in the case of Willie Goss. The performances of these four, combined with a curiously professional ballet sequence made this show stand out. The *Specials* Show offered some unremarkable clinical material but they could sing. *Clerks and Dressers* hurled outrageous pieces of corn at the audience, not unlike the present fashion in a certain radio show with an extraordinarily long title. Pete Jordan and

Top: *Theatre Staff in action.*
Bottom: *Sue 'n Mary 'n Jenny 'n Sue 'n Andrea 'n Carol, "All along, down along, into Q.E.!"*

his mob were good amusement value. The costumes in this show added a great deal to the effect of the performance, but King Harold minced too much to be funny.

The *House Show* was patchy in quality but had a remarkable absence of interminable and pointless chorus numbers to its credit. Dick Swain and Timothy John McElwain were funny in a zany doctor sketch though they needed more dialogue. I have never heard anything before like the song comparing the Psalm singing methods of different clergy. It was a cleverly written, well performed, boffo number. The insane 'Ferret Song' had all the right touches to make it a very effective number including good singing especially from the soloist Mark 'Ferret' Casewell. McElwain's lecture though a little long winded, was an excellent example of a parochial number, deserving its place in the programme because of its pointed, even barbed, references to the local scene.

I can think of no complaints about the lighting and general production, they were good. The use of 'flown' scenery helped to cut out any of the delays which were the nightmare of Compères a few years ago. Back stage discipline, essential for a smooth and quickly running show, is, I hope, firmly established as a necessity. Well done very nearly everyone. I enjoyed my evening enormously.

GRAHAM CHAPMAN

Postcript

A few words of thanks are also due to the Theatre Staff Nurses whose Cabaret at Matron's Party and the Pot-Pourri Party was much appreciated. Their appearance at the latter for the second year in succession seems to have started a tradition which we hope will continue.

J.A.S.

MATRON'S BALL 1967

The Lady

Matron's Ball is held on the first Wednesday in January every year—we have not been able to establish when it was first held. Preparation begins weeks before Christmas—possibilities are viewed, exchanged, bargained for and finally announced in that den of iniquity—the Nurses' Dining Room.

The day arrives and the visit to the hair-dresser is an entertainment in itself—as the changed personalities emerge from the dryer. The final touches nearing deadline follow the usual pattern of all mass social occasions—a race for an already swimming bathroom, a fight for the iron, and near hysteria as one spies one's neighbour's dress.

Transportation to the Grosvenor is often hazardous and bizarre; walking time is around seventy three minutes. The final disaster is averted as the tickets are handed to the Door-man and the partner glimpses an unknown name on the ticket.

The Ball this year was a fantastic success, male veterans of the event enthused—was it the company at table or the general atmosphere they asked—certainly we all enjoyed it immensely and preparations are in full swing for next year. Don't forget the corkscrew! There seemed to be many more from among the body of sisters—a trend we hope that will continue. The speed with which the evening passed can be a judge of its success. Our very grateful thanks to Matron for her much appreciated Christmas present.

E.F.

The Gentleman

For the impoverished inhabitants of College Hall, the annual pilgrimage to Grosvenor House on the occasion of Matron's Ball provided a welcome change from the refectory and Peter's refreshment bar.

How wise the founders were in their choice of date for this auspicious event; since it permits the nurses to select partners at the numerous social functions of Christmas (with minimal loss of face), while providing a suitable interim for recovery from the New Year revelries.

Despite the traditional references in the Pot Pourri and Nurses' Cabaret, as to whether it is the nurse or the student who encounters the greatest difficulty in acquiring a partner, all such considerations had long been forgotten by the evening of January 4th.

For the male participant the evening commenced with the downing of a few 'quick jars' at one of the local hostelries (to achieve the correct frame of mind after a hard day's work). Thereafter, with brightened spirits, the dinner jacketed hoards began to descend on the nurses' homes to collect their resplendent partners. On arrival at the Ballroom, (after more or less direct transportation), Matron greeted us, and there was time to dance up an appetite before dinner was served at 10.30 p.m. Now came the moment to play James Bond with the wine list—a rather expensive procedure at Grosvenor House.

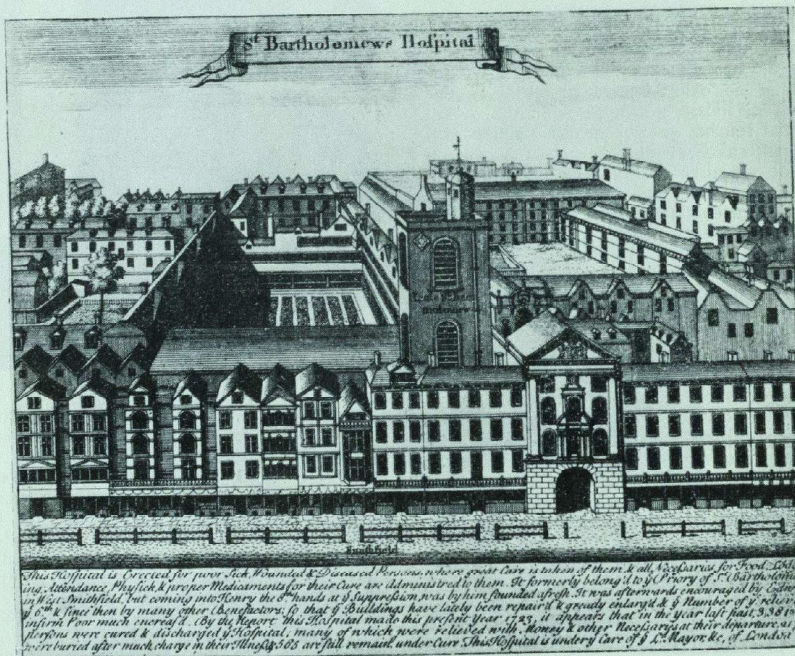
Following dinner, as the clatter of plates died away, hip flasks surreptitiously drained, stirred the sleepy replete to their feet again. Accompanied by two excellent bands, dancing began in earnest and the metamorphosis affected by changing apron and cap for evening dress was immediately apparent—the girls looked superb. But all too soon it was 1.30 a.m. and time for the merry throng to wend their separate ways (my condolences to the bowling fans who found London Airport's Alley closed this year).

Even the most critical and discriminating socialite was forced to admit that it had been a very enjoyable evening—our thanks to the founders of the feast.

J.G.

Old Prints of St. Bartholomew's Hospital

by Roger Clayton



The Stow's Survey view.

The College Library has an admirable collection of prints, newspapers and magazine cuttings concerning the history of the Hospital, which are at present being recatalogued. Amongst accounts of Sir James Paget giving lectures "on a pressing subject", a Morning Herald Leader informing the public of a new and revolutionary operation for the excision of a hideous maxillary antral cancer—it lasted only sixteen minutes, and old student dinner menus, one can find many eighteenth and nineteenth century prints illustrating the development of the Hospital over these years.

In this brief article I hope to point out the interest in these prints, for framed they can be most pleasing objects to hang on walls. I do not pretend to be in any way comprehensive.

Firstly, early prints showing the Hospital before the time of James Gibbs—these are difficult to find and may cost up to £5. The most well-known is that which appears in Stow's Survey of circa 1725 (p. 93): *"St. Bartholomew's Hospital, published according to the Act of Parliament for Stow's Survey"*. It shows the Hospital as it was between the building of the King Henry the Eighth Gate in 1702 and the Square as we now know it. King Henry is surrounded by houses and shops almost as tall as himself and the Hospital behind appears to have changed little in plan since medieval times. Behind the Church of St. Bartholomew-the-Less, that is to the south, stands the Old Great Hall—with cloisters and courts on either side. A window of the old Hall showing Henry himself is incorporated into the present Great Hall. Further to the south the other court was used as a washing and drying area and beyond is the burial ground for patients and parishioners with its Little Britain Gate. At this time houses and shops were scattered amongst the wards and offices of the Hospital. This is a most attractive print ($9\frac{1}{4}$ x $6\frac{1}{2}$ inches) and may often be found coloured by well-meaning print and booksellers. A print with contemporary colouring by hand would be an interesting find indeed, for publishers rarely coloured the illustrations in their books as it was both unpopular and expensive. Contemporary colouring can be distinguished by the fact that the colours are dark, often obscuring the engraving and sinking well into the paper—in fact the effect is not good, unless particularly well done, which is rare.

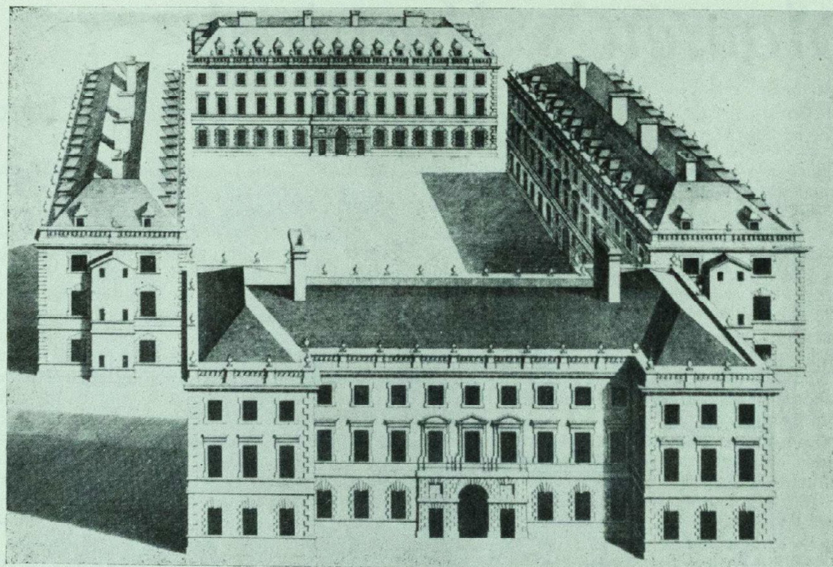
A similar print entitled *"St. Bartholomew's Hospital in West Smithfield"* has some information about the Hospital printed beneath it. It is $8\frac{1}{2}$ x $6\frac{3}{4}$ inches in size and may be from another edition of Stow.

The Henry VIII Gate was built in 1702 and faced with Portland Stone by Edward Strong Jnr., the nephew of Christopher Wren's mason. Prints solely of this Gate are uncommon. A very fine example was drawn and engraved by T. Higham for *"Walks through London"* (published 1816), and it is entitled "The Entrance to St. Bartholomew's Hospital from Smithfield" and shows two men before the Gate gesticulating with sticks, presumably passing the time of day, whilst a dog looks on. It is a small print ($2\frac{1}{2}$ x $3\frac{3}{4}$ inches). A larger one is seen in Lambert's "History of England" published by Thomas Hughes in 1805 showing *"The Principal Gate of St. Bartholomew's Hospital"*.

In 1723 James Gibbs (the architect of the Radcliffe Camera at Oxford and the Fellows' building of King's College, Cambridge) was elected a Governor to the Hospital and put on the Planning Committee. In 1729 the final plans were accepted and, while the money was being raised by public appeal, the North Wing was started in 1730 after the Cloisters and the Old Great Hall had been demolished. Ralph Allen faced it with Bath Stone which he was eager to introduce to London. The Official Opening was in 1734. The South Wing after four years building was opened in 1740, and the West Wing after ten years in 1753. Unfortunately Gibbs died in 1754 and when the Treasurer, Tuff, absconded with £4,000 of the Hospital funds the building of the East Wing was delayed. It was finally completed in 1766, at which time the old houses inside the thus formed Square were demolished and paving stones laid in their place.

An interesting print of this period ($9\frac{1}{2}$ x 14 inches) is known as *Tuff's plan*, it shows the South and East prospects and the arms of the Hospital and of "John Tuff, Esq.". "The General Plan of the new Building intended for St. Bartholomew's Hospital; consisting of four detached Piles about a Court or area two hundred feet long and one hundred and sixty feet wide, into which leads a passage for coaches, etc., through the Principal Front, on one side of which is the Counting House and the Clerk's House, on the other side a room for admitting patients and off that another room for the private examination of them. Joining to which is the Staircase leading up to the Hall which is ninety feet long, thirty-five feet wide and thirty feet high lighted on both sides. In the other buildings are wards for the sick; each pile containing twelve wards and each ward fourteen patients, in all five hundred and four. There is a private room off of each ward for the nurse attending it".

This plate is most humbly inscribed "to John Tuff, Esq., Treasurer to the said Hospital". It was engraved by Benjamin Cole who flourished from 1695-1700 and shows that originally there were four wards per floor in each block. Another large print ($13\frac{3}{4}$ x 14 inches) was draughted by R. West and engraved by Thoms: "A Perspective view of St. Bartholomew's Hospital,



Gibbs' Perspective.

shewing the four blocks in splendid isolation around the Square." This is the *Gibbs' Perspective*, presumably a definitive representation.

In the late eighteenth and early nineteenth centuries many smaller prints of the Square, the scene directed North, were published varying in size from about 3¾ x 5¾ to about 2½ x 1¼ inches and in price from about 15 to 50 shillings depending upon where one finds them. They appeared in various books of the period viz: "The Beauties of England and Wales" published by John Hains in St. Paul's Church Yard, October 1st, 1815, which shows a cripple hobbling across the Square to a central lamp surrounded by high railings; "The Royal Magazine" and "The Ladies' Magazine". Two very common prints are those by Thomas Shepherd (mid-nineteenth century) and Anthony Smith (1770s). Shepherd's shows the Clock above the second window above the Arch beneath the Great Hall, a horse-drawn carriage and various hatted and tailed gentlemen; a busy scene. Smith's is very plain and surrounded by an ugly cartouche; these show the various "fronts" or wings of the Hospital joined by an arch.

It is interesting to note that in "The Builder" of 1854 the Hospital was described thus: "Although Plain and Unpretending there is a considerable degree of elegance about the arrangement of these fronts but they are not in a fit state to be judged". Allen's Bath Stone was being rapidly eroded away, window heads were broken and cornices decayed. An "eruption" had thrown off layers of stone leaving "smallpox hospital" as it was referred to. The Bath Stone was swiftly replaced by Portland Stone soon afterwards and this is as we see it now, beneath all the grime of the City.

Finally, I cannot leave the reader without mentioning an *Illustrated London News* cutting of May 23rd, 1868. It shows "The Prince of Wales dining at St. Bartholomew's Hospital". This splendid scene is, of course, in the Great Hall. A long table is arranged along the length of the Hall (the south wall), adorned with five vast candelabra; the Prince of Wales sits beneath the fireplace in the centre of the table. Other long tables are arranged the width of the Hall and it appears that everyone is having a jolly good time. There are about two hundred and fifty diners with almost as many agile waiters to serve them.

The Tall Ships Race 1966

by P. Smyth and R. Williams

Copenhagen Harbour.

Last year there was an all Bart's crew aboard *Lugo* in the 600 mile Fastnet Race. This year there were three Bart's people in the crew of *Zulu* in the Tall Ships Race from Falmouth to the Skaw at the Northern tip of Denmark, some 800 miles. The Tall Ships Race is a highly organised event, and there were dinghy races in Falmouth as a curtain-raiser. The fleet was divided into three classes—square rigged ships, fore and aft ships, (such as the *Sir Winston Churchill*) and ocean racing yachts.

Zulu is a 19 ton Bermudan sloop, 48 ft. long carrying a crew of seven including the owner and skipper Brian Stewart. Not exactly Tall compared with the *Statstraad Lehmkuhl* displacing 1700 tons with a crew of 80, but there to provide competition and a contrast.

Ocean racing yachts are nowadays often as well equipped as ships, with electronic echo sounders, speedometer and log, and wind speed and direction indicators, everything except radar which the rules don't allow—it would make it all too easy!

We spent the day before the start loading her up with food—crates of the new *"Long Life"* milk which keeps for three months, loaves of bread, and tins of everything by the dozen, all wedged firmly in the bilges of the boat. Finally four gallons of assorted duty-free spirits, and 45 gallons of fresh water, which is carefully rationed at sea, and can be used for cooking and drinking only.

Falmouth was a magnificent sight with flags and bunting in the streets, and with no fewer than ten large sailing ships at anchor in the harbour. Enterprising fishermen were making money doing 'Trips round the Ships'. Cadets on the big training ships seemed to be polishing the brass all day—above them the Tannoy blared out in Norwegian and the radar antenna circled around, looking incongruous on ships designed even before the steam engine! Life for the cadets is still rugged however, for most are training for their Merchant Navies who believe there is no better form of character training than the team work and hardship that form the life in these ships. Indeed, character training is the whole point of the Tall Ships Race.

At last the start. A superb sunny day and every craft in Falmouth was out, loaded to the gunwales with sightseers. The racers cruised around waiting for the gun, while spectators waved, shouted good luck and 'bon voyage' and generally got in everybody's way. The gun went and thirteen ocean racers turned for the line, jostling for position as multicoloured spinnakers are broken out, for although there were five days of racing ahead, every second counted. With our big blue and red spinnaker blossoming out, we soon left Falmouth miles behind us. After a few hours the initial enthusiasm waned, and we paid more attention to the glorious sunset than to the sails, and cooked our first meal—an enormous stew eaten as are all meals with a bowl and spoon. We were split into two watches, and worked four hours on, and four hours off, for cooking and mending as well as sleeping. As time went on and one got short of sleep, being late on watch became a grave social crime!

As dawn of the second day came up we could see the leader of the fleet only five miles ahead. Identification at this range is done by the colour of the spinnaker—and she was *Lutine* a 35-ton yawl who gave us nearly ten hours on handicap for the race. It was a perfect day and *Zulu* romped along in ideal conditions, the wind filling the spinnaker as she rolled and heaved to keep up with it. In these conditions life is very pleasant—a good square meal with a can of beer, then sunbathing on the deck. Every day we listened on our radio to the noon positions which the bigger ships sent to our guard ship *HMS Dainty*. She carried a doctor and patrolled the fleet throughout the race to give assistance if needed. From the noon positions we were already miles ahead of the bigger ships, and these are their best conditions, so the biggest boats aren't necessarily fastest. Indeed, they are so unmanoeuverable that they were permitted to use their engines in the narrow confines of the Dover Straits!! Even with a well trained crew it can take half an hour to reset all the sails after altering course. We heard also, that one yacht was going into Dover to drop a man with a badly damaged knee. There was not much chance of that on *Zulu*, with five medical students aboard. The two from St. George's were considerably more qualified than the Bart's trio!, and we carried a very comprehensive medical kit, so it would take more than a knee to stop us.

By that night we had reached the Straits of Dover where one can often see the lights of twenty or more ships at once, besides the lighthouses on each shore to confuse the issue. This is the busiest shipping lane in the world and the ships are all too busy avoiding each other to notice a tiny yacht, so it's in the interests of self preservation to keep out of their way! In the middle of this navigator's nightmare, misfortune struck us. Due to a bad mistake (by a St. George's man!) our spinnaker was torn and had to be taken down. A similar mistake on Lutine at much the same time was the cause of two crushed hands and a knock-out. We put up the spare spinnaker, but a few hours later it tore as well, this time due to a gear failure, bringing the off-watch from their bunks to help manhandle the shredded sail out of the sea in pitch darkness and pouring rain. To add confusion to chaos, *HMS Dainty* steamed up and enquired our identity—by Morse Code sent at a speed quite beyond the capabilities of any yachtsman!

Spirits fell very low as we inspected the first and less ripped spinnaker. By a stroke of luck the wind changed and we could no longer carry a spinnaker anyway, but we began

the seemingly hopeless task of sewing the sail. How we envied a yacht on the Trans-Atlantic Race called *Ticonderoga*, which had two sail-makers and a sewing machine aboard! We were just able to lay our course for Denmark, but our very experienced skipper forecast that the wind would back to the west and thus free us later. So we sailed to the east of our course, but moving faster, and waited for the outcome of the gamble. Time was precious as Holland was in the way on our present course. Luckily the wind did change, with Holland only 20 miles ahead, and we sailed back onto our original course.

On the third day at sea, *HMS Dainty* appeared and enquired how we were. We explained about our spinnakers. They said that they had been searching 2000 square miles of the North Sea trying to find *Zulu* and *Lutine*, never expecting us to be so far ahead of the big ships. *Lutine*, they told us was only 17 miles ahead and we were second, which put us in the lead as *Lutine* by now had to be 50 miles ahead if she was to make up her handicap. Enthusiasm suddenly returned, the news was like a good nights sleep to us all. We heard the *Daily Express* reporter on *HMS Dainty* radio that night—*"Zulu* has blown out both her spinnakers in winds too strong for them, but with 48 hours left, *Zulu* and her crew of ocean scorching teenagers look sure of success as they go barnstorming across the North Sea". That's one correspondent to take with a pinch of salt in the future! We celebrated the situation with cans of beer, as *Zulu* shouldered her way through the waves sending up showers of phosphorescence.

Early the next morning a Danish bomber made several low swoops across our bows, presumably to try to read our name. Each time the pilot came a little closer, but finally either read it or shyed off the attempt. Just as well, the suspense was getting too much for us!

As we sailed into the Skagerak we hoisted our repaired spinnaker and both proudly and a little anxiously looked at our handiwork—much smaller than it looked when in heaps all over the cabin floor. It held, and on yet another perfect day, we surged past an ancient Danish light vessel to win the ocean racers class in the Tall Ships Race. *Lutine* was the first boat over the line, four hours beforehand.

We put into Skagen, the nearest harbour, and made straight for the Seamen's Hostel. The wash house was taken over, and we got out of the clothes we had worn for five days and nights. Singing sea shanties and other rude songs, we stamped up and down on the clothes in the shower as if treading grapes. Pulling a lavatory chain becomes unimaginable fun after days at sea, and in the shower what you had thought was a healthy suntan is really dirt, and dirt becomes bruises. Back on the boat, a dozen lagers awaited us with the compliments of a neighbouring yacht—the first trappings of fame! The next day we sailed forty miles south to Frederikshaven, and found *Sorlandet*, the winner of the square rigged class. They offered to take two of our crew down to Copenhagen, but strictly as crew—rather a big step down from having drinks in the Captain's cabin! One of these two was Tim O'Grady.

Zulu and crew.

They joined the ship and got issued with the uniform, a hammock, a locker, and a number. All the cadets were referred to and addressed as numbers, and even close friends wouldn't know each others surnames. The youngest of the cadets, aged about 15, enjoyed going up the ratlines to the very top, usually racing the rather nervous *Zulu* pair up there! Being seasick from the top of a swaying mast, some

150 ft. above the deck obviously requires precise timing if you are to remain popular! Other cherished memories of the *Sorlandet* were scrubbing the deck in bare feet three times a day with icy Baltic sea water, and eating soggy Cornflakes—small wonder for the competitions on the side of the packet had expired 18 months previously!

Eventually, we all met up in Copenhagen, where we were moored in a canal in the centre of the city. To get there we passed through many opening bridges, one reputed to be the fastest in the world, which could open in fifteen seconds. Copenhagen must surely take the prize for the slowest as well. When we came to leave, the authorities were embarrassed to have to explain that we were trapped. The spell of hot weather had jammed the new bridge! That night, the bridge was wrenched open by vast hydraulic jacks, and a couple of inches cut off the end by oxy-acetylene equipment. By dawn the deed was done, and hardly a soul in Copenhagen knew of the designers' miscalculations!

More fun and games for the cadets in Copenhagen were provided, including a trip to Elsinore, and more dinghy racing. A Bart's pair managed to walk off with the first prize in one event, against competition from the many crews entered by the big ships. They will be the first to admit that they took the initiative of procuring the best boat for themselves! The week of celebrations for the Royal Danish Yacht Club Centenary ended with the prize giving. All the competitors marched behind their national flags to the Tivoli Gardens. For some extraordinary reason the assorted and undisciplined British rabble found themselves at the front with the uniformed ranks of the big training ships behind! Perhaps they thought that being so near the band would help us to keep in step. No such luck!

The next day we left Copenhagen and sailed down the Sound to Kiel. The whole of the Baltic is still mined from the last war—mostly magnetic mines remain now, and ships are strongly advised to keep to the mine-free channels. Since these are marked by enormous black unlit buoys, sailing here at night presents a dilemma as to which course offers the least risk! We missed one bouy by a matter of a few yards, but at least we found out where we were at the same time! We reached Kiel and motored through the canal to the North Sea.

Here we soon realised that the return trip would not be the easy passage we had had out there. We had to shorten sail, and as soon as we changed course the wind followed suit, and increased as well, to add insult to injury! One person was so seasick that he was left in his bunk to suffer, while his colleague from St. George's amused us all by repeatedly demonstrating Chvostek's sign for tetany. At one point a racing pigeon collapsed in a damp bundle into the cockpit. After being dried out in a towel and fed a biscuit, the courageous bird flew off into the gale again, flying high up in the wind, and not gaining any shelter in the troughs as a seagull does. Is this as instinctive as flying itself to a seagull? Anyway several pigeons were lost on their race across the channel.

Zulu still pounded on, burying her bows in mountainous waves, and falling with huge crashes into the troughs. If we didn't get our character training in the race, we were certainly getting it now! Two hours at a time harnessed to the wheel in the spray from flattened wave tops, or for further training, struggling up to the bows, with the decks awash and sluicing your feet from under you! The wind was now gusting to a storm—Force 10.

Eating was a task requiring great patience as bowls of cereal were flung to the floor. Hot drinks were merely a cherished dream.

We put briefly into Dover to drop the two St. George's crew, the first time that the seasick one was *glad* to be back at work! 36 hours later we reached Portsmouth. After six days and nights in head winds we had reached our destination, a distance which we had covered in three days on the way out.

What makes one repeatedly indulge in such a masochistic pastime? The memory soon forgets what it doesn't want to remember, so one tends to remember only the good weather and exhilarating sailing. But an occasional gale is good, it reminds you of the fantastic power of the wind, and makes the good days seem even better.

LONDON MARKETS

2. Street Markets

by Paul Swain

Several are close to Bart's. Leather Lane is about the nearest. Can shop at it in a lunch hour if you hustle and still be back in time for a two o'clock lecture. It lies behind Gamages—or the quickest way from Charterhouse is out the back gate and straight down the Clerkenwell road. You can smell the way to it since at the bottom of Leather Lane is the Old Holborn Tobacco Factory. Its rich, slightly sickly smell of molasses forms part of the tangible atmosphere of this market. Chapel Market in the Angel Islington is close—a fourpenny bus ride from the back of Charterhouse. Well worth knowing about when in Bart's on a Saturday and you remember that the week-end shopping has still to be done.

Veg. This is the best buy in these markets. The fruit and vegetables are cheaper and the variety is terrific. There are the yams and various other kinds of sweet potatoes—aubergines—once I bought a pound of aubergines for sixpence; that's boasting but after shopping in these markets I always feel like boasting. There are avocado pears usually cheaper than two bob, courgettes and also slightly larger young marrows. And all sorts of peppers; the green ones, various shapes of red, and the dangerous little pointed red ones which have elicited a triple response in my mouth every time I've tried them. These are the okra which have the very beautiful alternative name of ladies fingers.

Fish Stalls. Eel stalls are in several of the markets. Eels you can buy live from a wriggling mass in a basin; it is rare to be able to buy fish live in England and in London rare to be able to get fish fresh. Eels can be bought jellied or cooked in lumps floating in a curious herb sauce which you can take away in jam jars. It takes guts the first time.

Shell Fish; Chapel Market has a much better collection of shellfish than is to be seen in most fishmongers. On the stalls you can buy an ashtray full of the different sorts of these. An ashtray full costs sixpence—and help yourself to salt and vinegar. Shrimps, prawns and scampi at two and six, four and six, and six bob respectively and you buy them by the pint which is rather a strange measure for a fish; the measured pint is a battered enamel mug.

Books. Leather Lane sells Olympia Press editions—Chapel Market doesn't. But it did have one stall selling nothing but American comics which interested me. A little old woman was selling them for ninepence and chanting, "Threepence back on all yer old comics when

yer wants to change 'em". I was nostalgically hoping to see some of the horror comics which had been one of the minimal debaucheries of my childhood—but I was disappointed—these were all Superman epics, batmanesque, and more subtly depraving than straight horror comics. Perhaps within the disappearance of the horror comics we really have an example of a literary genre completely supressed by censorship.

Miscellany; The bags and briefcases in Leather Lane are much cheaper than inside Gamages. The cheap jewellery isn't as good as might be expected; after all, Leather Lane is at the back of Hatton Garden the trade centre for the City jewellers and watchmakers. At four bob a pound in the butchers in Chapel Market you can get a rib cut of meat marked Scotch, and the cut is reputedly unique to the market.

Toys at these markets are always interesting and the spielers are well aware of the Christmas trade emphasising that their line in teddies won't hold out till Christmas. And whatever you buy they always manage to make you feel you've bought a bargain—which is a happy feeling.

The talk; "Have you heard about it? The old squire's been foully murdered." He was selling hairspray and he grinned. I don't know what he meant but it stopped me in my tracks as it was meant to do, and I'd have bought anything—except hairspray. The spielers art is well worth listening to; he's the man who sells by talking, and some of patter is terrific. And it sells; the best of them can command an audience of forty to fifty and need several helpers to hand out the goods he's spieling about and to collect the money. A heady rhythm underlies a good patter; this combined with an assertion of quality and above all an appeal to a primitive bargaining instinct. There is this coffee pot: "I don't want fifteen or ten, not even six and five but half a crown" and its gone. The syntax is exciting for instance several used the curious construction; "Buy this off me." The spelling too has its fascination—how much trust is to be put in a piece of cardboard on top of a clock with red crayon lettering spelling out GUARRANTEED.

The anticipated contemporaneity; well there are all the expected cheap mini skirts. The Beatle's *Revolver* is selling cut price at twenty five bob. And large toy pandas, at the present time of writing poor Chi-Chi has just returned doleful eyed and fruitless from Moscow:— "Pure nylon, no sawdust to come out; you have to be careful of your cheap pandas, this one is really colour fast". And Batman everywhere "Half-a-crown a Batman". How about that for a modern street cry of London—nearly worthy of Private Eye's series. The crier was a vast thickset man and patiently standing beside him was a tiny kid—a child model with a Batman hood mask and a serrated shoulder cape made out of blue polythene. Together the two of them formed an amusing inversion of the roles of the dynamic duo.

Poverty; It's closing time and the stalls are lit with strings of electric bulbs which makes the scene look like a carnival with fairy lights. Some of the stalls are pulled away into an arena walled by corrugated iron, a circus where the stalls are locked for the night. Some mini skirts being unloaded from a stall are taken back into Linda's shop. I hadn't realized that some of the stalls were extensions of the nearest shop. Piles of rugs are going a similar way through Dimond's shopfront doorway, the lintel of which is heraldically hung with a rug gaudily depicting Micky Mouse. Dormobiles everywhere are being loaded with cartons. An old woman is picking a cabbage out of the gutter.

Prospect

"What sort of doctor is he?"
"Well, I don't know much about his ability, but he's got a very good bedside manner."
PUNCH 1884.

Mastery of the bedside manner is mastery of the art of communication between patient and doctor. Consultation is the doctor's essential function, the necessary preliminary to any treatment. Nevertheless "we seldom discuss it with our students and never instruct them in its management." (Sir Ronald Bodley Scott; Presidential Address; The Medical Society). Perhaps this is because the teaching staff of the hospital have to some extent allowed their skill in consultation to fall into disuse. They are sheltered from the ultimate confrontation by a bodyguard of registrars and house officers, to whom they delegate the responsibility of the critical interview. Preliminaries may be brief or require weeks of careful investigation, but ultimately the explanation of the condition frequently falls to the lot of the junior staff.

If it is fair comment that teaching staff lack communication with patients, the recent press comment on mishandling of teaching subjects is likely to contain some element of truth.

The doctor's aim is to gain and retain his patient's confidence. The diagnostic phase of consultation is often relatively simple. Clinical patterns repeat themselves but the personality of the patient is a constant variable. Far greater are the difficulties of explaining the situation to the patient; of persuading him of the necessity for treatment; of breaking bad news and perhaps of confessing the inadequacy of therapy, while at the same time retaining his confidence. The patient is forced into a position of childlike dependence. His view of the doctor is ambivalent: he resents the restrictions which the doctor may be forced to recommend but at the same time he welcomes his authority.

Television provides the public with images that they are coming to regard as typical of the doctor may be forced to recommend but at suggesting that we should model ourselves on the serial hero but their popularity shows that they manage to fulfil the requirements of their role. They illustrate also the advisability of avoiding social entanglements. When patient and doctor meet socially their relationship is immediately altered and the doctor may find himself in a false position. Take for example the recent story of the doctor called to the police station to certify as drunk and unfit to drive, a man with whom he had been at a cocktail party an hour before.

Patients are becoming increasingly well informed. Television has had tremendous impact on the profession. It spreads information but confines publicity to the rare and dramatic, witholding the drab and commonplace diseases. Patients' associations insist upon the rights of their members to know and understand their illnesses and the reasons for the treatment the doctors recommend. Nevertheless, the public is fundamentally unable to assess the doctor's ability. Their judgement depends on that intuitive and intangible quality, "the bedside manner."

E.A.M.

BART'S CHORAL SOCIETY

DIDO and AENEAS by Nahum Tate and Henry Purcell

A Concert Production in the CITY TEMPLE: 7th December

Dido and Aeneas, the only true opera that Purcell wrote, takes little more than an hour to perform, and was written for a girls' boarding school in 1689; thus it is a chamber opera ideally suited for amateurs, and an interesting illustration of the powers and limitations of the musical idiom of the Restoration.

The idiom can express many different moods, but is not satisfactory for certain dramatic purposes. Purcell's representation of horror of the supernatural, in the orchestral prelude to the witches is inadequate; solemnity rather than horror is the main mood expressed. And afterwards, when the chorus, representing witches for the moment, sings "Harm's our delight and mischief's all our skill," they might just as well be celebrating a bucolic festival for all the music does to help the illusion.

On the other hand, the final recitative of Dido "Thy hand, Belinda", followed by a chromatic descending scale on a solo cello leading with a cadence into the final lament "When I am laid" has a quality of restrained anguish impossible in any looser idiom, and is rightly regarded as one of the great things in music.

Of the singers, Janet Kenny provided a magnificently powerful and well acted rendering of the sorceress with a pure tone lacking the excessive vibrato that often creeps into contraltos' voices. Jill Gomez, as Belinda, sang some technically difficult passages with liveliness and precision, and on the whole came over more favourably than Jean Temperley (Dido), whose intonation lacked the precision of the former, and who did not quite capture the magic of some of the arias, in particular the final lament.

The chorus was extremely good, in spite of a slight weakness in the male parts (especially the tenors), probably in the main due to their position at the back of the stage and lack of numbers. Particularly impressive were the jaunty tune "Come away, fellow sailors, come away", the solemn "Great minds against themselves conspire", when the chorus stands right outside the story, and the finale "With drooping wings."

A very enjoyable production as a whole, presented as a concert performance, which is on balance preferable to a full operatic presentation, because the action is too stylised for modern audiences.

D.T.H.

Penguin Reviews

FRESH LEMMON

The Penguin John Lennon. Price 7s. 6d.

Here's a chance for all enthusiastic Lennonites to buy both the books, *In His Own Write* and *A Spaniard in the Works*, now published as one (slim) volume. It is some indication of Lennon's more lasting appeal as a writer that Penguin Books have undertaken this new copy now that Beatlemania is on the wane.

Primarily, this is a book to 'flick' through, and it is the drawings which catch the attention first. They have a Thurber-like quality and a wicked sharply focussed humour—wildly funny at times and rather sick at others. Frivolous penstrokes, which produce hump-backed ladies, protruding bellied men and a galaxy of creatures with human characteristics, wander from one page to another.

But the real fun begins with the printed work. There's no particular theme to either book; instead they are peopled by Franks, Henrys, Harrys, Sad-Michaels and Little Bobbies, with their accompanying tales of love and woe. Lennon's use of words is completely uninhibited by their true meaning. His descriptions have a certain aural similarity to the words one might expect to hear, but there the similarity ends. From here he leaps on to even more absurd word associations, which, when they are spontaneous, are very funny. Unfortunately much of what he writes is so laboured that it ends by being merely boring. This boredom may be alleviated on the next page with a nicely satirical piece on how "Harassed Wilson won the General Erection, with a very small marjorie over the Torchies".

Few could fail to be amused by some section of this *Penguin* as long as they don't first throw it away from themselves in disgust.

Jacqueline Hall.

PSYCHOLOGICAL TRIO

Attitudes, edited by Marie Jahoda and Neil Warren. Price 8s. 6d. *Penguin Modern Psychology.*

Modern psychology over the last twenty years has become increasingly complex, and semantic confusion over the meaning of psychological terms is very widespread. This book on "Attitudes" edited by Jahoda and Warren clarifies the concept of attitude before it considers research, theory and method in the field.

In the introduction, the authors explain that attitude is not a purely psychological term—it is in fact an interdisciplinary term bridging psychology and sociology since attitudes have social reference in their origins. This book therefore is likely to be of interest to the sociologist as well as the psychologist.

The order of presentation of the subject-matter in the book reflects the editors' priorities. Therefore, Part One is concerned with the concept of Attitude with its history, its essentially inferred nature, overlap of its component terms, and a discussion of the possible cognitive nature of attitudes (i.e. an attitude may be regarded as an organisation of experiences and data with reference to an object, or as a sort of preconception).

The second part of the book is devoted to research into attitude content, research into the origins and development of attitudes, and investigations of attitude change. The second-mentioned is often overlooked in the literature of attitudes and therefore the sections appraising the developmental approach of Piaget and the genesis of authoritarianism are welcome.

The variables and processes involved in attitude change are an understandably important problem in modern attitude research. Several interesting chapters on specific topics as "Thought Preference of Chinese Intellectuals" by R. F. Liftlen and "Inducing Resistance to Persuasion" by W. J. McGuire are accompanied by a more theoretical chapter on the processes of social influence by Kelman.

Part Three of the book is subdivided into two sections—the first on attitude theory, and the second on the methodology of attitude measurement. R. B. Zajonc invokes the concepts of balance, and dissonance to explain attitudes which he says are essentially rational and therefore can be explained by such mechanisms. The second section studies the choice of research design, the method of data collection and quantification, and the logic of interpretation and inference.

Generally, this book seems a useful contribution towards increasing the non-specialist's knowledge of a complex subject.

M. C. Jennings.

Motivation. Edited by Dalbir Bindia and Jane Stewart. *Penguin Modern Psychology.* Price 8s. 6d.

Penguin Books have for some years been providing their public with a series of books covering many psychological topics. The quality of these has been varied, but without doubt, the editors should be rewarded for their efforts to enlighten people on the variety of research and approaches in a subject which has long been misunderstood and mistrusted.

With the advent of the Modern Psychology series they are attending to a further need. Each book covers a major topic in psychology by presenting a series of articles published in the last sixty years or so by authors subscribing to a large number of psychological creeds. Thus we are offered a view of each problem in all its complexity. We are also given insight into the difficulties of scientific investigation in psychology (i.e. reproducible objective measurements and evaluation). Further, there are complete lists of references for each article, plus a comprehensive subject index to each book, two things which previous psychology paperbacks have notably and irritatingly lacked.

Historically and theoretically, the variety of readings in "Motivation" is wide, providing what is probably a representative sample of views on the problem.

First, there are papers considering motivation from a semi-philosophical viewpoint (originating in the nineteenth century from people like William James, in connection with problems concerning volition and voluntary action). Second, a variety of psychological viewpoints are offered for comparison, ranging from the extreme behaviouristic approach, which employs measurable variables only in its theoretical formulations, to theories involving complex mathematical relationships between hypothetical concepts employed to explain variation in behaviour. Third, papers have been included which consider, with experimental evidence, the physiological correlates of psychological concepts of motivation, such as "drive" and "reinforcement", and their relation to the behavioural phenomena for which they have to account.

In this book there is a large amount of information on the controversies involved in the development of theory related to motivation,

and the approaches and problems involved in the implicated psychological mechanisms. Well subdivided, referenced and indexed, it provides a more than adequate book on the subject for the layman, and also a useful tool for the student looking for a comprehensive starting-point into the field of motivation.

Judith A. Cockett.

Personality Assessment. Edited by Boris Semeonoff. *Penguin Modern Psychology*. Price 8s. 6d.

All students of psychology will welcome the new Penguin series of collected readings; previously such books have only reached us across the Atlantic and at grossly inflated prices, which mocked the concept of the paperback.

"Personality Assessment" presents, at very reasonable cost, a great deal of essential material and will amply repay the investment by first-year psychology undergraduates and D.P.M. students. Some of the articles would be hard to find in any but the very best libraries. Without doubt, the diligent reader would come away with a very broad awareness of what psychologists have attempted and achieved in this field. That the picture which comes over is a good deal too rosy, is perhaps inevitable where authors are largely presenting their own works, though it could have been avoided to some extent by more critical editorial comments.

Professor Semeonoff has chosen to represent the history of the subject solely by an extract from Francis Galton's writings, perhaps intending to persuade us that the British really started the whole business. It is to be regretted that Ulumdt's equally early, and surely more prophetic, dimensional work and speculations, do not warrant an article, only a bare mention.

While the book does contain a great deal that is essential reading on its subject, some of the inclusions and exclusions are rather puzzling to this reviewer. Sheldon's work on somato-typing surely belongs to the volume on "Theories of personality that we are promised later; War Office selection procedures have not really produced sufficient knowledge to justify two long extracts; the inclusion of Schafer's early, highly speculative article on scatter analysis of intelligence tests seems almost perverse in view of the subsequent poverty of valid results from this approach. The most surprising exclusions are: a more critical assessment of modern Rorschach technique; a much wider coverage of individual-centred psychometric methods, such as Kelly's Repertory Grid or Shapiro's Personal Questionnaire; finally, and most important of all, an adequate theoretical treatment of the problems presented by personality assessment.

This last is partially covered by the articles of Vernon on "Validity", and Edwards on "Social Desirability Response Bias", but there is much more to the whole subject than this. Without such a theoretical framework, which could have been found in the writings of Cronbach, or perhaps supplied in a more useful editorial introduction, many readers will find the individual articles difficult to evaluate. A firmer and more critical editorial presence throughout would have been entirely beneficial.

W. Penn.

THEATRE FROM THE INSIDE

The Garrick Year, by Margaret Drabble. Price 3s. 6d. *Novel.*

Margaret Drabble's "The Garrick Year" although not exactly unprecedented in the field of romantic theatrical novels has, nonetheless, an easy to read flowing style and is the kind of book I find difficult to put down before finishing. The writing is often sardonic and humorous and as such, I found some passages amusing enough to raise a chuckle, but the most poignant feature is the identification which I felt with the author; she has a keen intelligence of human weaknesses and failings, and narrating the book in the first person with such natural fluidity and so honestly, one wonders just how much is, in fact, autobiographical. The refreshing lack of the use of clichés and coincidental events, raises the author above most of her contemporaries, but it was a pity that the type of generalisation about the easy sexuality of actors, which is all-knowingly passed on by gossips and "scandalisers" should have been used as sidelines to the story to create a "theatrical atmosphere" (e.g. the dumb actress willing to sleep around to further her profession, and the homosexual actor continually chasing his latest fancy, Julian). This, one felt was slightly superfluous and unnecessary and the short though pitiful account of the latter's death was, in truth, almost like padding to what would otherwise be a rather short novel! The subtle ending confirmed my opinion of Miss Drabble's sensitivity for people and if her next novel is as good as this one, then I eagerly await it.

Carol Rigby.

THE

MEDICAL PROTECTION SOCIETY

FOUNDED 1892

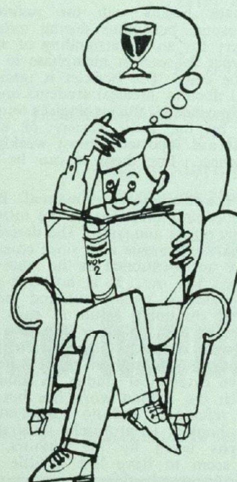
MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Senior Medical Secretary Herbert Constable MRCS, LRCP

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Dental Secretary Frank Allott, LDS



Gynae. Pharm. Biol. Anat.
Urology & Renal.
Immunol. & stuff like that.
Neurol. The Duodenal.
None can hope all this to learn
Except he labour for it,
Strength so used will soon return---
Sip Guinness to restore it.

MEDICAL BOOKS

Addiction

Alcoholism: Its Facets and Phases by Marvin A. Block. London: Oxford University Press, The John Day Co., 1965. Price 35s.

There are no very accurate figures on the incidence of alcoholism in this country, but the best evidence suggests that 200,000-300,000 people are drinking to a degree which is damaging their physical or mental health, or interfering with their social adjustment. Whatever the exact statistics, there is no doubt that alcoholism is a relatively common disease and that it is a diagnosis very commonly missed. Recent work in America has shown how the false stereotype held by most doctors, who come to think of the alcoholic as an unshaven and shabby down-and-out, leads them to overlook the very obvious cases which come into the hospital wards. Only 1 or 2% of all alcoholics are on Skid-Row. There is some evidence too, to suggest that in England general practitioners miss the diagnosis in nine cases out ten. In psychiatric practice it is not uncommon to meet the alcoholic who has had a partial gastrectomy, who insists that the surgeon concerned never asked him about his drinking habits—and a check of the surgical notes seems often to confirm the story. Alcoholics must also contribute quite generally to the work of casualty departments, but how many of us, when we have been preoccupied with splinting the fracture, have really had time to enquire in any detail as to how the fracture occurred?

Clearly, alcoholism is a disease which ought to be found more space in the medical syllabus. It deserves more attention than it has previously received, not only because it is a common disease—there must be many conditions clammering for more space in the syllabus—but also because it is a disease eminently valuable for teaching. If we can understand the alcoholic, all the old platitudes about man's behaviour being the result of inter-action between his personality and his environment stop being platitudes, and become live realities. If you get to know the alcoholic, you suddenly see the vital importance of understanding a man's whole life from childhood onwards, the importance of understanding the quality of his marriage, and the hopelessness of a clinical orientation which sees general medicine and psychiatry as either or approaches. Up to now, one of the difficulties facing anyone who wanted to inform themselves about alcoholism was the relative shortage of good books on the subject.

Doctor Block has written a very good and very readable book. It is an introduction to the subject, and does not attempt to go into recent research in any great detail. It could be as warmly recommended to nurses as to doctors. Social workers should certainly put it on their reading lists. Some of the chapter headings give an idea of its scope. The first section is headed "The Illness Called Alcoholism", and here Dr. Block analyses the reasons why alcoholism should be considered an illness rather than a moral failing. He goes on to discuss "Why people drink". There is now a fascinating literature on normal drinking which has shown the vital influence of social mores on drinking behaviour. A Drunk Jew is rare because Jewish mores regard drunkenness as inept. Treatment of alcoholism is then fully discussed. There is a chapter on Alcoholics Anonymous, and here it is worth noting that if anybody wants a quick way to understand alcoholism, one of the best methods is to look up A.A. in a phone book, and arrange to be a guest at an evening's open meeting. Then Dr. Block discusses "Alcoholism and Industry", and it's interesting to see how in America there is a growing recognition of alcoholism as a very serious industrial illness, and the tendency now is to invite employees to come forward for treatment, rather than to have a punitive policy which drives the disease underground.

These then are only a few of Dr. Block's 27 chapters. If you read this book, you will start seeing alcoholics.

Griffith Edwards

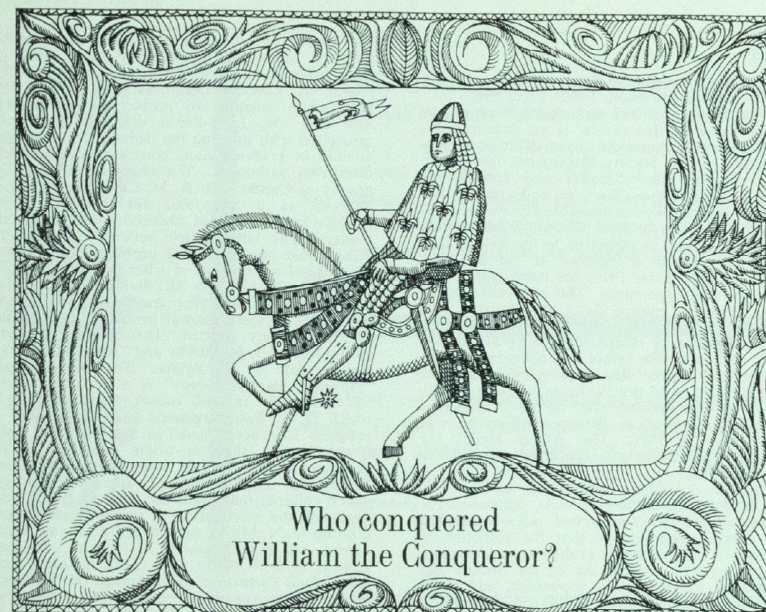
Genetics

Human Chromosomes: an illustrated introduction to human cytogenetics, by A. Bishop and P. Cooke. Published by William Heinemann Medical Books Ltd. Price 8s. 6d.

This paperback begins with the rudiments of normal chromosome behaviour during mitosis and meiosis necessary for an understanding of abnormal human karyotypes as seen at metaphase in cultures of human tissue cells. The booklet is intended for those interested doctors, medical students and nurses who have been puzzled by the cytologist's terminology and confused by the great variety of abnormal karyotypes that are reported almost weekly in the *B.M.J.* and *Lancet*. For them it can be strongly recommended.

The booklet is not a laboratory manual. Biologists will find the over-simplifications in the introductory part and the few errors annoying. The description of chiasmata formation is vague and, since crossing-over and linkage are not mentioned in the later sections, it could be well left out. It is not true that the first meiotic division is reductional and the second equational. The chiasmata result in each division being a mixture of both. Neither is it true that the two chromosomes in each homologous pair are genetically identical. The authors make no reference to the extensive cytological studies in animals and plants on which the human work has been based. There are no references and no suggested further readings. The booklet is profusely illustrated with photomicrographs taken by the authors. Unfortunately they seem to have lost a little of their original quality in reproduction.

M. Hollingsworth



No one.
But he still worried a lot.
About his acne.
It was unconquerable too.

Today, William's plight is still shared by many adolescents.
But now Neo-Medrone Acne Lotion
– the modern comprehensive acne control agent –
removes the frustration of uncontrolled acne.

Whenever you need a staunch ally
against acne, signify

Neo-Medrone Acne Lotion

Supplied: 25 cc. plastic squeeze bottles. Upjohn UPJOHN LIMITED · CRAWLEY · SUSSEX
REGISTERED TRADEMARK: NEO-MEDRONE GB 3855.1

History

The British Red Cross in Action, by Beryl Oliver. Faber & Faber, London, 1966. Price 63s.

To do ample justice to this remarkable book within the limited space of this review is an impossibility. It is a thoroughly documented survey of the innumerable activities of the Society throughout the world, ranging from the many treaties and conventions which led to its formation, the work and organization entailed, the personalities responsible for its development, and its activities in crises both major and minor.

Dame Beryl Oliver, as Archivist to the British Red Cross Society, and as a member of the St. John Ambulance Brigade from 1910, has made full use of her resources and experience. The impressive result is no dry record of names, dates and statistics, but represents a thoroughly readable record replete with detailed descriptions of campaigns and events, beginning with Alexander the Great and terminating with earthquakes and similar disasters in 1962. It is of special interest to note the inclusion of John Melly, a Bart's man, who became head of the British Red Cross Ambulance Unit in Ethiopia where he was killed on May 5, 1936. The Albert Medal for Gallantry was posthumously conferred on him by King Edward VIII.

Food parcels, clothing, information services, recreations and sports, library services, assistance for civilian as well as military personnel—all are recorded in some detail, reminding us that the activities of the Society are as multiferous as they are widespread. Always prepared for instant action, the Society has often achieved the seemingly impossible, and those who have derived benefit from its services are grateful to those keen individuals responsible for its development and success. Two incidents from the last war are called to mind. The Red Cross jeeps dashing between the combatants to pick up the wounded under heavy fire, the attendant clinging on the side waving the flag bearing the Red Cross: and the small figure with the Red Cross arm band leading several hundred German prisoners out of Bremen, where fighting was still taking place. The Brigadier asked him if he was armed, but pointing to the armband, he said, "Of course not, but I think the chap at the rear of the column is!".

This illustrated record of a great organization is not only a definitive history, it is a study of man's attempt to relieve suffering under all conditions, wherever necessary, irrespective of race and creed. Such unselfishness deserves adequate recognition, and this book should do much to achieve it.

J. L. Thornton

Medicine

The Scientific Basis of Medicine; Annual Reviews, 1966. Published by The Athlone Press. Price 40s.

The Scientific Basis of Medicine Anual Review series is now well established as a valuable source of key review articles. The present volume maintains the high standards set by its predecessors. It begins with a thought provoking chapter "The Ethical Basis of Medical Science" by Sir Robert Platt. W. V. Mayneord's chapter "Environmental Radioactivity and Its Biological Significance" will help nonspecialist readers to see the problems of 'radiation protection' in the medical context, against the perspective of a view which has to be taken, when one considers the natural background radiation to which all forms of life have been exposed since the beginning of time, and which may have been partly responsible for their initiation and evolution. "Ultrasonics in Clinical Diagnosis" (P. N. T. Wells) summarises attempts to probe new depths with a new tool. W. Lane-Petter discusses the problems associated with meeting the demand for experimental animals of known genetic constitution and which are free from pathogens. The chapters on the "Demography of Cancer" (R. A. M. Case) and "Long-Term Dialysis as a Substitute for Kidney Function" (S. Shaldon) will be of particular interest to clinical readers. The latter article reviews both the instrumental and purely clinical problems associated with the general application of what he terms the chronic nephritic's 'Insulin' to all the patients needing it. The results of applying modern protein-chemistry techniques to some clinical problems are summarised in the chapters entitled "Disturbance of Immunoglobulins" by J. R. Hobbs and "Rheumatoid Factor" by the late J. R. Squire. The problem of the "Hospital Staphylococcus" is a recurring one and M. T. Parker reviews recent work on this topic; while D. J. Bauer reminds the reader that more progress has been made in the field of Antiviral Chemotherapy than is often thought. J. W. B. Douglas contributes an interesting article on the educational implications of the different ages at which children reach puberty. The remaining chapters deal with the mechanisms of urine concentration and dilution (J. N. Mills), sodium and potassium transport across cell membranes (I. M. Glynn), the nervous control of limb blood flow (I. C. Roddie), cerebrospinal fluid formation and drainage (H. Davson), the histochemistry of dental tissues (A. R. Ten Cate), the distribution of pulmonary blood flow (J. B. West), tissue oxygen requirements (I. S. Longmuir), and the relationship between the thyroid gland and central nervous development (J. T. Eayrs). These are all good reviews of original work which should appeal to clinical readers who often have all too little time to pursue the original 'basic science' literature except where it abuts onto some problem with which they are immediately concerned.

R. W. E. Watts

Microbiology

Review of Medical Microbiology, by Jawetz, Melnick and Adelberg. 7th Edition. Published by Lange, California: Blackwell, Oxford. Price 50s.

A clear indication of the popularity of this book is given by the fact that this is the seventh edition since 1954 and that there are Spanish, German, Italian and Greek translations with one in Serbo-Croatian under way. It is intended for medical students, house officers and practising physicians, although it should be remembered that most American students are exposed to considerably more basic science in microbiology than are their British counterparts.

The first thirteen chapters are mainly concerned with the general properties of bacteria, their genetics and metabolism and the reaction of the host to their attack. The chapter on antimicrobial chemotherapy has been re-written since the last edition. The remainder of the book, apart from sections on medical mycology, diagnostic medical microbiology and parasitology, is taken up with chapters on bacteria and viruses. It is interesting to note that the latter claim the greater space.

WHAT DOES

STAND FOR?

IT STANDS FOR **security and peace of mind from the day you qualify—until the day you retire—and after.**

IT STANDS FOR **the provision of advice on all your professional problems . . . . for legal assistance in any difficulty or proceedings of a professional nature . . . . for unlimited indemnity in respect of damages and costs in the event of an adverse verdict or a settlement out of Court.**

IT STANDS FOR THE MEDICAL DEFENCE UNION **the oldest and largest organisation of its kind in the world. Further particulars can be obtained from**

THE MEDICAL DEFENCE UNION

Tavistock House South Tavistock Square London W C 1

Secretary: Dr. Philip H. Addison

Dental Secretary: A. H. R. Rowe, M.D.S., F.D.S.

Engagement Rings

25% DISCOUNT

All types and styles of Rings always in stock

Also Watches, Clocks & Wedding Rings, etc., at 10% – 20% Discount

Write for Ring Catalogue to the actual manufacturers

J.&A. JEWELLERS.

96, HATTON GARDEN, LONDON, E.C.1

Telephone: CHAncery 6025 and 4020

Business Hours: Weekdays 9.0-5.30 Saturdays 9.0-12.30 Evenings by appointment

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

The annual Subscription to THE JOURNAL is only 25/- per year (42/- post paid anywhere in the world). Perhaps you know someone who would like to become a subscriber.

Further information may be obtained from:

The Assistant Manager (Subscriptions),
St. Bartholomew's Hospital Journal,
St. Bartholomew's Hospital,
London, E.C.1.

As a substantial introduction to microbiology, this book can be strongly recommended, and there seems little doubt that it will be as successful as preceding editions.

R. A. Shooter

Philosophy

Evidence in Science, by G. K. Stone. Published by John Wright & Sons Ltd. Price 17s. 6d.

This book, by an eminent rheumatologist and former Research Fellow at Barts, is written in the belief that "logic is an indispensable study for all who are in complete ignorance . . . . of those simple principles of reasoning which are employed . . . . in all scientific work". This is certainly true and probably few medical students could honestly admit to any specific training in even the elementary principles of logic. Instead, it is hoped that they will pick up at least some of the disciplines of scientific thought at various stages of their course. Yet there is very little doubt that a more rigorous use of logic would help both their understanding of the scientific basis of much modern medicine and also its applications at the bedside.

Dr. Stone begins by discussing and defining such concepts as credulity, truth and falsity, knowledge and belief and then goes on to describe Aristotelian and later theories of deduction. In later chapters on the scientific method, causation, and controlled experiments he gives some excellent examples from the work of Mendel on the genetics of peas, Reed on yellow fever and Pasteur on anthrax. These are followed by a discussion of mathematical probability in research, in which some elementary statistics is introduced, and the book ends with a chapter on the art of sophistry. This is both a warning of the traps into which one untrained in logic can fall and also an exposé of some of the tricks which sophists can use to convince their audiences.

Much as I would like to recommend this book, I am doubtful if it would hold the attention of many, except the most determined readers, on account of its rather dull style. However, those who are able to persevere to the end (and it is only a short book, covering a remarkable amount of ground in a short space) should find the effort rewarding, with considerable gain to the clarity of their thinking.

J. D. Hawkins

Physiology

Advances in Respiratory Physiology. Edited by C. G. Caro. Published by Edward Arnold Ltd. Price 75s.

This book is not a text-book but a review of certain specialized branches of respiratory physiology, and is written by eight physiologists, all well-known for their original contributions to this field. The topics are well-chosen and cover those fields in which there have been the most rapid advances in recent years. For instance, Dr. R. A. Mitchell discusses the relation of respiration with special reference to the work on the role of the intracranial chemoreceptors and of changes in the pCO_2 and pH of the cerebrospinal fluid. Dr. R. E. Pattle who has contributed a great deal to the problem of the properties of the layer of lipoprotein lining the lung alveoli, discusses this matter in detail and particularly in relation to the respiratory distress syndrome in the newborn. There is also an interesting chapter by Dr. J. B. West on recent developments on the subject of the distribution of pulmonary blood flow and ventilation in the lungs. His own work on isolated perfused lungs of the dog has resulted in a new attractive hypothesis to explain the mechanism of the high pulmonary vascular resistance often seen in patients with raised pulmonary venous pressures, and this is fully described.

These chapters together with others by Drs. C. G. Caro, F. P. Chinard, L. E. Farhi, I. S. Longmuir and J. G. Widdicombe form a well-balanced book describing the growing points in this advancing field of physiology. However, it must be pointed out that only those who have a good basic knowledge of respiration and are familiar with the use of respiratory symbols, abbreviations and equations are likely to gain much benefit from this book. This is not to detract from its usefulness or value; on the contrary, it is written for advanced students, doctors and physiologists interested in respiration, and to this extent, it has succeeded and is to be highly recommended.

The book is very well produced and the standard of the reproductions is high. The index is adequate and there is a comprehensive list of references at the end of each chapter, mainly to recent work.

M. de Burgh Daly

Psychiatry

Human Behaviour in Illness, by L. Gillis. 1st Edition. Published by Faber. Price 7s. 6d.

The authors of this most useful book have set out to introduce medical students and nursing personnel to the concept of the "whole patient". Although medical teachers frequently exhort their pupils to regard the patient as a whole rather than the sum of his vital organs, most students find it hard to follow this advice. "Human Behaviour in Illness" provides the necessary background information for the student to appreciate what problems patients may face as a result of their illness and how, in some cases, psychological and social problems themselves can be important factors in the pathogenesis of the illness for which the patients find themselves in hospital.

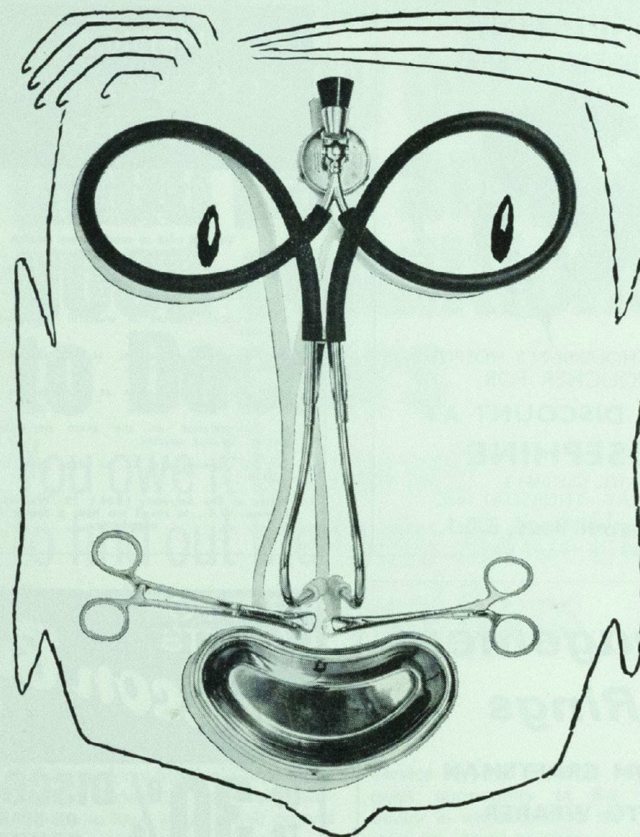
In addition, this book gives a clear account of elementary human psychology and development, although it leans too heavily at times on Freudian hypothesis. In the section on psychosomatic medicine the authors unfortunately follow the concept of "specificity"—that is, there is a specific personality type for each illness. This notion is now outmoded and while we know that patients who suffer from psychosomatic conditions are generally somewhat anxious or over-meticulous, there is no specific personality for each illness.

Mental illness is perforce only briefly touched upon and this leads to some oversimplification. In contrast, however, the section on psychotherapy is a model of its kind.

At the end of each chapter is a series of discussion topics and questions designed to stimulate further consideration. For those who, like myself, find these somewhat irritating, it is quite easy to skip over them.

I would strongly recommend this book to all those coming into contact with patients for the first time in their medical or nursing career.

J. T. Silvertsone



The St. Bartholomew's Hospital Office, which is opened for your especial use, is under the management of Mr. R. B. Harrison, West Smithfield Branch, 59 West Smithfield, E.C.1 and enquiries will be welcomed.

ELEGANT HAIR STYLES at

JOSEPHINE

of REGENT STREET

CITY BRANCH

ST. BARTHOLOMEW'S HOSPITAL
VOUCHER FOR

20% DISCOUNT AT

JOSEPHINE

TEL: CLE 0464-3
MONDAY—THURSDAY incl.

30 Goswell Road, E.C.1.

Valid for February 1967

MEDICAL
CORRESPONDENCE
COLLEGE

Are you preparing for a

**MEDICAL OR
SURGICAL EXAMINATION?**

**Do you wish to coach in any Branch
of Medicine or Surgery?**

* The activities of the Medical Correspondence College cover many departments of Medical, Surgical, and Dental tuition.

* Desultory reading is wasteful for examination purposes.

* The secret of success at examinations is to concentrate on essentials.

* First attempt success at examinations is the sole aim of our courses.

* Concentration on the exact requirements is assured by our courses.

* Our courses are up to date and frequently revised.

Write to The Secretary (B.H.) 19, Welbeck Street, London, W.1., to see if we have a course for your examination.

Engagement Rings

FROM CRAFTSMAN
TO WEARER

25% DISCOUNT

"FINEJEWELS"

88-90 HATTON GARDEN, E.C.1

Telephone: HOLborn 8058

Weekdays 9.30-5.30, Sat. 9.30-1

FIRST FOR CARPETS

Dodson Bull

UP TO 30% DISCOUNT ON BRANDED CARPETS

Wiltons • Axminsters • Orientals • Tufted

£200,000 Carpets on display

in our extensive London and Northern Showrooms

- All makes available with full Manufacturers Guarantees.
- Free Delivery U.K.
- NO IMPERFECT GOODS SOLD
- Expert fitting service available most areas

Write stating requirements or for introduction to showrooms in most main cities

Open 9.30 to 5.30 Mon. to Fri. 9.00 to 12 noon Sats.

DODSON-BULL CARPET CO LTD

2, 4 & 5, Little Britain London EC1 (1 min St Paul's)
Tel: MON 7171 (10 Lines)

The Army offers good pay and good conditions to Doctors

You owe it to yourself to find out the facts about the Royal Army Medical Corps

The Royal Army Medical Corps offers Medical Cadetships to suitable students who have passed their second M.B. or equivalent examination. In addition to the payment of tuition fees and the provision of books and instruments while the student continues his studies, these Cadetships carry a probationary rank of Second Lieutenant with basic pay of £730 plus generous allowances for board and lodging to a total of over £1000 a year. On registration, Officers are promoted to Captain and, if married, would earn over £2,000 a year.

Service in the R.A.M.C. offers a great opportunity to the young doctor in whatever field his interest may lie—from practice in one of fifteen specialties to general practice, including the care of women and children.

Full details are contained in the booklet "A Career for Doctors in the Royal Army Medical Corps". Write now for your copy to:-

Colonel A. D. Young, D.S.O., M.B., The Ministry of Defence (A.M.D. 2), Dept. 463, Lansdowne House, Berkeley Square, London, W.1.

A cricket player has his bat
A boxer has his gloves
A wet bob has a wooden oar
A tennis type his loves
A rugger man can have a try
A golfer has his clubs
A runner has some spiky shoes
A drinker has his pubs
But whether you are qualified
Or still a hard worked student
There's one thing that you ought to have
if you are wise and prudent

. . . and that's a policy with
The Medical Sickness Annuity and Life Assurance Society Limited
P.O. Box 449, 7-10, Chandos Street, Cavendish Square, London W.1.
Telephone: Museum 1686 *(Member of the British Insurance Association)*

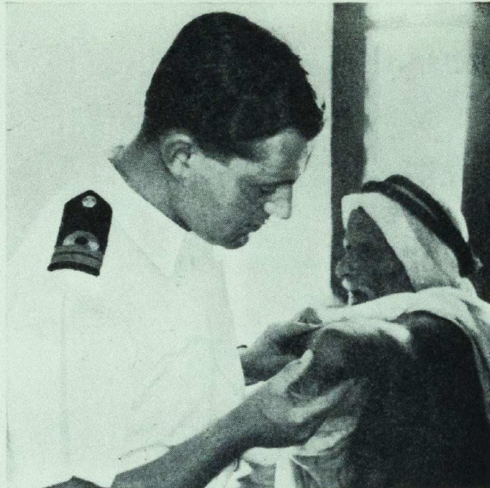
Printed by The Studio Press (Chelsea) Ltd., 37 Petergate, London, S.W.11.

London Jazz

SAINT · BARTHOLOMEW'S · HOSPITAL · JOURNAL

VOL. LXXI No.3

MARCH 1st, 1967



How you can see the world and gain valuable medical experience

(before you settle into general practice)

Would you like to see the Far East, the Mediterranean, or the West Indies? Study the new sciences of aviation, underwater or nuclear medicine? Have complete clinical freedom, modern medical equipment and the opportunity to practise a very wide and varied field of medicine? Lead an active, exciting outdoor life against a world-wide backcloth?

These are some of the opportunities open to you as a Medical Officer in today's modern and expanding Royal Navy. During a 5-year Short Service Commission you can gain valuable, practical medical experience, treating both Royal Navy personnel and civilian families.

And you'll see something of the world—before you settle into the routine of general practice. You will be well paid, with a starting salary higher than that of a civilian hospital registrar. Marriage and other allowances can add considerably to your income. And, if you wish, you can apply for a Permanent Commission after 1 year's service. Later, you can study (with financial backing) for higher degrees, and you could aim for consultant status.

3 Ways of Entry.

1. As a fully registered doctor; civilian experience counts towards your seniority.
2. During your pre-registration year.
3. As a student any time after passing 2nd M.B. For fully registered women doctors there is a special Short Service Commission.

If you would like more information, write to the address below, giving details of your age and qualifications. A personal interview can be arranged if desired.

The Medical Director-General of the Navy, Dept. 26FR8, Empress State Building, London, S.W.6.

Royal Navy

UNIVERSITY EXAMINATION POSTAL INSTITUTION

G. E. OATES, M.D., M.R.C.P., London

POSTAL COACHING FOR ALL MEDICAL EXAMINATIONS

Carefully designed courses under the supervision of specialist tutors. Advice on reading, guidance notes to each lesson and solutions to all test papers are provided.

PROSPECTUS AND LIST OF TUTORS

on application to

Dr. G. E. OATES,
17 Red Lion Square, London, W.C.1
Telephone: HOLborn 6313

R. E. F.

PHOTO SERVICE

Wedding Specialists

Covering England

10% DISCOUNT

TO ALL HOSPITAL STAFF

Enquiries, full details;
13 HORNSEY RISE GARDENS N.19.

GAMAGES

Call for immediate service or telephone

HOLborn 8484

for an appointment

NEW! FRENCH OF LONDON
HAIR BOUTIQUE *Main Entrance to Perfumery department ground floor*
REAL HAIR PIECES from 1 to 16 gns.

LADIES' HAIRDRESSING SALON

Under the direction of FRENCH of LONDON

The largest and most up-to-date Salon in Central London —and so convenient for Bart's girls. Why not try it? Completely air-conditioned. Popular prices.

- *All staff specially trained in the unique* **French of London** *Hairdressing methods.*
- *Sterilised brushes and combs for every client.*
- *Complete Manicure service*
- *Special Natural-Lighting Cubicles for tinting*
- *Private cubicles, if required, for treatments*
- French of London *Postiche available when extra hair is required*
- *Permanent Setting, and contract service for Permanent Waving*
- *Plug-in Telephone available, as well as free use of typewriters and stationery if required*
- *Tea, Coffee and Sandwiches served at reasonable prices*

GAMAGES, HOLBORN, LONDON, E.C.1 — **Open Thursdays until 7 p.m.**

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

The annual Subscription to THE JOURNAL is only 25/- per year (42/- post paid anywhere in the world). Perhaps you know someone who would like to become a subscriber.

Further information may be obtained from:

The Assistant Manager (Subscriptions),
St. Bartholomew's Hospital Journal,
St. Bartholomew's Hospital,
London, E.C.1.

NEW BLACKWELL BOOKS

Common Symptoms of Disease in Children
R. S. Illingworth, M.D., F.R.C.P. D.P.H., D.C.H., March, 1967. 296 pages, 4 illustrations. About **42s.**

Lecture Notes on Gastroenterology
R. D. Tonkin, M.D., F.R.C.P. May, 1967. 208 pages, 1 illustration About **18s. 6d.**

Lecture Notes on Cardiology
J. S. Fleming, M.B., CH.S., M.R.C.P., and M. V. Braimbridge, M.A., M.B., B.CHIR., F.R.C.S. Autumn, 1967. 160 pages, 40 illustrations. About **18s. 6d.**

Textbook of Pharmacology
W. C. Bowman, PH.D., B.PHARM., M. J. Rand, M.SC., PH.D., and G. B. West, D.SC., PH.D., B.PHARM. April, 1967. 992 pages, 250 illustrations. About **£5**

Clinical Anatomy
Harold Ellis, M.A., D.M., M.CH., F.R.C.S. *Third Edition*, 1966. 398 pages, 208 illustrations. **40s.**

A Course in Renal Diseases
G. M. Berlyne, M.B., M.R.C.P. 1966. 414 pages, 62 illustrations. **37s. 6d.**

New and Standard Titles

An Introduction to Electrocardiography
Schamroth (*Third Edition*) **20s.**

Human Microanatomy
Elias and Pauly (*Third Edition*) **80s.**

The Paediatric Prescriber
Catzel (*Third Edition*) **22s. 6d.**

Lecture Notes on Obstetrics
Musgrove (*Second Edition*) **25s.**

An Introduction to Social Medicine
McKeown and Lowe **50s.**

Handbook of Obstetrics and Gynaecology
Benson (*Second Edition*) **42s.**

Handbook of Paediatrics
Silver (*Seventh Edition*) **42s.**

Basic Endocrinology
(*Second Edition*) **36s.**

BLACKWELL SCIENTIFIC PUBLICATIONS
OXFORD AND EDINBURGH

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL BARTS STAFF
ON OUR OWN MANUFACTURED GOODS
DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings,
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. -Teasets & Plate.

10%-20% DISCOUNT TO ALL BARTS STAFF
on all Branded Goods — ALL SWISS WATCHES, Clocks, Cutlery, Pens, and Lighters and on Second-hand Jewellery.

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTON GARDEN, E.C.1
HOL 0700 or 6431
OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00
Special attention to order by post or phone

FIRST FOR CARPETS Dodson Bull

UP TO 30% DISCOUNT ON BRANDED CARPETS
Wiltons • Axminsters • Orientals • Tufted
£200,000 Carpets on display
in our extensive London and Northern Showrooms

- All makes available with full Manufacturers Guarantees.
- Free Delivery U.K.
- NO IMPERFECT GOODS SOLD
- Expert fitting service available most areas

Write stating requirements or for introduction to showrooms in most main cities
Open 9.30 to 5.30 Mon. to Fri. 9.00 to 12 noon Sats.
DODSON-BULL CARPET CO LTD
2, 4 & 5, Little Britain London EC1 (1 min St Paul's)
Tel: MON 7171 (10 Lines)

ACQUIRE THAT NEW ELEGANT HAIRSTYLE TO SUITE YOUR PERSONALITY.

Mayfair Trained Staff
Modern, Pleasant Surroundings

AT THE CITY BRANCH OF

-Josephine-
OF
REGENT STREET
CLE 0464-3

ST. BARTHOLOMEWS HOSPITAL
VOUCHER FOR
20% DISCOUNT AT
Josephine
MONDAY—THURSDAY incl.
30 GOSWELL ROAD, E.C.1.
VALID FOR MARCH, 1967

'ANTEPAR'
EXPELS THREADWORMS & ROUNDWORMS

No supportive measures are necessary.

'Antepar' does not contain a laxative, nor does it stain the stools.

Seven consecutive daily doses remove threadworms effectively–one dose removes roundworms.

'Antepar' brand Elixir contains Piperazine Citrate, B.P., equivalent to 750 mg. piperazine in 5 ml.
'Antepar' brand Tablets contain Piperazine Phosphate, B.P. equivalent to 500 mg. piperazine.

Immigrants from tropical countries may harbour both hookworms and roundworms. In single or mixed infections 'Alcopar' brand Bephenium Hydroxynaphthoate is the decisive answer.

'Alcopar' brand Dispersible Granules are issued in single-dose sachets of 5 G. containing bephenium hydroxynaphthoate equivalent to 2.5 G. bephenium base.

BURROUGHS WELLCOME & CO., LONDON
(THE WELLCOME FOUNDATION LTD.)

Saint Bartholomew's Hospital
JOURNAL

Vol. LXXI No. 3 — 1st March, 1967

CONTENTS

Communication ... 82
Letters to the Editor ... 83
News ... 84
Examination Results ... 85
Abernethian Society ... 86
Unauthorised Immigrants by S. G. Browne ... 87
Exposure and Survival by R. J. Horton and R. E. Franks ... 89
Cartoon by Cull ... 92
University of London Drama Festival ... 93
Prospect ... 93
The Rahere Ensemble at College Hall ... 94
Hydranencephaly by M. R. B. Keighley ... 95
Jazz in Britain—Origins and Development by Roger Rolls ... 100
Improvise Yourself by Peter Hill ... 103
The Jazz Week—London ... 104
The Jazz Score by Peter Hill ... 105
Thirty Years Ago by Sir Herbert Seddon ... 107
Reviews; Records ... 108
Penguin ... 109
Medical Books ... 111
Sports News; Editorial ... 113
Rugby Club ... 114
Golfing Society ... 117
Judo Club ... 118
Squash Club ... 118
Hockey Club ... 120
Swimming Club ... 120
Boat Club ... 122
Cross Country ... 122
Rifle Club ... 122

THE JOURNAL STAFF

Editor: **J. A. Sills**
News Sub-Editor: **Miss E. A. Macdonald**
Reviews Sub-Editor: **I. D. Fraser**
Social Sub-Editor: **R. C. D. Staughton**
Sports Sub-Editor: **P. A. Ashby**
Photographic Sub-Editor: **C. G. Fagg**

Manager: **J. P. D. Reckless**
Assistant Managers: **C. S. B. Roch-Berry**, **N. T. Goodchild**, **M. Castleden**
Charterhouse Representatives: **P. Swain**, **Miss J. Hall**
Nurses' Representatives: **Miss E. Ferreira**, **Miss P. M. Kilshaw**

COMMUNICATION

One of the problems which exists for us all in this age is that of communication. In particular the interchange of views between students and staff in academic communities, and between both of these and the outside world, is often a great problem. For many years the British Student has had a more docile generic image than his brethren in other countries, some of which enjoy political stability but others of which have a more temperamental political climate. In these latter, student militancy is often an important political force and there are frequent reports of student demonstrations, and even of flagrant rioting, which have led to important sequelae; many is the government that has had its confidence undermined by student opposition.

In Britain it is rare that Student Opinion (*sic*) becomes sufficiently aroused and indignant as to react actively *en masse* by public protest. Recently Rhodesia and the Government decision to increase the fees payable by overseas students have been sufficient to rouse many. Unfortunately, one of the demonstrations, which was perhaps more violent than necessary, ended in a tragedy that focused the attention of the Press on the demonstration itself rather than on the aims and ideals behind it.

Thus the methods of disseminating opinion have come under scrutiny; the traditional ones of writing to newspapers and lobbying M.P.s may appear ineffective to many, and this uncertainty can lead to the adaptation of other methods of action. The traditional methods can be surprisingly effective, especially if the interest of the Press is aroused; and with reference to the increase in fees it seems likely that there will be some form of reappraisal.

Nonetheless, militant action will still appeal to many, but they should be warned of the hazards of such action; for if there is violence it is quite likely that all they will succeed in doing is antagonising the public, so that far from sympathy for the cause, the effect will be the opposite one of alienation. Thus great care and discipline is required if militant action is to be at all effective.

In smaller communities the machinery for communication between staff and students is usually defined, and on the institution depends the efficiency, but it does exist for the use of any with a grievance or constructive ideas. For example, in this community official channels exist within the Students' Union and the Teaching Committee, and there is also the "Letters to the Editor" column of this *Journal*, which incidentally has been disappointingly free from controversy recently. It appears that even the most astringent public criticism of one section of the student body can bring forth not one reply—is this an indication of timidity or of a lack of articulation?—and it has been left to the *Journal* itself to attempt a balanced evaluation. The use and disuse of channels of communication such as these is surely an indication of the vitality and awareness of a community.

Students today, due to the peculiar environment of the present and its changing values of morality, religion and loyalties, can view problems from angles that may be difficult for their elders to appreciate, and can thus form a balance in opinion. It is important that it be appreciated that to have effect opinions should be disseminated, as a first resort at least, in as responsible a manner as possible that relies on reasonable argument rather than on emotionally charged histrionics, but the premise is that opinion is held.

LETTERS TO THE EDITOR

"JELUNDA" SMITH

Sir,—I enjoyed reading Henry Stallard's article on Cataract Surgery in the January issue of the *Journal*, and as I read about the history and evolution thereof, I was particularly interested to see the reference to the intracapsular technique of Smith.

When I was House Surgeon to the Eye Department (1923-24) I had heard of the technique, but gathered that it was much frowned on by London Ophthalmologists.

After Smith, always known as "Jelunda" Smith from the name of the place where he worked in India, retired from the Indian Medical Service, he occasionally operated in England and I was fortunate enough to have the opportunity of seeing him perform his own operation, through the kindness of his son, who at that time was a student at Bart's.

He and I journeyed to a house in the West of London, near where the Great West Road now runs. There in a second floor back bedroom overlooking fields, with only his son and myself as spectators and with the least possible fuss and palaver the great man carried out his operation on a patient. In his hands it appeared extremely simple and took but a few minutes.

I remember that I was very hesitant about telling my Chiefs at Bart's what I had been to see.

Yours faithfully,
JOHN HOSFORD,
Reguengo,
Portalegre,
Portugal.

20th January.

2ND M. B. SENIOR SCHOLARSHIP

Sir,—The 2nd M.B. senior scholarship this term has been arranged so that candidates will be required to spend five consecutive Wednesday afternoons doing practicals or three hour written papers. Admittedly any prize must be won and some personal sacrifice made. However, such an arrangement precludes any active sportsman — or woman — from participating in the examination. This is especially so where team members are concerned or where Wednesday afternoon is the only possible opportunity for training in a particular sport—e.g. canoeing. No doubt any other arrangements would present difficulties as far as lectures and practicals are concerned but I feel these need not be insurmountable. Some advocate awarding the scholarship on the 2nd M.B. results—this has advantages and disadvantages. Either way surely outdoor activities are important during such intense studying as precedes 2nd M.B. and should be encouraged. Healthy body—healthy mind.

Yours faithfully,
ADRIENNE HUSKISSON,
College Hall,
Charterhouse Square,
London, E.C.1.

6th February.

TWO "G"S — BOTH GREAT

Sir,—I read with much pleasure the article in the January '67 *St. B.H.J.* about Twillingate Hospital, Newfoundland. One or two reminiscences may be of interest.

In Khartoum in the early 1920s on a day of staggering heat (114° to 120°F. in the shade) we dutifully made our way into the Cathedral for Evensong where I was to assist an organist friend. Sir Wilfred Grenfell, introduced by Bishop Gwynne, took the chancel steps and froze our perspiring bodies as he related his experiences in Labrador. Later we adjourned to the Bishop's Palace for supper, at which Sir Wilfred and Lady Grenfell were the guests, and the next morning I received Sir Wilfred to inspect my Kitchener School of Medicine.

Bishop Gwynne was an interesting character, his diocese was the sizeable one of Egypt and miles. In Khartoum, every Friday morning, he the Sudan; an area of several million square held a conference for lepers outside his Palace. Most people dropped their coins into the sand but he placed his contribution firmly into the hand of each patient. They naturally adored him.

One admitted weakness was his inability to close a sermon. On one occasion, however, this was done for him. He was giving a pep talk in the 1914-18 war to young troops about to go *over the top* for the first time next day. "You never know," he said, "any one of you lads might get the Victoria Cross." A voice replied: 'Much rather get the Victoria bus, bish." And that was that.

On his return to England after the First World War he joined in the Red Sea a Bibby Line boat, at that time not yet converted from being a troop ship. He went aboard in the heat of the afternoon for a snooze in his curtained bunk. Later he heard two returning soldiers: "Heard the news?" "No, what?" "Got a bl . . . y bishop coming into our flat." The bishop parted his curtains and said: "You're quite right, I am the bl . . . y bishop." He told me he never had such a happy voyage!

The last time I saw this Grand Old Man was at a meeting of the Sudan Diocesan Association. The Central Hall Westminster was packed and the Bishop, who must have been at least 80 years old came on to rapturous applause and spoke brilliantly for half an hour without notes. One minute he had us streaming with tears, the next raising the roof with laughter.

Has anybody, I wonder, written a biography of this great and lovable man?

Yours faithfully
NORMAN F. SMITH,
Flat 101, Lord's View,
St. John's Wood Road,
London, N.W.8.

23rd January.

SIGMOID UNIT

Sir,—During some amusing speeches at the recent farewell dinner for Sir Clifford Naunton Morgan in the Great Hall I was reminded of "the most normal rectum in the world". It was recorded by a student on the firm when I was Chief Assistant. He wrote—"Sigmoidoscopy N.A.D. to 25 CNM's"!

Yours faithfully,
M. F. HUNT,
Layer de la Haye,
Colchester,
Essex.

30th January.

Engagements

MATHESON—SAUNDERS.—The engagement is announced between Dr. Iain Matheson and Miss Lorraine M. Saunders.

CHURCH—CUPITT.—The engagement is announced between Jeremy J. Church and Miss Carol Cupitt.

Births

KNOX.—On November 8, to Susan (née Williams) and Dr. Andrew Knox, a daughter (Sally Janet Catherine).

Deaths

GRAY. — On January 28, Leonard Gray, M.R.C.S., L.R.C.P., aged 89. Qualified 1905.

MASON.—On January 16, Thomas Owen Mason, M.R.C.S., L.R.C.P. Qualified 1938.

MILLER.—On January 24, Thomas Mackinlay Miller, M.C., M.R.C.S., L.R.C.P., aged 81. Qualified 1908.

WIGAN.—On December 21, William Cecil Wigan,, M.B.E., M.R.C.S., L.R.C.P., aged 90. Qualified 1908.

Change of Address

Mr. J. C. Ainsworth-Davies to Townsend Farmhouse, Stockland, Nr. Honiton, Devon. Tel. Stockland 257.

Announcements

Orthopaedic Department

The current exhibition in the Clinical Lecture Theatre is "Giant Cell Tumour of Bone".

Drama Society

Bart's Drama Society presents its main production on the evenings of March 7, 8, 9, 10. The play is Harold Pinter's "The Birthday Party".

March Duty Calendar

Sat. & Sun., 4th & 5th.
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Ballantine
Mr. Dowie

Sat. & Sun., 11th & 12th.
Mr. Tuckwell
Dr. Oswald
Mr. Aston
Dr. Jackson
Mr. Fuller

Sat. & Sun. 18th & 19th.
Prof. Taylor
Prof. Scowen
Mr. Jackson Burrows
Dr. Boulton
Mr. Cope

Sat. & Sun. 25th & 26th.
Mr. Hunt
Sir Ronald Bodley Scott
Mr. Aston
Dr. Cole
Mr. McNab Jones

Physician Accoucheur for March is Mr. G. Bourne.

EXAMINATION RESULTS

CONJOINT BOARD FINAL EXAMINATION JANUARY, 1967

Pathology

Tatler, G. L. V.	Macfarlane, D. E.	Kennedy-Scott, J. P.	Coles, R. W.
Evans, C. W.		Clayton, R. J.	

Medicine

Browne, D. S.	Riddell, R. H.	Foster, E. A.	Barnett, R. J.
Macfarlane, D. E.	Watkins, C. J.	Roberts, M. E.	Porcherot, R. C.
Clayton, R. J.	Ferguson, A.	Church, J. J.	Rousseau, S. A.
Hillen, H.	Newbold, M.	Coltart, D. J.	Burgess, E. M.
Rawlinson, K. F.	Thomas, W. O. H.	Morris, R. H.	Evans, G. A.
Turner, J. M. M.			

Surgery

Harfitt, R.	Morison, S. R.	Browne, D. S.	Barber, E. R.
Keighley, M. R. B.	Royds, R. B.	Barnett, R. J.	Griffiths, N. J.
Thomas, W. O. H.	Etheridge, R. J.	Wheeler, T.	Church, C. G.
Coles, R. W.	Mathur, V. K.	Blackburne, J. S.	Challen, P. D.
Pope, D. C.	Jennings, J. A.	Sykes, E. E.	Coltart, D. J.
Brown, A. A.	Pindred, J. R.	Foulkes, J. E. B.	

Midwifery

Evans, C. W.
Cameron, D. J.
Bowen, M. M.
Keighley, M. R. B.
Darch, G. R.
Macfarlane, D. E.
Barrington-Ward, E. J.
Townsend, J. A.
Challen, P. D.
Mitchell, J. N.
Miller, R.

Hambly, M. T.
Fogarty, P. M.
Bradley-Watson, P. J.
Harker, N. E. M.
Stallard, M. C.
Davies, P. P.
Dunn, G. O.
Kennedy, P. B.
Johnson, G. W. E. J.
Johnson, R. W.
Greig, A. M. W.

Volkers, R. C.
Sykes, C. A.
Hobbs, J. H.
McCaldin, C. L.
Setchell, M. E.
Pemberton, J.
Spring, J. T.
Ratsey, D. H. K.
Miles, D. P. B.
Libby, G. W.
Jeffries, J. D.

Barker, M. J. M.
Goss, W. H.
Quinn, P. M.
Silverton, J. S.
Mumford, G. H.
Lamerton, R. C.
Jack, B. A.
Harker, P.
Gribble, R. J. N.
Begent, R. H. J.

The following have completed the examination for the Diplomas M.R.C.S., L.R.C.P.

Browne, D. S.
Barnett, R. J.
Turner, J. M. M.
Coltart, D. J.
Blackburne, J. S.
Thomas, W. O. H.
Morison, S. R.

Abernethian Society

Thursday, 26th January:
Sir Derrick Dunlop, M.D., F.R.C.P., F.R.S.Ed.,
"The Drug Problem".

It was a great privilege at this first meeting of the term to be addressed by Sir Derrick Dunlop, formerly Professor of Clinical Medicine and Therapeutics at Edinburgh, and now Chairman of the Drug Safety Committee. In a lecture of great charm Sir Derrick showed himself to be a man of intellectual perspicacity, thoroughly abreast of the developments and problems of therapeutics.

It has been said that the medical knowledge gained over the last fifteen years is equivalent to the whole of that gained in the previous six millenia. The advances in therapeutics have been exceptional, and few fields have needed more attention to separate the unavailing from the efficacious. In his opening remarks, Sir Derrick commented that with increasing age he seemed to acquire an interesting ability to visualise the intricacies of both sides of a question. In support of this he treated us to a brilliant satirical exposé of the "drug trade" vis à vis the "pharmaceutical industry", the moral of which seemed to be "beware of dogmatism".

Sir Derrick then described in broad outline how a new drug is evaluated. Animal and limited human trials lead to full scale clinical trials. There is an essential need for *controlled* trials, a principle which is a product of the last century, and yet which is still not applied to every trial. There are many problems involved in trials, but one of particular note is caused by the practice of multiple drug therapy—in the medical wards of one hospital, the average number of drugs taken by each patient was 14! Ethical problems are raised too when well tried remedies may have to be withheld whilst a new drug is being assessed.

Sir Derrick concluded with a brief synopsis of the work of the Committee that familiarly bears his name. Since its foundation in January 1964, following the thalidomide disaster, data concerning 2,000 drugs had been submitted for assessment. This represents *every* new drug and formulation released in this country, although there is no law binding the manufacturers to submit their products. After assessment, a few drugs were withdrawn spontaneously by the drug companies, and of the rest none had been rejected outright, although some 60 were referred back for more information.

It is a rare pleasure to listen to a man with the unusual combination of erudition and humility, and the Society fully endorsed Dr. Paul Turner's warm vote of thanks to Sir Derrick.

P.B.W.

UNAUTHORISED IMMIGRANTS

by S. G Browne

No legal enactment can keep them out. No imperturbable immigration official knows how to detect them or has the authority to send them back home. And the prying eyes and insinuating fingers of the fussiest of customs officers fail to find them. They get through without causing the merest flicker of an eyebrow.

I am not referring to the frightened snake that on occasion slithers from a cellophaned bunch of bananas at Covent Garden, or to the twelve-inch lizard that once popped out of a brief-case of mine when I was flying from Lagos to London—to the consternation of the air hostess. Smaller and more dangerous travellers become air-borne within the pressurized cabin of a "jet", and ticketless anopheline mosquitoes and glossinae, as well as *Culex* sp. and *Aedes* sp., may well smile disdainfully at a few perfunctory squirts of insecticide-impregnated aerosol, and live to bite another day.

Other guests, visible to the naked eye, whose activities are felt by the naked skin, may be transported in the hidden intimacy of clothing, or in the hairy arcanae of the body all the way from the lush tropics to the harsh concrete wastes of Clerkenwell.

Such uninvited guests pursuing their journeys for unauthorized purposes pose considerable problems as vectors of unfamiliar diseases, but —fortunately for medical officers of health— conditions are rarely propitious for either multiplication of the vector or development of the disease agent. Thus, apart from a rare localized appearance of yellow fever or malaria, an outbreak of vector-borne disease where the index case has entered by ship or 'plane, is quite uncommon; given the existing standards of hygiene and sanitation, such diseases have little chance of becoming established in this country.

It is quite otherwise in the case of diseases whose transmission is not dependent on the availability of vectors with well-defined environmental requirements. Thus, smallpox and tuberculosis introduced from abroad could once again prove to be considerable—if not major—public health hazards. The concatenation of susceptible individuals and opportunities for dissemination of the agent—with no need of a vector or of a particularized micro-environment—may yet produce a few headaches in the public health sector. And when, as in the case of tuberculosis, a highly susceptible population is living in suboptimal hygienic conditions and exposed to resistant strains of organisms, the stage is set for interesting, and perhaps serious developments.

Much water (highly odoriferous, and noxious from sewage effluents, by the way) has flowed under the Thames bridges since the iconoclastic and dramatic episode of the Aldgate pump a century ago, and we today are inclined to pride ourselves on our freedom from major water-borne epidemics. But the salmonellae are by no means permanently banished from our shores, as recent events have shown, and the toxic and lytic activity of Shiga and Flexner and their relatives, and doughty pathogens like *E. histolytica,* not to speak of the new-fangled exotic or native viruses—all serve as reminders both of the vulnerability of the human gut and the ubiquity and diversity of its enemies.

It is, however, the individual who has been exposed to environments in which certain infections and infestations are far commoner than in temperate climates, who poses the

majority of the diagnostic problems for the practitioner in Britain. Not only are there in this country about a million people who were born outside these shores, but every year, travelling by air and sea (and, when the Channel Tunnel becomes a reality, by land) millions of staid little Englanders will spend as long as (and as much as) the Chancellor of the Exchequer will allow, in "furrin parts". Travel not only broadens the mind; it may infect the brain (with viruses or trypanosomes), and contaminate the blood (with malarial parasites and Bancroftian microfilariae), and parasitize the intestinal tract and lymphatic vessels (with worms and snails, and cercarial tails).

Nowadays, the geographical history of a patient may be more important than the family history or the record of childish ailments. "Where have you been?", "When were you there?". "How long were you there?" are questions that should come unbidden to the tip of the tongue whenever the practitioner sees a patient. And, of course, asking such questions presupposes at least a nodding acquaintance with geographical pathology—what diseases exist where, and how they manifest themselves, and how they are transmitted . . . and, for good measure, how they should be treated. The main point, of course, is to get into the habit of thinking of these exotic visitors and of including them in the differential diagnosis—not in bold capitals necessarily, but certainly in small and clear print towards the end of the list.

If this were done routinely, we should be spared the tragic spectacle of deaths from undiagnosed malaria in folk who had spent a single night at a North African port while on a Mediterranean holiday cruise. Nor should we have to wait for the development of paralytic clawing of the hand before leprosy is correctly diagnosed in a man who has borne the label "hysteria" for several years, or see cases of the erythema nodosum of leprosy confidently reported as examples of familial Weber-Christian disease.

Some diagnostic errors are amusing and instructive: others may be fraught with serious, and perhaps fatal consequences. And, in any case, the practitioner has failed to provide the patient with the competence and consideration he has the right to expect. The ordinary doctor cannot of course attain a compendious knowledge of every disease, and like Goldsmith's schoolmaster bask in the admiring gaze of the rustics who wondered "that one small head could carry all he knew." Nevertheless the rare is now commonplace and the exotic has become native.

Today, the practising urologist must be familiar with the cystoscopic appearances of schistosomiasis, just as the proctologist must be able to recognize the sigmoidoscopic picture of amoebiasis. It is not only trachoma that presents itself in our Eye Departments, but onchocerciasis and the acute irido-cyclitis of leprosy and toxic amblyopia. The palmar hyperkeratosis of tertiary yaws may pose diagnostic problems to the dermatologist, just as the bony manifestations of this disease may puzzle his orthopaedic colleague. Trypanosomiasis must now enter into the differential diagnosis of cervical adenitis, apyrexial tachycardia and persistent headache; Bancroftian filariasis may simulate diverse lymphatic conditions. To the long list of causes of splenic enlargement must now be added a number of conditions found commonly in the tropics.

Helminth infections, nutritional deficiencies, blood dyscrasias, thalassaemia, abnormal haemoglobins, iron-deficiency anaemias, tropical neuropathies and dermatoses, are all being seen in increasing numbers in temperate climes. Some neoplastic conditions like Kaposi's sarcomatosis, Burkitt's lymphoma, primary hepatic carcinoma and melanoma are met with among the dark-skinned more commonly than among Caucasians. A confident diagnosis of furunculosis may be suddenly upset when larvae of certain tropical flies emerge from the "boils". Other larvae may wander under the skin or in the central nervous system.

'Tropical diseases' do not exist, just as the entity that used to be called 'tropical medicine' is now seen to be a misnomer. With the tremendously accelerated opportunities for contact today and the greater mobility of populations, exotic visitors from abroad not only come unbidden to our shores but some of them actually make themselves at home among us. For the sake of our patients and the community, we ought to get acquainted with them and learn something of their habits and pathogenic proclivities. Perhaps we shall then be able to limit their depredations.

EXPOSURE AND SURVIVAL

by R. J. Horton and R. E. Franks

In this Age of leisure more people every year leave the crowded cities at weekends and go into the mountain areas, where they can wander all day without meeting a soul. Regrettably this idyllic state is all too often shattered by accidents occurring to people enjoying themselves in the hills. Over 200 accidents occur annually; some involving physical injury, especially to rock climbers who are pursuing a dangerous sport and taking calculated risks. However, the sad catalogue contains many instances where a death has occurred as the result of exhaustion and exposure, mostly in circumstances which could have been avoided.

It was on the note of "survival" that a recent conference, organised by the Boy Scouts Association, South London, was held, and various aspects of the problem considered by the leaders of one of the largest groups to be found on the hills today. The meeting was addressed by Dr. L. G. C. E. Pugh, an expert on exposure, who examined some of the recent research on this subject, and others who spoke on more general aspects of mountain safety.

The climate of the British Isles, with its liability for rapid deterioration in the weather, is probably the worst for bringing about the exposure situation. Many of those who go into the hills of Britain for recreation have little knowledge of the countryside, are unable to read a map and are inadequately equipped. It is not generally realised that, should the weather deteriorate, the temperature on the top of a mountain can fall very rapidly to around freezing, and is often accompanied by strong winds and rain. It is under these conditions that disaster can occur, as a result of cold combined with wet and wind. An example will serve to illustrate the kind of situation where exposure occurs and some of the results that may arise from it.

"A.B., aged 35, and his brother Z.B., aged 16, set out on August 24th 1962 in heavy rain and mist to walk across Carneddau ridge. When they reached the ridge, visibility was poor and there was a strong wind. They had a compass but appeared to be walking in circles. Eventually they began walking either side of the ridge. Communication was impossible because of the high wind, and after some time they lost contact. When darkness fell, Z.B. lay down behind some rocks and slept. He woke later and moved to a better shelter and slept again. At daylight he found he could not move his legs. The weather was clear but by the time sensation had returned to his legs it had deteriorated again, and he sat there until the early afternoon. Eventually the weather cleared and he found his brother dead within 50 yards.

He made his way down to Bethesda and gave the alarm. His brother, who was an experienced hill walker was found sitting below the crest of the ridge with his rucksack on his back, with a sleeping bag in it. He was wearing a cellular vest and pants, a thin khaki shirt, denim trousers and an anorak." (Pugh 1966.)

The factors which might appear to have led to the death of A.B. are: Weather conditions; inadequate clothing; exhaustion and lack of fitness; inexperience under the conditions and lack of judgement. From this and many similar instances it becomes clear that the most important factor in the exposure situation is the presence of wet/cold conditions, and the above factors, and others, act to modify the effect.

Under the wet/cold conditions commonly met with in British mountains, there is a rapid fall in the thermal insulation properties of clothing worn by average walkers, and under these conditions there is rapid heat loss. Experiments carried out using this type of clothing (Anorak, shirt, string vest and pants, jeans, socks and boots.) have shown that the major heat loss of the body occurs from the head and also from the waist down; about half the total body surface. The insulating value of this type of

clothing is about 2.5 clo. (1 clo is the insulation afforded by a business suit at 70°F in still air). Under wet/cold conditions the insulation falls to about 0.5 clo, most of which is supplied by the layer of air between the skin and clothes. The insulating property of clothes falls still further on movement because of the bellows action of tight clothes, moving stagnant air out and replacing it with cold air. In this situation heat loss is very great and in many cases it is not possible for a person to maintain an energy output sufficient to counteract this heat loss. About half the body energy must be expended in heat production so that efficiency is about halved. This brings about a vicious circle of increasing heat loss and falling energy production, leading to a fall in the deep body temperature. In fit individuals it has been shown that their energy output is so great that heat loss is easily counteracted and they operate as if in dry conditions (Fig. 1). In the wet/cold situation, subjects become exhausted in half the time it takes under dry conditions. If by injury to himself or another member of his party a fit person is forced to travel slowly, his energy production may fall below the critical level, and he too will fall a victim of exposure. Heat loss does not affect the body immediately, as has been shown by most of the accidents that have occurred in British mountains. Except in exceptional circumstances, even unfit people take about 5 hours before the combined effects of fatigue and heat loss begin to take effect and the body temperature starts to fall. The subject then begins to show a series of symptoms of increasing importance, until death occurs.

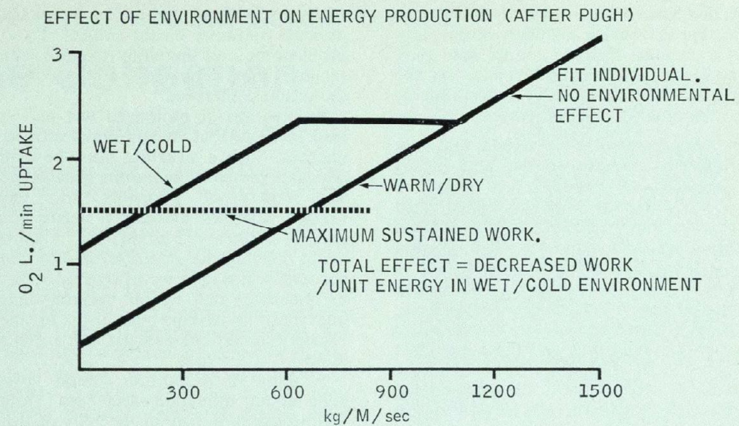
A comparable situation is met with following shipwreck. In the *Lakonia* disaster of December 1963, of the 124 deaths as many as 113 can be attributed to the effect of hypothermia and this despite the relative warmth of the sea in which the disaster took place (17°C.). Effectively one is immersing the unfortunate subjects in a constant temperature water bath, but the same factors hold as for the wet/cold environment in air. Even in water, clothing can provide a considerable degree of insulation, and it was perhaps fortunate in this respect that the Lakonia sank on a cool night. Experimentally exercise invariably increases heat loss, whether clothed or not, and thus once clear of the sinking ship heat loss is reduced by just floating. It was noted that any alcohol which may have been taken by passengers before entering the water is unlikely to have hindered their survival since it does not appreciably hasten heat loss and it may have even helped by lessening the discomfort.

In its early stages exposure may be difficult to detect, and even seemingly minor complaints of cold or tiredness may provide the first clue. Physical and mental lethargy and failure to comprehend questions or directions are also early indications. Complete apathy to the situation is well illustrated by the death of Mr. A. B. who failed to use the sleeping bag in his rucksack, brought for just such an eventuality. The state of apathy may advance to the extent of physical resistance to help, and outbursts of unexpected energy. Sudden fits of shivering, slurring of speech and, in particular, abnormality of vision, may represent the later and thus more severe manifestations of advancing exposure. Perhaps the most serious are the early mental effects leading to confusion which make concentration difficult and often lead to wrong decisions being taken, which, had they been made correctly could have averted the later and more serious situation.

The state of people who have been rescued from mountains varies considerably, from slight confusion to coma, and the extent of the treatment varies according to the severity of the case. Since many cases are in a state of collapse, efforts must be made by the rescuers to prevent further cooling, by protecting the patient from wind and wet. An effective method is to place the patient in two sleeping bags within a waterproof cover (such as a polythene bag) to conserve heat. Once this is done, most patients revive spontaneously. Removal of wet clothing is considered inadvisable as, although still wet, it has a considerable insulation value, once heat loss is prevented. If there is to be a long evacuation by stretcher it is probably better to allow the patient to revive, and provide the patient and rescuers with protection, by camping on the spot, as even with mild cases of exposure a long evacuation has its risks to both patient and bearers.

Some rather macabre research by the Germans during the last war showed that hypothermic subjects could be revived quite rapidly by the use of body warmth, provided in this instance by a prostitute. In this respect it is interesting to note that two such sources of warmth were less effective than one! However, despite its unattractiveness at first sight, similar methods are known to be of considerable practical value, where other sources of external heating are not available.

In cases where stretcher evacuation is feasible or necessary, care is called for in preventing 'head-up' positions since these can lead to cerebral anoxia and convulsions, in hypothermic persons, due to postural hypotension. After rescue, the duration of the hypothermia can be reduced by a number of means, including electric blankets and hot baths. With the hot bath treatment there is massive peripheral vasodilatation and hypotension may result, so that this method can only be used safely for conscious patients. It has however the advantage that patients can be immersed fully clothed. Immersion of the arms alone has been advocated and is said to have a similar rapid effect without hypotension, and might therefore be safer for unconscious patients.



Clearly in this case, as in all others, prevention is better than cure. As was stated at the recent conference, obviously the safest place is at home in bed, but if one must go walking in the hills, preparation is most important, and adequate equipment necessary. Example may be taken from the shepherds and ghillies, who have long been roaming the hills with no ill effects, for they try not to venture forth when the weather is bad, but when they are forced to, do so suitably clothed in a long macintosh and wellington boots. Light waterproof overgarments from top to toe might well prevent most exposure casualties, but they should be voluminous enough to prevent condensation from soaking the clothes beneath. Since not worn continuously, such clothing should be light enough to be carried and used in emergency. As an extra precaution, spare warm clothes might be carried, but it is of little value once wet.

Parties have often started out in fine weather only to be caught up in the hills by bad weather later on. It has already been noted that one of the symptoms of hypothermia is apathy and the tendency under these conditions is to carry on until exhaustion is far advanced and counteraction is more difficult to take. In deteriorating weather, it is best to try to avoid the wet/cold situation entirely. Sometimes it is possible to get off the mountains in time, but more often it would be better to camp and keep dry rather than carry on and get wet. A long and dangerous descent has often landed people in worse trouble than they were in before. For maximum protection it would be ideal if a tent was carried, but many of those currently available are either too heavy or provide inadequate protection. A tent for this purpose would need to be light enough to be carried by one person, strong enough to stand up to high winds, and be completely waterproof.

It has already been noted that fit people tend to survive better, mainly because of their higher energy output and greater reserves of energy. Hence, it would be advisable that all people contemplating fell walking were at least moderately fit; the state of fitness given by regular sporting activity is probably quite adequate. It has been suggested that even a previous mild illness, such as a cold, could contribute to the more rapid onset of exhaustion in some cases, and it might be inadvisable to go hill walking within two weeks of such an illness. The composition of the walking party is also of importance; a wide range of ages in a party will

probably also mean a wide range of stamina and ability, so that the weaker members of the party will tend to become fatigued sooner than their companions and force a slower pace on the whole party, rendering all more susceptible to the wet/cold situation should it occur.

Studies on swimmers have shown that thin people lose heat rapidly at rest and during exercise in water, but fat people lose heat more slowly at rest and may even get hotter when swimming. The importance of subcutaneous fat in preventing heat loss in the wet/cold situation has not yet been completely evaluated, but in the fatalities that have occurred, it has been noted that the majority of deaths were of tall, thin people. Women appear to survive better under wet/cold conditions, and there are some cases where women have survived but men have died. This may be due to the thicker layer of subcutaneous fat with which women are endowed.

In writing a suitable conclusion to this article we were faced with the problem of making certain recommendations as to the prevention of exposure, without setting ourselves up as the ultimate authority on the subject. To solve this problem may we therefore reiterate some of the remarks that were made at the conclusion of the recent conference.

A situation of prolonged wet and cold can lead to a state of hypothermia with its consequences. Such a situation must be avoided by adequate preparation and the provision of warm and waterproof garments and emergency rations, however unlikely it seems that these may be necessary. Further, it is much better to avoid meeting the situation than to combat an encounter, however well prepared. It is as well to remember that by hill walking unprepared one may be risking the lives of the many rescuers should one ever get into a difficult situation.

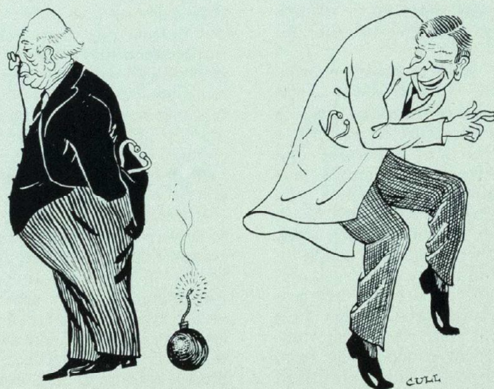
A sense of proportion should however be kept about mountain accidents. Despite the 200 accidents a year in the hills of the British Isles, they only represent a small proportion of those actually indulging in such activities, and it is probably much safer than crossing Oxford Street in the rush hour.

REFERENCES

KEATINGE, W. R. (1965): Death after shipwreck *B.M.J.*, **2**, 1537.

PUGH, L. G. C. E. (1966): Accidental hypothermia in walkers, climbers and campers: Report to the Medical Commission on Accident Prevention. *B.M.J.*, **1**, 123.

BRITISH MOUNTAINEERING COUNCIL, (1964): *Exposure.* Joint circular of the British Mountaineering Council and Association of Scottish Climbing Clubs.



'THE REGISTRARS ARE MORE SENIOR DOCTORS, MOST OF WHOM INTEND TO BECOME CONSULTANTS IN THE COURSE OF TIME'

St. Bartholomew's Hospital PATIENT'S HANDBOOK.

University of London Drama Festival

The Collection

by Harold Pinter

"I congratulate the producer (Mike Knowland) on the marvellous job he has done with one of Pinter's less convincing plays" was the verdict of the adjudicator, Miss Claire Pethick, on the Bart's entry for the University of London Drama Festival. "The Collection" is certainly lightweight Pinter, with a low content of shock lines although bearing the author's hallmark of superb contrapuntal dialogue, but this production succeeded in generating both tension and laughter in a large and appreciative audience. It could be argued that the plot, hingeing on whether James, a young dress designer of lowly origins living in a plush Belgravia flat with Harry, 20 years his senior, did or did not go to bed with Bill's wife Stella, was tipped off balance by the Producer's seeming insistence that James was merely Harry's flat mate rather than a partner in a relationship of higher temperature. Certainly this bias prevented their several catty exchanges from getting off the ground and gave little support for James' insistence to the slighted Bill that sleeping with his wife was "not in my line of country at all". However this did not detract from the excellence of the production as a whole. In Pedro Vieyra, the producer found an actor of real stature, able to portray violence with a refreshing lack of ham, Jonathan Lask, Chris Wood and Barbara Appleby also gave admirable accounts of themselves, and, regardless of the result of the Festival, Bart's can be proud of a fine play.

Richard Staughton

Results: The production gained SECOND PLACE in the *Freshers* Class. Pedro Vieyra won the *Best Actor* award in the same class.

Prospect

"Medicine is a magnificent training for almost anything. Doctors have this wonderful feeling of superiority about human beings and that is what life is about—human beings and the way they act."

Richard Gordon, author (World Medicine.)

Studying medicine can make one appreciate art; meaning art in a more expressive sense than simply as a technique distinct from scientific skill: Art which expresses the beauty of the human form and the variety of life mirrored in it: Art which achieves the feat of reflecting that mirror, of creating that form. On the whole it is the portrayal of the human subject which seems to have caught the imagination of generations. We remember da Vinci for his Mona Lisa and Franz Hals for his Laughing Cavalier. Perhaps it is the perpetuation of brief gestures from a familiar routine which appeals most powerfully. Artists traditionally are very close to the substance of life. They record the daily scenes in the ordinary lives around them; the brushing of hair, old men playing cards, a figure carrying an umbrella. People were as essential to their form of art as to ours. They deal as we do with the essential aspects of life itself: childhood, motherhood, old age and death.

When Michaelangelo was attempting to

create the human form in the only way men can, he scoured the streets of Florence watching the blacksmiths, the stone-masons and the sand-dredgers on the Arno. In their activity he found both inspiration and frustration. He was attempting to create from within, the shapes he saw only from without. Figures in the round had to be complete, seen from every angle. A sculptor could not create movement without perceiving what caused the propulsion. Michaelangelo's great ambition, misguided though it may seem to the sheltered modern student, was to dissect. This he accomplished at dead of night in the mortuary of a Florentine charity hospital, taking with him only one three-hour candle to prevent his fascination from blunting awareness of time. At this period of superstition and religious preoccupation in which Savaranola thrived, the penalty for violation of the dead—was death. Even Michaelangelo had qualms. He vowed to refrain from dissecting the soul should he stumble across it.

In our profession we are in the position not only of seeing the subject as the artist might see him and assessing facial expressions and attitudes in visual terms, but also of knowing the history from which they result. We may not excel at naming and dating a work of art (Botticelli isn't a wine—it's a cheese: *Punch*). As Richard Gordon said in World Medicine recently, "It's a big vulgar hospital full of big vulgar students." But at least we can make, first hand, our own assessment of the greatest work of art yet perfected; a design conceived, pondered upon and devotedly created, with some assistance, by the female of the species.

E.A.M.

The RAHERE ENSEMBLE *at College Hall*

David Baker, *Flute*; John Brett, *Violin*; Michael Spira, *Violin*; David Havard, *Violin*; William Goss, *Cello*; James Swainson, *Viola*; Alan Gray, *Virginals*; Janet Wayes, *Flute*; Hugh Whitfield, *Basson.*

On the evening of 2nd February, Bart's Rahere Ensemble gave its second major chamber concert. The large audience heard a programme that was in many ways a considerable advance on its predecessor, and in most respects their enterprise was a complete success.

This time the group was augmented by a bassoon, three violins, a viola and a second flute—thus enabling a wider range of works to be heard. Amongst the least notable was Villa-Lobos' Bachianas-Brasileiras No. 6 for flute and bassoon. David Baker and Hugh Whitfield, undaunted by its negligible musical content, produced some faultless and impressive musical calisthenics from the score, and it was interesting to hear a piece in which the bassoon features entirely in its own right, instead rather than as a glorified substitute for bass continuo.

This, with two of Handel's trio sonatas—both played with style and sensitivity—made up the first half of the programme.

A Pergolesi concerto for flute, two violins and continuo opened the second half, and taken in conjunction with Beethoven's duo for flute and bassoon which followed, certain points emerged. In general, I felt that the tempi adopted by the group were a shade too fast to allow them to phrase with real confidence and assurance, music that is well within their ability otherwise. Though this is more obviously relevant to the allegro and presto sections, the heart of such music often exists in the slow movements, and it is here that to breathe and expand is of the essence. With their evident sense of style, the ensemble need have no fear that broader tempos might diminish the vigour or momentum of the music. Quite the reverse in fact, as they showed in the 4th Brandenburg Concerto which concluded the programme—where the technical difficulties of the last movement must have compelled a slower tempo than one usually hears. This was in every way admirable and there emerged as a result countless details of the score that tend to become obscured in more hurried readings. It was a fluent and beautifully conceived performance.

The Rahere Ensemble remains perhaps one of the finest institutions this Hospital can boast.

R. S. Thompson

Hydranencephaly

by

M. R. B. Keighley

A Report of a case seen at

NOTRE DAME BAY MEMORIAL HOSPITAL, Twillingate, Newfoundland

Antenatal Booking

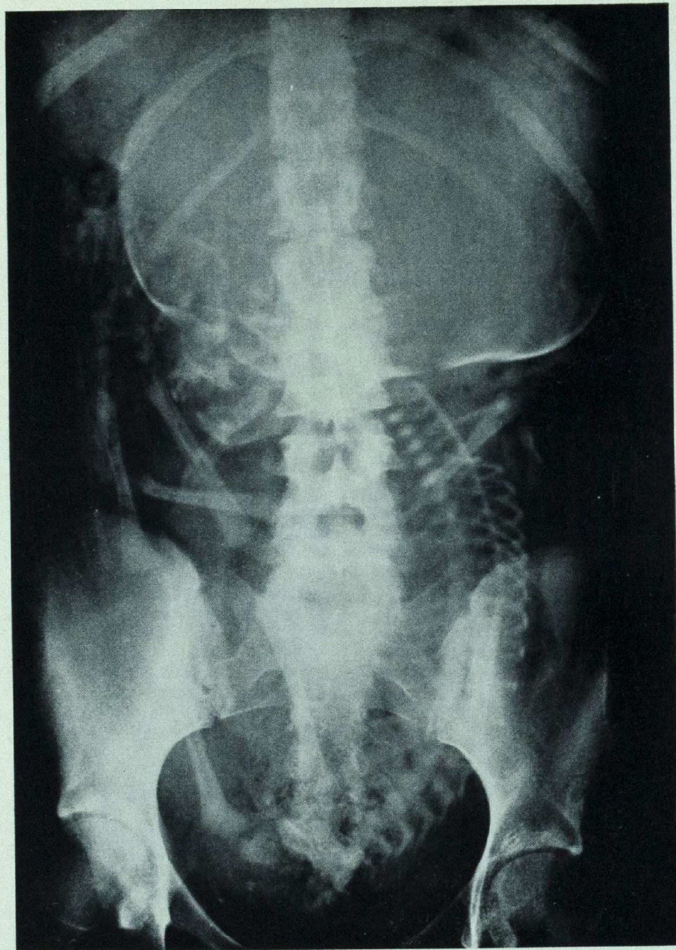
A sixteen year old Primagravida was sent up to the outpatient department as a case of a breech presentation to be confirmed by X-ray. It was at this time that the patient was first seen. She was then at full term. Having enquired when she had last seen her doctor for an Antenatal check up, it soon became apparent that she had only once attended and this was when she was 25 weeks pregnant. This is so typical of many young Primagravida in this part of the world, having missed two or three periods they attend the doctor to confirm that they are pregnant, and are not seen again until term. The patient gave a history of an entirely uneventful pregnancy and a previously regular menstrual history with some congestive dysmenorrhoea. Examination revealed a full term uterus with a tense abdominal wall now presenting as a breech with extended legs. The head, however, felt very large; there was no evidence of Hydramnios and the foetal heart was heard just to the left of the umbilicus. On assessing the size of the pelvis both spines felt prominent, the promontory was just palpable and the intertuberous diameter only three knuckles in width. A diagnosis of breech presentation, hydrocephalus and outlet disproportion was made, which was confirmed by X-ray showing gross Cephalo-Pelvic disproportion. The patient was Rhesus positive, her haemoglobin was 72%, the W.R. was negative and further investigations were all normal.

Caesarean Section

It was decided that an External Cephalic version under general anaesthesia was out of the question because of the disproportion and the foetal size. Vaginal delivery and cephalic decompression was considered. Despite her parity and the complications of the classical Caesarean section, it was suggested that for the size of the head and its position an elective classical operation should be arranged before labour began. The operation was performed by Dr. J. M. Olds, M.D., and on opening the uterus there was no evidence of hydramnios, on the contrary very little amniotic fluid was seen. The head was grossly enlarged and despite the length of uterine incision took 4-5 minutes to deliver after breech extraction. The child cried soon after birth and was placed in the incubator, closure of the abdomen and uterus was uneventful and the patient returned to the ward in good condition.

Paediatric Assessment

The infant, a girl weighing 10 lbs. 3 oz. remained well for the 48 hours after delivery. Examination suggested that neurologically there appeared to be no gross deficiency. The eyes appeared active and responded to light, she cried normally but in a rather weak manner and responded to painful stimuli. The sucking reflex was present as were the "Moro" and grasp reflexes. The occiput felt extremely boggy and fluctuated on palpation, there was a soft haematoma over the left parietal region but this became progressively organised. The question of determining whether the hydrocephalus was of communicating or non-communicating type was discussed, but it was felt that as the child appeared to be a good operative risk, the danger of introducing infection contra-indicated this procedure.



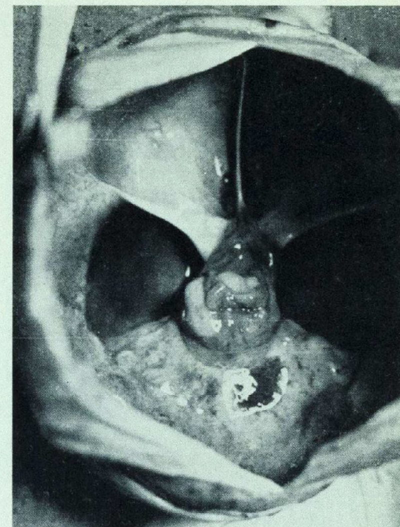
X-Ray showing Cephalo-Pelvic disproportion and Hydrocephalus

Decompression Operation and Post-Operative Course.

A drainage operation was arranged, but because of previous post-operative blockage using the Spitz-Holter valve technique, Dr. Olds had decided if possible to attempt drainage by his own method. This is an operation whereby the thoracic duct is cannulated rather than incorporating a valve. He has found that the mothers in Twillingate are unable to keep the valve patent by pressing it each day. The thoracic duct has a series of competent valves at its distal end and because of its attachments to the subclavian vein it makes despite its size an excellent natural valve to the right heart. This enables a decompression to be performed without the use of the Spitz-Holter valve—an advantage in cost and the complication of subsequent valve blockage.

A small incision was made over the mid-temporal region of the left side and a flap of bone raised. The dura was carefully incised and a lumbar puncture needle inserted into the ventricle. The cerebrospinal fluid was collected and a pressure of 200 mm. was recorded; the fluid showed Xanthochromic staining and appeared straw coloured. A length of polyvinyl tubing was guided along the bore of the lumbar puncture needle which was subsequently removed and the fluid allowed to drain freely; a specimen was sent to the laboratory. A 1½ inch incision was made parallel to, and just above the clavicle and the sternomastoid retracted medially. The subcutaneous tissues appeared very oedematous and the structures were identified with great difficulty. A thorough search was made for the thoracic duct, but it could not be identified, the jugular vein was abnormal and only a small vein could be found. The thoracic duct operation was abandoned and it was felt that the vein exposed might just be large enough to cannulate for the insertion of a Spitz-Holter valve. 2 c.cs. of 2% Xylocaine (without Adrenaline) was injected into the vein in order to dilate it so that the cannula might be inserted; the vein responded and the cannula was fed down towards the right heart. The child soon became very blue and respiration almost stopped, the heart rate was low and heart sounds very soft. Pure oxygen was given and 0.75 mg. of Nikethamide injected intravenously. The child's condition improved and colour returned to normal. The subcutaneous tissues were tunnelled from both ends. The cannula in the neck veins and the tubing draining the ventricle were connected to either end of the valve and placed between the two incisions subcutaneously. The decompression was shown to be patent by saline injection and cerebrospinal fluid drained freely. The bone flap was closed and sutured with wire and both incisions closed. The child returned to the ward in a satisfactory condition.

The child was reassessed 3 hours later and she appeared to be breathing well, crying normally and her eyes reacted to light. The following morning she appeared much as before. 24 hours after the operation, she was breathing poorly and there was a marked bradycardia, another 0.75 mg. of Nikethamide was given with intravenous "Reverine". She showed some improvement but died half an hour later.



Intra-cranial pathology:—absent cerebral hemispheres brainstem remnant, and cerebellum under the tentorium.

Post-Mortem Examination

A post-mortem was arranged that afternoon. On opening the abdomen the stomach was acutely dilated but no other abnormalities were found. The chest and neck were normal apart from the venous drainage to the right heart. The Innominate vein was abnormally high and very small and both Jugular and Subclavian veins on the left side were very small. There was no evidence of dysmaturity, and no further congenital abnormalities apart from the cerebral pathology were found. On opening the skull and dura, despite the fact that these structures did not appear to be under great tension, 500 cc. of clear straw coloured fluid poured out. On looking into the cranium nothing could be seen, only an empty cavity previously filled with cerebrospinal fluid. Taking a more careful look, there was a tiny nubbin of brain tissue at the base of the skull which was medulla and mid-brain covered by choroid plexus. There were no cerebral hemispheres, the cerebellum was intact under the tentorium. The cause of excessive production of fluid soon became apparent, as

and middle cerebral vessels are present. there was a blockage in the Aqueduct of Sylvius, and the choroid plexus above the brain stem lay cerebral to it. This was a case of hydranencephaly, a rare cause of neonatal hydrocephalus.

Discussion

(a) *Obstetric Presentation and Management*

In most cases of breech presentation after 36 weeks no known cause can be found, but it is worth remembering that in 6% of cases this is not true, and these conditions should be considered when one is confronted with a presenting breech near term. Pelvic contraction, placenta praevia and pelvic tumours are all implicated as causes of the head being unable to descend into the pelvis. Oligohydramnios is said to prevent normal rotation of the foetus and multiple pregnancy is a further cause. The Grand Multipara and the patient with hydramnios are both associated with abnormal presentations. The baby may deliver before normal rotation in utero occurs, and thus there will be a high incidence in premature babies. Of the foetal abnormalities hydrocephalus is the commonest cause of breech presentation from failure of the foetus to rotate or failure of the head to descend into the pelvis. This patient not only had a hydrocephalic foetus, but also a contracted pelvis and evidence of oligohydramnios to account for the presentation.

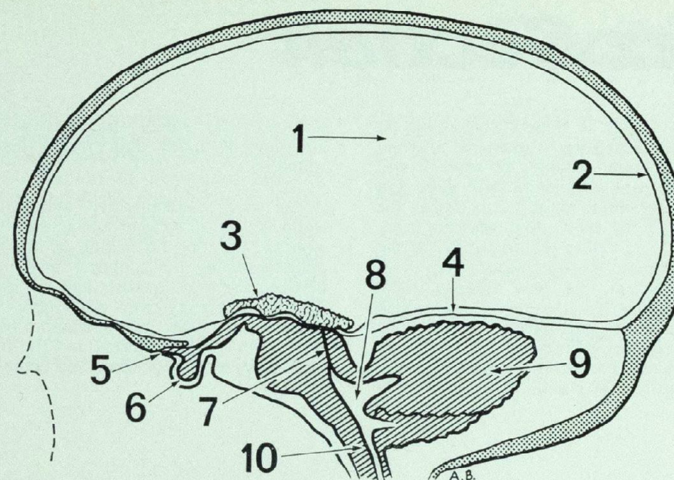
The management of a hydrocephalic breech presentation depends on many factors. Some would say that in a viable foetus with a small hydrocephalus an attempt should be made to deliver a live infant, in these cases a subsequent drainage operation will be most beneficial. However, most people consider any form of hydrocephalus an indication for a destructive procedure. Careful assessment of the foetal skull measurements and pelvimetry are made before excluding vaginal delivery. In the case described the degree of hydrocephalus and the gross pelvic disproportion meant that even if a destructive procedure were adopted, vaginal delivery would be impossible. The latter was considered, but owing both to the small pelvis and large infant it was considered that the risk of damage to the pelvic structures was too great, especially with the added risk of sepsis that might also occur after a long vaginal manipulation. In a dead foetus or one with gross abnormalities detected on X-ray, delivery of the after-coming head vaginally is possible by tapping the cerebrospinal fluid, by spinal puncture or a catheter up the spinal canal, to decompress the head. The classical Caesarean section has largely gone out of practice now, because it is known that with a lower segment section the risks of adhesions, the isolation from the main peritoneal cavity and the added protection that the loose lower segment peritoneum affords, all make the operation a more isolated one from the abdominal cavity and thus fraught with few subsequent complications. The incision is less vascular and it is said that it heals better in the puerperium, with a lowered risk of uterine rupture in subsequent pregnancies. However, the lower segment incision is a difficult one to enlarge should the delivery be difficult and if this occurs splitting of the uterine incision and rupture of the uterine arteries can be a rapidly fatal complication if the bleeding cannot be controlled and will often necessitate a Caesarean Hysterectomy. It was for reasons of gross hydrocephalus that a classical incision was decided upon for the delivery of this child, and even then delivery proved difficult.

(b) *Treatment of Congenital Hydrocephalus*

Many surgical procedures have been attempted in the treatment of congenital hydrocephalus but most have been disappointing. Openings in the corpus callosum and floor of the third ventricle have been made and excision of the choroid plexuses in the lateral ventricles was adopted, but these procedures have fallen into disrepute. Attempts have been made to drain the cerebrospinal fluid into the peritoneal cavity or to use the ureters. The most popular method today is the use of the Spitz-Holter valve in the drainage of fluid from the lateral ventricles to the jugular vein. It was interesting to find in this out-lying hospital at which the patient presented, that the surgeon there had added to the list of the above procedures and had devised his own drainage operation of the lateral ventricle by using the thoracic duct with its own valve system, thus dispensing with the Spitz-Holter valve.

(c) *Pathology and Clinical features of Hydranencephaly*

Hydranencephaly is a congenital anomaly of unknown aetiology characterized by a complete or nearly complete absence of cerebral hemispheres. From case reports it would appear that the degree of absence of brain tissue is variable, but in all cases the vault of the skull is normally developed. There may be normal development of the third and fourth ventricles and aqueduct with a shell of cortex around a sac of cerebrospinal fluid. This is thought to be due to gross hydrocephalus which has occurred early in neonatal life and on arteriography the anterior



1 Fluid filled space of C.S.F.
2 Ependymal lining of sac of C.S.F.
3 Choroid plexus
4 Tentorium Cerebelli
5 Optic Nerve
6 Pituitary
7 Blocked Aqueduct
8 Third Ventricle
9 Cerebellum
10 Brain Stem

A Diagram of the Post-mortem Findings

Simple agenesis of the cortex occurs in some cases and no forebrain exists at all, in these cases arteriography only shows vestigial arteries above the bifurcation of the carotid. Obstruction in utero is another cause, a high intrauterine pressure preventing enlargement of the head with cortical atrophy, this is sometimes associated with oligohydramnios. A condition has been described in which cytomegalic inclusion disease has been found in association with the condition. Pathological variations in this condition are numerous but the majority of cases seem to have intact basal ganglia, the cerebellum, midbrain and hindbrain are all present with a variable degree of cortical preservation. Aetiological factors apart from those mentioned above include congenital syphilis, listeria monocytogenes and toxoplasmosis, but none have been proven.

The clinical features of this condition are that of an infant with a large head at birth and prominent superficial veins with wide sutures and a fluctuant swelling beneath the sutures, there is a palpable thrill. The diagnosis is confirmed by transillumination in a dark room and by ventricular tap, when fluid will appear immediately the dura has been pierced. Strangely enough the child behaves in a fairly normal manner soon after birth, with normal primitive reflexes. Impaired cerebral functions become apparent after a few months, few children attain the age of one year.

Summary

A case of hydranencephaly seen in pregnancy as a cause of breech presentation in a primagravida requiring a classical caesarean section for delivery is described. Despite a low pressure being recorded from ventricular 'tap' at operation and the fluctuant cranial swelling seen pre-operatively, a drainage operation was performed in this rare congenital anomaly, the prognosis of which could not have been improved.

Jazz Section

The word JAZZ is almost impossible to define adequately because it provokes different responses in different people. To some it still has an unfortunate association with dope and the seedy underworld, to others it means the music of the early 1960's that was the great commercial sound before the arrival of the big beat group sound, Beatles, Stones, etc. This "Trad" era brought the New Orleans sound into most homes of the land, but today the "trad scene" has lost much of its following among the youthful clientele of the clubs and the record shops. To others the word signifies a form of music that claims to be considered seriously and which deserves the listener's attention as more than just a background sound.

The more contemporary, and some would claim, advanced style of jazz is that designated *modern*, but this distinction is in some ways perpetuated by the snobbery and antagonism between the traditionalists and the modernists. This brief survey will deal more with this modern jazz, since the contributors believe this is the music of the present and the future, but trad, however, is not dismissed completely out of hand.

Jazz Section

Jazz aficionados are a mixed bunch, they come in all shapes and sizes, and from all walks of life (Russian Premier Kosygin it is reported, is an ardent admirer of Thelonious Monk!) and are united by their common interest. They are a minority group and in consequence tend to adopt a rather aggressive attitude to criticism, which is reflected in the somewhat offbeat humour that is part and parcel of the jazz scene in Britain today, and the fanatic intensity of discussion among the cognoscenti, whose conversation may seem completely unintelligible to the casual eavesdropper. *The Jazz Score* pokes gentle fun at this.

The other articles attempt to orientate the reader historically and musically, but jazz is the music of the individual or individuals, it is the spontaneous creation more or less of the moment, and while recordings provide much pleasure, there is as in Classical music, no substitute for the "live" sound! Live jazz can be dull or exciting but it is always interesting for one must attend to the pattern of improvisation and the forms of the musical arrangement. Hence the final guide to the "London Scene".

JAZZ IN BRITAIN ORIGINS & DEVELOPMENT

by Roger Rolls

Jazz is a creation of the American Negro, born in the prisons and cotton fields of the United States. Many developments in its form have taken place since those beginnings and jazz has established itself among people all over the world.

Negro music from America was not unknown in this country during the last century. Several visits were made by American Minstrel Singers, and Spirituals became as well known as traditional English songs. It was not until 1919, however, when the Original Dixieland Jazz Band arrived in London that jazz made its initial impact in this country. An earlier visit had been made by the Original American Ragtime Octette to the London Hippodrome in 1912 which had resulted in scores of bands springing to life up and down the country, all claiming to be jazz bands, but which were essentially dance bands playing heavily syncopated versions of standard dance tunes. The accent was on novelty and noise, and for this reason the early exponents of this new musical form had a very mixed reception. The musical director of the Coliseum defined jazz as "a piece of music entirely surrounded by noise". Not only were there very few enthusiasts, there was also an overwhelming antefaction. Large sections of the Church and older generation *en masse* denounced the music as a menace to morality.

The Original Dixieland Jazz Band opened at the London Hippodrome along with George Robey. After only one night's performance they were dropped. The audience wanted George Robey and neither wanted the O.D.J.B. Then, on 28th October, 1919, the band was featured at the Hammersmith Palais. Surprisingly they were a success, though it has always been doubtful whether their success was due to the music or the brand new luxury ballroom.

Jazz was slow to develop and by the 1920's Dixieland had almost been washed from our shores. Big bands were the rage, and men like Jack Hylton and Bert Ambrose led bands which, even if they showed some degree of jazz influence, were a far cry from the jazz bands playing concurrently in America. Gramophone records and occasional visits by American musicians were the only experience England had of jazz at that time. Most people still regarded jazz as an irresponsible cacophany, an image not helped by the Mound City Blue Blowers' visit in 1925 which featured guitars, kazoo, suitcase and wrapping paper as its main instrumentation. But there was one small group of musicians who did not share this infamy; led by Fred Elizalde a Spanish-American undergraduate at Cambridge, they were first featured in a "Footlights" revue and subsequently called themselves the Quinquaginta Ramblers. Fred played piano alongside his brother, Manuel, who switched between clarinet and saxophone. By 1927 Elizalde had made several records and was becoming a minor sensation. He was invited to play at the Savoy Hotel, an event which indicated that a change in attitude towards jazz was approaching. Until 1930, when he returned to Spain, Elizalde was a regular contributor to the Melody Maker. His place, both as a band leader and as contributor to the paper, was taken by Spike Hughes. But it was not long before Hughes left for America.

In the next ten years a number of important figures were to emerge, among which George Chisholm is probably the best known. But about this time, a severe blow was struck against British jazz. A dispute between the *Musicians' Union* and America's *Federation of Musicians* in 1935 resulted in a ban on all visiting American bands and it was not until 20 years later that the dispute was finally settled and the ban lifted. The absence of visiting musicians isolated British jazzmen from the developments taking place in America, and the only contact was through records or informal visits made to America by British musicians.

The nineteen forties saw a revival in New Orleans jazz, both in America and subsequently here in England. The revival movement was initiated by a pianist, George Webb, who led a band of amateur musicians playing at the Red Barn, Bexleyheath. Among George Webb's band was Humphrey Lyttleton, today possibly the best known jazzman in Britain. By the end of the decade, jazz had gained a popularity which it has probably never seen at any other time in this country. The B.B.C. began a regular Saturday night jazz broadcast called "Jazz Club" which was eventually replaced by a similar programme

now running on Sundays called the "Jazz Scene." These broadcasts have done a great deal to foster the interest in jazz amongst those never having heard the music before.

Jazz Clubs were unknown until the 1940's and sessions were mainly held at "bottle parties" which became popular in London at that time. Clubs like the "Fallardo" (Compton Street), the "Nut house" (Regent Street) and the "Bag o'Nails" (Kingly Street) became favourite spots for keen jazzmen, who would congregate after hours for a jam session. The first Jazz Club, as we know them today, opened at 100 Oxford Street. Originally called the "Feldman Club", it reopened as the "100 Club".

Around this time, *modern jazz* was slowly making its appearance in this country. Recordings of Dizzy Gillespie and Charlie Parker were being brought into the country and were having a profound effect on the course of jazz during the next few years. Musicians like John Dankworth and Ronnie Scott made several visits to America to hear Parker performing. Most important they were able to realize that in this new music was an entirely new conception of harmony and not just a new stylization or way of phrasing. The one British musician who did most to unravel the new harmonic conceptions was Dennis Rose. Rose, who had deserted the Royal Army Medical Corps and was continually in danger of arrest by the Military Police, still managed to play at many of the sessions around London. Later he opened a basement jazz club in New Compton Street called the "Metropolitan Bopera House" where the band, featuring himself on trumpet, often included Scott, Dankworth, Tommy Pollard, Tony Crombie and Lennie Bush. But the club ran for only a few weeks before a much larger club "Club Eleven", was opened in Great Windmill Street in December, 1948. Here musicians could be heard rehearsing or playing most of the day. Subsequently Dankworth left the club to open on his own with his new band at 50, Carnaby Street. However, things began to go wrong almost immediately. Enthusiasm was dwindling and arguments arose over the financial side of the club. The Vice Squad moved in and six musicians were held on drug charges; moreover, Dennis Rose was finally arrested by the Military Police. In no time at all the club which had been the Mecca of British jazz development was dragged in the mud and forced to an ignominious close.

During the early fifties, a number of jazz clubs opened around the West End and it was in one of these that Dennis Rose reappeared with an 11 piece band. The band included Tubby Hayes who was only 15 at the time. Indeed it was in these clubs, notably the "Flamingo" (Coventry Street) and "Studio 51" (Great Newport Street), that many of our present musicians began playing and the period can rightly boast the genesis of British jazz.

To return to Traditional Jazz, the revival of Dixieland, which had begun with George Webb, limped into the middle fifties when it began to fade from the popular music field. Skiffle, a sort of Jug Band revival, was dominant until the paradoxical second coming of Trad in the sixties. Musicians on the breadline suddenly found themselves rich overnight—Traditional Jazz was a "Hit." But like all booms this one had to fail, and it was rhythm and blues that took over. American blues singers made hit records, Blues Festivals became a frequent event and other forms of jazz were cast into the shade. Many jazz clubs turned to the more lucrative sound and even the B.B.C. was carried away by the wave of enthusiasm and the long established "Jazz Club" was dropped. The Rolling Stones and Beatles ousted more jazz conscious exponents like Alexis Korner from the popular record market, and jazz remained the music for an enthusiastic minority. Perhaps the best reason for its decline is given by Mezz Mezzrow, he says "Dizzy Gillespie went to the South of the U.S.A. to play a dance for his people. After the band had finished the first set, some of the negroes came up to him and said—Man take that stuff back up North, we can't put our feet to that, play something we can dance to—."

Personally I don't think that jazz is dead in Britain, rather that it is lying dormant. In the modern field there are a number of new and very talented musicians. Many of them began playing at University but very few of them have become more than part-time musicians. A fine tenor player, Art Themen, can be heard in odd pubs and clubs when not practising medicine. Another doctor is a member of the New Jazz Orchestra. Many of the older established jazz men have come to rely financially on playing "sessions", film contracts or recordings requiring a jazz accompaniment. Others like George Melly and Wally Fawkes, who undertake Flook in the *Daily Mail*, have jobs unrelated to music. Sandy Brown and Humphrey Lyttleton both work with the B.B.C., while Ronnie Scott, with his club in Frith Street, is one of the few jazzmen who devotes his whole time to jazz.

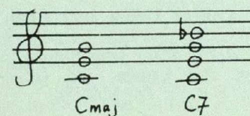
IMPROVISE YOURSELF

by Peter Hill

In the good old days in New Orleans you didn't play a solo in any number, you played along with everyone else slight melodic variations on a basic tune. The trumpet indicated the melody, the clarinet weaved in and out of the trumpet's line and the trombone filled in phrases below. The rhythm section rhythmed rather heavily. For one chorus one of the front line might play a little louder than the other two, but it was not until the 1920's that the concept of the solo was born. In a solo you're out on your own with just the rhythm behind you to play a variation on the tune. In traditional jazz you play a variation on the melody, in mainstream (or thirties jazz) on the melody and the underlying chords, in modern the major part of the improvisation is on the chords and their related chords. Protagonists of "New Thing" don't rely on anything very well defined.

Your solo lasts for one or more choruses. A chorus is four verses of a popular song (32 bars), or one verse of a blues (12 bars). The blues is a sequence of three chords immediately recognizable as the boogie bass, and widely used as a basis for pop tunes (Roll Over Beethoven, Route 66, Goin' to Kansas City, etc.).

Every tune is based on an underlying sequence of chords. In trad jazz the chords are few and simple. Also, when improvising only a few notes sound right over any one chord. These are the notes of the primary triad of that chord, or occasionally the minor 7th a note (here Bb).



which is utilized to lead in a different chord, G7 helps move from Gmaj to Cmaj or C7:

G:G7:C

G:G7:C7:F7:Bb

So, in traditional jazz, the soloist could play a variation on the tune using mainly the three notes of the triad of the chord underlying that phrase of the melody. The minor 7th note (Bb in the case of C7) could be a useful bridge (to Fmaj in this case).

In addition there are the so-called "blue notes", the flattened 3rd and 7th of the scale, which play a strong expressive role, particularly in the blues. These blue notes are a hallmark of jazz and have no parallel in classical harmony.

The mainstream musicians of the 1930's found that certain chords could be replaced by others, though the same melody was retained. This meant that the soloist could (for example) take advantage of the bridging power of the minor 7th to indicate a chord sequence such as:

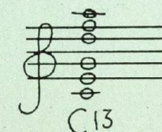
G:G7:C7:F7:Bb:G

(to replace six bars of Gmaj)

by choosing the notes of his solo carefully to hint at his choice of substitute chord.

This downward run of 7th's might well be suggested by descending the scale, and could be emerged from by moving from, e.g. Bb to Gmaj a third below—or from Ebm to Cmaj. Thus a whole new sequence of chords could replace the original pattern, and this sequence is indicated by the soloist's choice of notes. In addition the use of more ambitious intervals, the flattened 5th (Bb in Em), the minor 9th, 11th, 13th, and the use of major 7th became accepted. Thus the jazzman of the 1930's was free to elaborate on both the melodic and the harmonic implications of his chosen tune.

It was Charlie Parker who discovered that by using the 9th, 11th and 13th intervals of an underlying chord, a new triad upon which a whole new series of harmonics could be based. In the case of Cmaj, the higher intervals would be D, F and A, forming the primary triad of Dmin.



In this manner it became possible to substitute a very large number of related chords for the original triad. The development of complex sequences in modern jazz tunes rapidly eliminated all but the fastest thinkers from the advance guard of what we now call modern jazz. Those that remained, pursued even more complex harmonies over even more demanding changes. The phrasing of the soloist became more angular, and often more garrulous, with new approaches to rhythm (four quick taps to the bar rather than two heavy ones). Later Miles Davis began to experiment with scales rather than chords, and recently the Indian raga has become an innovation which may help to solve the problem of where do we go from here, now that it has indeed become possible to play almost any note over a given chord. And get away with it.

The Jazz Week —London

One can listen to jazz any night in London, in Club or Pub. One may define three types of establishment.

On its own is **Ronnie Scott's Club** (47 *Frith Street*, W.1.) the featured artists are often American "greats" who play monthly seasons at the Club. The admission charge varies with the artist appearing, but usually it is around 15s. for members, guests being charged £1, it is useful to realise that members of the N.U.S. are automatically members of Scott's. The Club is open from 8.30 p.m. to 3 a.m. (Sundays 7.30 p.m.—midnight), and one can wine and dine there in reasonable style.

The second group may be termed the *Circuit Pubs and Clubs*, these feature the best of British modern Jazzmen, are usually open till "closing time" and most charge an admission fee.

Ronnie Scott's Old Place, 39 *Gerrard Street*, W.1, nightly except Sunday 8-11.30 p.m., all night sessions Saturday 8.30 p.m.—7.30 a.m. admission around 7s. 6d., members of Scott's 2s. 6d. cheaper.

Bull's Head, *Barnes Bridge*, S.W.13, every evening, with special sessions Sunday lunchtime, admission 4s.—10s. depending on the artistes.

Palm Court Hotel, *Richmond*. Friday, Saturday and Sunday evenings, no admission charge.

The Phoenix, *Cavendish Square*, W.1, operates on Wednesday evenings only, but it is one of the most comfortable spots. It features circuit artists and the admission fee is 4s. 6d.

Artists one might hear "on the circuit" include soloists Tubby Hayes, Dick Morrisey, Art Ellefson, Art Themen, Harold MacNair and Ronnie Ross, they may appear with their own groups or be backed by resident rhythm sections. Definitive groups which may also appear on the circuit, include the *Don Rendell-Ian Carr Quintet*, whose recent LP "Dusk Fire" is outstanding, the *Graham Collier Septet* a new group which is making a reputation for thoughtful adventurous jazz, the *Art Themen-Dave Gelly Quintet*, the *Mike Westbrook Septet*, the *Stan Tracey Quartet* (featuring Bobby Wellins on tenor), and the new *Chris MacGregor Group*, a "new wave" combo that has an exciting African saxist Dudu Pakwana.

The third category includes the many pubs that have jazz on one night or so a week, the group being in general the same each week. The following list indicates what is open where and when, who plays and how much it costs (if anything) besides drinks.

Monday

University College Union Jazz Club, Gordon *Street*, W.C. 1, term time only, 4s. Modern

The Ship, *Bermondsey* (sometimes). Modern.

The Angel and Crown, 235 *Upper Street, Islington*, N.1, 2s. 6d. Modern.

Tuesday

The London Apprentice, *Old Street*, E.C.1. Various.

Wednesday

The Phoenix, Modern, vide supra.

Thursday

The Crown and Anchor, *Cross Street*, N.1. Traditional.

Klooks Kleek, *Railway Hotel, West Hampstead*, N.W.6. Traditional.

The Tally-Ho, *Fortress Road*, N.W.5. Modern and mainstream, this pub has sessions most other evenings as well. There is a resident rhythm section and the front line is made up of whoever turns up; people just drift in with their instrument, play a couple of solos and then quietly drift out again, or join the drinkers at the bar.

Friday

The Whyte Hart, *Drury Lane*, W.C.2. Various.

Birkbeck College Jazz Club, *Malet Street*, W.C.1, term time only, free. Modern.

The Gatehouse, *Highgate Village*, N.6, 4s. Modern.

Jazzland, *Thomas Street, Woolwich*, S.E.18. Modern.

The Little Theatre Club, *Garrick Yard, St. Martin's Lane*, W.C.2 has late night sessions on Friday and Saturday nights, 10.30 p.m.—1.00 a.m., these usually feature the leading avant-garde new wave British Group, *The Spontaneous Music Ensemble*. Admission for Club members is 4s. Membership (student) is 10s. 6d. p.a.

Saturday

Eel Pie Island, *Twickenham*. Variable music and admission.

Six Bells, *King's Road, Chelsea*, S.W. Traditional and mainstream.

Sunday lunchtime

Bull's Head, Vide supra.

The Crown and Anchor, *Cross Street*, N.1. An excellent place to forget that Sunday morning feeling! Having seen Trog's cartoon in *The Observer*, one can then hear him playing clarinet under the pseudonym of Wally Fawkes in the Johnny Parker Band.

King's Arms, *Peckham Rye*, S.E.15. Big Band Jazz.

Sunday evening

The Whyte Hart, *Drury Lane*, W.C.2.

Footnote

A full list of who is playing where, is to be found each week in the *Melody Maker* hidden among all the hot news of the pop scene.

The JAZZ SCORE

by Peter Hill

Name dropping in jazz is a delicate art. Like car enthusiasts, jazz aficionados spend as large a part of their worshipping time in conversation, as in the actual practice of their devotion.

It is necessary to bear in mind the interaction of personal preference, critical recognition, fashion, patriotism, bigotism and journalism when listening to someone's name droppings. Fashion moves fast and unerringly erringly; how else can the current upsurge of interest in Paul Whiteman be explained, except with reference to the ethos of *high camp*. This latter fact indicates that an artist may happily violate all canons of taste, and still find a market for his music among highly sophisticated and discerning circles. Sheer artistic ability is not enough to rank a jazz musician in his musical hierarchy. Too many factors are at stake. Hence, from grounds of personal and painful experience, these few words of advice.

Clearly in any name dropping contest it is you and not the artist of your reference which is at stake. Never be led into a spirited defence of any jazz musician. If the other chap doesn't think much of your choice allow yourself one throwaway line ("well he *did* invent chromatic scalar harmonic progressions on a vertical conceptual strategy . . .") and move on *very quickly* to someone else. This is a game of assumed knowledge, taken-for-granted and also taken-for-a-ride. If you don't know much about music, refer to the musician's historical im-

portance. Benny Goodman had precious little contribution to make to jazz musically, but was influential historically for his economic success and his multiracial sextet which re-admitted the American Negro to his rightful position in money-making jazz.

We may start by stating that the following musicians are unknockable on account of both their great artistic ability and their historical influence:

Louis Armstrong, *trumpet, cornet* T
Charlie Parker, *alto sax* M
Duke Ellington, *bandleader, composer, pianist* S
Bessie Smith, *vocal* T
Miles Davis, *trumpet, fluegelhorn* M

Unfortunately simply because these are giants they are not good point scorers, and because they are giants do not enter into controversial conversational interchange. Therefore score your first points from the droppings of the following musicians whose names spell "good taste" to the connoisseur:

Lester Young, *tenor sax* S
Bill Evans, *piano* M
Jo Jones, *drums* S
Bix Beiderbecke, *cornet* T
Buck Clayton, *trumpet* S

Notice that I have identified each musician with T, S, or M. These letters classify the musician as Traditional, Mainstream (S for Swing, its alternative nomenclature) and Modern. Roughly speaking these are the predominating styles of pre-1930 (T), the jazz of the thirties (S), and post-war (M).

There are, of course, those giants who have been toppled, and who are now extremely knockable, by way of compensation:

Gene Krupa, *drums* S
George Lewis, *clarinet* T
Harry James, *trumpet* S
Bunk Johnson, *trumpet* T
Dave Brubeck, *piano* M
The Modern Jazz Quartet M

Should you wish to be regarded as an out and out hipster it is advisable to be cognizant of the oeuvre known currently as "The New Thing" with a salting of traditional avant-garde, viz.:

Albert Ayler, *tenor sax*
Ornette Coleman, *alto sax* (*once plastic, now more concrete*).
Charles Mingus, *bass.*
Thelonious Monk, *piano.*
John Coltrane, *tenor, soprano.*
Roland Kirk, *manzello, stritch, bananas, etc.*

But *retournez à nos moutons,* if indeed you need to count them at this stage. Prestige may be acquired by the knowledge that certain musicians have at times been decidedly uneven in their development, and the following may be quoted only with minute attention to recording dates:

Billie Holliday, *vocal* S
Kid Ory, *trombone* T
Dizzy Gillespie, *trumpet* M
Sonny Rollins, *tenor sax* M
Coleman Hawkins, *tenor sax* S

Trad fans are an odd bunch. They are often very hot on definitions and like their jazz hot (whatever that means) and black. If your opponent shows signs of being rather more scholarly than appreciative when his kind of trad is under discussion, *don't* mention Benny Goodman, the Original Dixieland Jazz Band, or even Louis Armstrong, for these have lost their faith and have departed from the straight and purist path. Mention of white jazz musicians of trad persuasion is risky but having kicked off with a solid Negro footing like:

Buddy Bolden, *trumpet.*
King Oliver, *cornet.*
Baby Dodds, *drums.*
Ma Rainey, *vocal.*
Jelly Roll Morton, *piano, arranger.*

Why not try astute reference to the talents of the white school:

Pee Wee Russell, *clarinet.*
Jack Teagarden, *trombone.*
Wild Bill Davison, *trumpet.*
Dave Tough, *drums.*

To patriots, there are names which will always have a melting ring to British ears. Those few, who are felt to have made a contribution to world jazz:

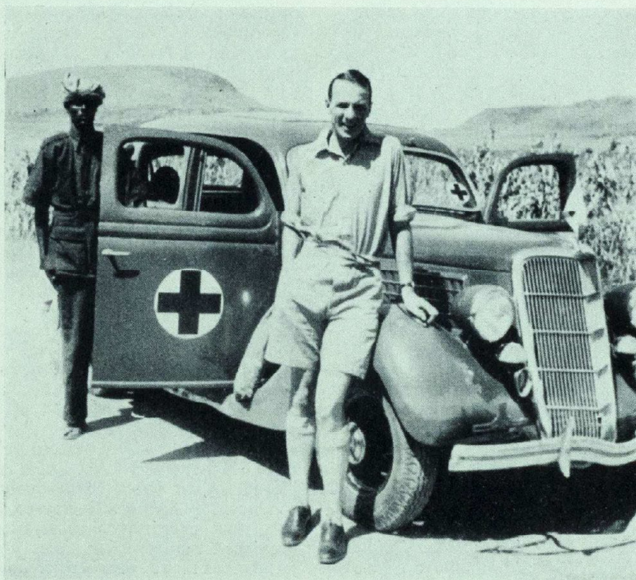
Tubby Hayes, *tenor sax* M
George Shearing, *piano* M
Humphrey Lyttleton, *trumpet* S
John Dankworth, *alto sax, arranger* M
Alan Haven, *organ* M
Victor Feldman, *vibes, piano* M

Decry Gerry Mulligan, laud Stan Getz. Hallow Oliver Nelson but eschew Cannonball Adderley. Spare a kind word for Johann Bach. And at the final hour the broad uplands of victory can be yours with a flourish at the drop of the hats of:

Alcide "Slow Drag" Pavageau, *bass* T
The Melbury Bub City Jug Band.
Flat Foot Floogie With The Flying Feet.
I Got Those I Ain't Got It, But If I Had It I'd Give It All To You Blues.

Thirty Years Ago

by Sir Herbert Seddon



In 1935 Mussolini embarked on his invasion of Ethiopia, an event that encouraged another dictator, with evil consequences that still plague us. Among the many young people who at that time were moved to indignation was a Bart's man called John Melly who decided to do something about it. He had already been in Ethiopia and was planning to establish a mission hospital there. Melly and his sister, Nell, organized a Red Cross unit and John set out to do what he could in a country where even to-day the medical services are thin. The story of his efforts in the face of what proved to be overwhelming difficulties has been told by Kathleen Nelson (now Lady Liddell Hart), widow of another Bart's man, and Alan Sullivan in "John Melly of Ethiopia." The end came in May 1936. Melly and what remained of his unit were driven back into Addis Ababa and there, in the general disorder, he was shot by an Ethiopian. He was buried in the little cemetery in the Embassy compound. This last October I visited Addis Ababa for the first time and I went to see Melly's grave. The compound is one of the loveliest places I know, a rambling park on the hillside with groves of enormous eucalyptus. You pick your way through their tangled roots and reach a small silent clearing. There he lies and on the stone is inscribed "Greater love hath no man than this, that a man lay down his life for his friends."

I came across a few of these friends, Ethiopians, senior men in government now, who have not forgotten. The photograph, which for thirty years has been in whatever has been my main place of work, shows Melly as we knew him. Gay, as it seemed almost to insouciance, strikingly handsome and indeed a dandy; but John Melly was a devout Christian and he showed his faith by his works.

Record Reviews—Classical

Sensuality and eroticism are qualities that one would hardly expect of a devout church organist; yet it was in such terms that no less a composer than Liszt expressed his amazement and shock at César Franck's first big chamber work, the Piano Quintet in F minor. At its first performance the composer, Saint-Saëns, to whom the work was dedicated and who had played the piano part on that occasion, left the platform in disgust, leaving behind the score which Franck had publicly offered him. Today, although the work is accepted as a great masterpiece, controversy still rages over matter of interpretation. Should Franck's music be played in a strong Germanic style, or should it be approached rather with the delicacy of the French school? Modern opinion is decidedly in favour of the latter, and yet a recent biographer has said, "A Liégois by birth, a Netherlander, later a Belgian, later still a Frenchman by naturalization, Walloon by upbringing, French at heart, Franck came none the less from Germany," his mother's ancestors being purely German as were most of his father's. To continue the argument further against the modern trend, Franck's music has undeniable roots in that of Beethoven and Schumann, and it is known that at the time of the composition of his String Quartet (some ten years after the Quintet) he was studying the similar works of Schubert and Brahms. The relevance of this dicussion becomes apparent when one listens to **FRANCK's** *Piano Quintet in F minor*, played by **Eva Bernathova** (piano) and the **Janacek Quartet** (SUA 10471). Here, in spite of the characteristic warmth of the playing of these superb Czech musicians, the desire to perform the work in the "correct" French style allows some degree of reticence to creep into the performance, and the overall impression is one of some coolness. This is perhaps a purely personal criticism, and one cannot deny the otherwise magnificent rendering of a most beautiful work with which you should waste no time in becoming acquainted if you do not already know it. This particular disc was awarded the *Grand Prix National du disque* of Paris, one of the greatest acknowledgements a record can receive.

In the age of Schoenberg, Webern and Boulez it is all too easy to forget the revolution caused by an eighteenth-century composer: Johann Sebastian Bach. In chamber music, for example, he was perhaps the first to abandon the figured bass continuo using instead a fully written out keyboard part. This is very much in evidence in his sonatas for violin and harpsichord where both instruments are of equal importance and there is no question of one merely accompanying the other. Modern interpreters often fail to appreciate these points. Menuhin, for example, in his recordings uses an additional string bass continuo: technically this is incorrect and superfluous, although there is something to be said in favour of balancing the prominent treble voice of the modern violin with an additional bass. Much more important is the fact that neither instrument should dominate the other: herein lies the failure of Supraphon's recordings of **BACH's** *6 sonatas for violin and harpsichord by* **Josef Suk** (violin) and **Zuzana Ruzickova** (harpsichord) (SUA 10549 & 10550). In all other respects these performances are admirable. Suk is a superb violinist with a faultless technique and a great sense of style; and Ruzickova's playing has an elegancy and delicacy that is most attractive—all the more reason that she should not have allowed herself to be so dominated by her partner. Nevertheless, in spite of its big fault, the freshness of this account of these great works enhances the value of these records: their complete lack of affection enables them to bear repeated playing.

Finally, there is a recording of **BEETHOVEN'S** *Symphony No. 7 in A major, Op. 92*, played by the **Czech Philharmonic Orchestra,** conducted by **Georges Georgescu** (SUA 10008). The slow tempi, verging at times on sheer heaviness, remind us at times of Klemperer: but there, I assure you, is where all resemblance ends. The work should surely seem to spring from the soul of one who knew only joy and happiness: it should not ponderously remind us of the tragedy and despair that was the fate of the composer in his later years. For an introspective mood, this record (on which, incidentally, the Czech Philharmonic play with superb precision) would be eminently suitable.

Michael Spira.

These Supraphon records represent a selection from the company's complete list, there being no new releases at the time of writing. They are available in mono and stereo verions, and are priced 17s. 6d. each.

Jazz

The Champ: Dizzy Gillespie Big Band, *Music for Pleasure*, MFP 1041.

Big Band music is nowadays not the force in jazz that it used to be, and Dizzy Gillespie has in fact altered his style too in recent years to fit the scope of the small group. This record is a selection of Big Band material from the period 1954 to 1957. Its title track is perhaps the finest on the record, and "Annie's Dance" —a perversion of "Anitra's Dance" from "Peer Gynt"—is more delicately performed than other pieces which tend to be somewhat vociferous and pedestrian in comparison. As a whole, the record is not of great content but easy listening and pleasant.

D. B.

Interpretations: Stan Getz, *Music for Pleasure*, MFP 1023.

This recording from 1953 displays Getz in an early phase of development, it dates from the period after his initial success in the Woody Herman Big Band, but about ten years before his real commercial success with the Bossa Nova.

On this record Getz shows himself to be a most lyrical player who seems to coax smooth sounds out of his tenor sax with no effort at all, on the medium tempo numbers he swings beautifully, and on a ballad such as *Willow weep for me* he breathes his way through his solos.

The front line is shared on this record by Bob Brookmeyer (trombone) and this must have been one of Brookmeyer's first recording dates. His sound is instantly recognisable and his skill as an ensemble player is manifest even at this early stage of his career.

The rhythm section is most competent and the pianist, who sounds a trifle alien to the Mulligan-like sound of the front line, gives good accompanying support and plays some interesting West Coast style solos.

Getz at any price is worth hearing, this record will grace any collection, and will provide many hours of interesting listening.

The Jazz Couriers in Concert: *Music for Pleasure*, MFP 1072.

In February 1958 the Jazz Couriers, a quintet featuring the tenor saxes of Tubby Hayes and Ronnie Scott was recorded in concert. This record is a selection of the material. Like all "live" recordings there are irritations, for instance some of the introductions which have been left on are indistinct and careful attention is necessary to pick out some of the gems of off-beat humour in the announcements. There are also the occasional "wrong" notes, but to offset this there is a feeling of tension in the music that might not come over in a studio recording.

The music is mainly up-tempo and the twin spearhead front line attack produces some driving solo work, Hayes also takes a turn on the vibraphone, which provides some contrast in the sound. One track on the record is outstanding; a Scott original *Some of my best friends are blues*. Hayes takes the first solo on vibes, Scott follows with a searing solo, but the piano solo by Terry Shannon steals the thunder, indeed his piano playing both in solo spots and when accompanying is one of the best features of the music, Phil Bates (bass) and Bill Eyden (drums) both give excellent support.

Both Hayes and Scott have ballad numbers, Hayes takes his vibes for *Time was* and Scott swings through the Kurt Weill tune *Speak low* in a rather Getzian manner.

A record of differing moods with great contrast in some of the tracks, it is a useful reminder of how well British Jazz could swing even back in the dim distant days of the late fifties.

J. S.

Music for Pleasure records are priced at 12s. 6d.

Penguin Book Reviews

INADEQUACY EXPLORED

The Unicorn by Iris Murdoch. Price 4s. 6d. Penguin. *Novel.*

"The Unicorn" is the latest addition to "Penguin's" of Miss Murdoch's novels, and being a great fan of hers I read it with the usual enjoyment.

On the cover, it is described as "a novel that can be read on many levels" and this is as true of "The Unicorn" as it is of all her novels.

The first few pages are deceptive and it starts off with the arrival of a young woman—Marian Taylor—at Gaze Castle, as a governess, in answer to an advertisement in a paper. This is where any semblance to any other stories of a similar beginning finishes completely. Her "pupil" she discovers to be a wealthy woman—Mrs. Cream Smith, and her duties no more than that of a confidant and companion. Marian Taylor soon finds out that Hannah Cream Smith is in fact a prisoner—not held by physical force but captive by an inability to face the real world by virtue of her strange past.

The mysterious figure of Hannah Cream Smith's maimed husband is forever with us as is his homosexual relationship with one of Hannah's jailers and the housekeeper's son. In fact, one comes to the point where it seems indeed that very few of the characters are sane.

It all makes for suspense and exciting reading, and is a subtle and wide-ranging study of the possibility of human relationships.

By the end of the intrigues and violent deaths, it is not at all surprising that Marian Taylor's objective is reached—the reason she went to Gaze Castle—to forget an unhappy love affair.

Diana Morley Evans

COLD BARRIER

The Ice Saints, by Frank Touhy. Price 4s. 6d. *Novel.*

For anyone who has been to Poland, this book will be a fascinating reminder of some of the things that made a strong impression on him while he was there, for the details of life in a small Polish town are authentic and vivid.

But there is much more to this book than that. It is concerned with the visit of an English girl to a University town where her sister lives with her Polish Professor husband. For the English wife, the life of dragging grayness which they lead has meant much unhappiness and conflict with her husband, and though she is resigned to it for herself, she is determined that her son Tadeusz shall have a chance to see and choose another way of life. When her sister brings news of a legacy for him, it seems to be the way of achieving her aim. (In present-day Poland it is only possible to leave the country by paying for the whole trip in English, American or German currency.).

Tadeusz's reactions, however, are unexpected and, for the sisters, quite inexplicable. The ensuing struggle of emotions is deeply moving and reflects much wider issues than the private concerns of this one family. As the English girl returns to Warsaw for her flight home, she is oppressed with a feeling of futility and disappointment. She says to a Polish friend who is travelling with her "I hoped for so much." His reply seems to catch the whole essence of the book—"In this country we must be very careful with hope."

Ann Brown

PREDICTABLE FALL

A Season in Love by Peter Draper. Price 5s. Penguin. *Novel.*

Peter Draper was a new novelist to me though it seems he is well known as a writer of television plays.

The book begins with Sam Wilson arriving back in London after working abroad as a newspaper reporter. He dreams of finding London and all his friends as he left them. Poor Sam is quickly disillusioned, particularly so by the break up of the relationship between two of his best friends Bruno and his mistress Sophy. Sophy in her sorrow turns to other men for consolation whilst Bruno has become engaged to a young French art student, Claudine.

Sam, determined to avenge Sophy, sets out to seduce Claudine whilst Bruno is away. Sam's well planned operation is thwarted at every attempt and Claudine proves to be much more than he bargained for. The obvious happens, and Sam falls in love with Claudine, a thing he never planned to do.

A sad ending perhaps—but the book was very enjoyable and well worth reading.

Diana Morley Evans

STRATEGIC EXERCISE

A Wolf Adventuring by Jean Forton. Price 4s. Penguin. *Novel.*

This exploration into a relationship is narrated through the mind and faculties of the author, the wolf of the title. He is a recluse from society living on a private income torn from his brother and sister-in-law. He lives in a single room and has contact only with his neighbour and his wife. Bored with life and seeking a diversion, a chance encounter in the street with a young schoolgirl leads him into falling in love with her.

He resolves to make contact with this girl and this develops into an exercise in seduction. The reader is led through a detailed account of all the stages of acquaintance, friendship and intimacy, to the carefully contrived seduction.

So successful is his manoeuvre, that the girl falls completely for the wolf, although he begins to despise her soon after their first meeting. He rejects her, and is so insensitive to her pleas, that to rid himself finally of her, he humiliates her, but is totally unaffected by the result of this trauma.

The author writes in a painstakingly intellectual style, and with such dispassionate detachment that some descriptions turn out not far short of depravity. The whole tone of the book is one of uncompromising decadence. The absence of any emotional concessions to the girl, the absolute selfishness of the wolf, and the lack of concern or remorse for the consequence of this exercise in seduction leave one with a sense of despair on finishing the book. But this does not preclude the recommendation of the book, on the contrary its very decadence makes it interesting and stimulating, but not particularly enjoyable.

J. A. S.

MEDICAL BOOKS

Biochemisty

Human Biochemical Genetics, by H. Harris. Published by the Cambridge University Press. First paper-back Edition 1966. Price 12s. 6d.

The information on the reverse of the title page of this book tells us that it was first printed in 1959 and there have been three reprintings since. The present book is the first paper-back edition.

The reviewer somewhat incredulously, reached for his original 1959 copy to confirm that this book had suffered no alteration for seven years. The belief was confirmed and further inspection of the references showed that the latest were mainly of the 1957-58 vintage.

It therefore seems a great pity that no opportunity has been taken for revision of the text, especially in view of the fact that biochemical genetics has been a field of great activity.

Presumably the reason for the paper-back venture is to make the book readily available to students at a price well within their reach. If this is so, one must then consider if this is truly a text book suited to the needs of medical students, but the answer here is no.

From the point of view of the student the title should read "Some Aspects of Human Biochemical Genetics". The book was not intended to be comprehensive and subjects such as Congenital Adrenal Hyperplasia, the Lipoidoses, Periodic Paralysis, are not covered. On the other hand some detailed description in the chapter on Blood Group Substances is quite unsuited to undergraduate requirements.

The last six pages of the book are devoted to the Watson-Crick hypothesis but the text is now so out of date that it would have been better to omit it altogether. Most students should be able to answer the question "How, for example, is the genetical information which is supposed to be coded by the base pair sequence subsequently transferred in functional activity?"

In conclusion, it should be said that this book was the best of its kind in 1959, and today there is still a great deal of valuable and relevant information. It should not, however, have reached paper-back form without some revision.

J. C. B. Fenton

Biography

Almroth Wright, Founder of Modern Vaccine-Therapy, by Zachary Cope, K.T., B.A., M.S., F.R.C.S. Published by Nelson. Price 42s.

This biography of one of Britain's outstanding medical figures is one of a series on British men of science. The story is neatly told in Sir Zachary's own easy style, yet I found it vaguely unsatisfying. Wright is a sizeable nettle for the biographer to grasp. It is hard—certainly for a non-immunologist—to assess the significance of his work, and to place it accurately in the modern complex. It seems hard, too, for those who knew Wright to avoid being either protective or vindictive about his personality. Within recent memory an old pupil of Wright's, called upon to deliver a celebratory address on the occasion of some anniversary of the great man left the audience in some doubt about the value of his work and in no doubt about his carborundum nature. Sir Zachary is on both counts more generous.

I doubt whether Wright's early career would appeal to some of my idle young friends. He spoke French and German from childhood and was well versed in Latin and Greek. He obtained first class honours and the gold medal in modern languages and literature at Trinity College Dublin. Simultaneously he took the medical course and qualified at the same time.

A year after graduation he entered the Middle Temple as a student and after only 6 months came top of the list in the examination. He was awarded a two year legal scholarship but before this had expired he entered the examination for the higher Civil Service, and being successful was posted to the Admiralty. There he managed his duties with such ease that he had time to undertake research at the Brown Institute where his ultimate career was launched.

Besides his ability and prodigious memory he was blessed with an enviable capacity for falling on his feet. After only about five years in research of one sort of another he was appointed Professor of Pathology at the Army Medical School despite the fact that one of his competitors was David Bruce, who was already the assistant Professor. Ten years later, finding that the Army lacked the foresight over antityphoid inoculation which it had displayed over his appointment, Wright resigned. Fortunately the post of pathologist and bacteriologist to St. Mary's Hospital had just become vacant and he was appointed. He was knighted at the age of 45, when the Minister for War, we are told, was anxious to build him up as a "Great Public Man".

Sir Zachary records the work on Malta Fever, Anti-typhoid inoculation, Vaccine Therapy, and War Wounds. He tells us of Wright's view on women, his passion for neologisms, and his life's work on his own brand of logic. He claims for Wright a major part in the establishment of medical research in this country. It is a good story well told. It is probably quite unreasonable to feel (and unreasonable to feel concerned) that we see both the work and the man through faintly rose-coloured spectacles.

F. W. O'Grady

Medicine

A Course in Renal Disease by G. M. Berlyn. 1st Edition. Published by Blackwell. Price 37s. 6d.

As Professor Black suggests in the foreword to this book, a willingness to learn is not synonymous with the ability to readily assimilate medical knowledge. Probably the only satisfactory solution to this problem is a comprehensive tutorial system. However, in the absence of the latter, "programmed learning" as provided in this book, makes a valuable contribution to medical teaching. The author is to be congratulated for undertaking the not informidable task of producing a book of this type which is easily readable, succinct and up-to-date.

The book covers the whole spectrum of renal disease with initial chapters on anatomy, physiology and clinical investigations. It takes the form of short sections of text followed by questions relevant to the

text, the object being to ensure assimilation of the facts set out in each part before proceeding to further sections.

The text is clear, concise, and despite the relatively small size of the book, includes a remarkable amount of information. In general it gives a well-balanced view of current opinion in nephrology. Inevitably the need for a clear didactic presentation introduces some opinions which are not universally acceptable. Thus the advocacy of radio-active Vitamin B_{12} clearance as an easy and reliable method for measuring G.F.R. must be questioned. Similarly the casual use of digitalis in patients with acute glomerulonephritis is to be deplored. Long term antibiotic treatment in chronic pyelonephritis is far from established. There seems little point in arbitrarily carrying out renal biopsies in subjects with acute renal failure "immediately after the second dialysis" when dialysis therapy is planned for five to six weeks, by which time diuresis may have occurred. The explanation given for the bleeding diathesis in acute and chronic renal failure is not generally acceptable.

In a book of this size, it is extremely difficult to present a clear explanation of certain aspects of renal physiology. Thus although remarkably concise, the sections on urine concentration and dilution and acid excretion are somewhat obscure. This is not helped by the isolated and confusing statement (para. 2.31) regarding water passing through the wall of the loop. of Henle. There is also a failure to clearly distinguish between acidification of the urine and total acid excretion—a distinction seldom fully appreciated by students and clinicians. Comments on the relationship between urine flow-rates and osmotic loads without reference to water intake in the section on polyuria, are also confusing.

One or two printing errors have crept into the text ("anaemia of polycythaemia" and a more unfortunate addition of "not" in para. 17.32 line 14), but the printing and layout is generally of a high standard.

The use of the question "Don't know" is of doubtful value. The answers to this question, although occasionally helpful, are in general irritatingly paternalistic, particularly on account of their constant repetition. A future edition might well be improved by their omission.

These various criticisms must be considered of relatively minor importance in what is a very comprehensive and authoritative text. I think it provides, as the author intended, an excellent tutorial course for advanced students and postgraduates. I would suggest, however, that it be read *after* standard monographs have been studied.

W. R. Cattell

Livingstone's Pocket Medical Dictionary edited by Nancy Roper, tenth edition, published by E. & S. Livingstone Ltd. Price 8s. 6d.

The tenth edition of this popular medical dictionary, written with the student nurse in mind, maintains its high standard. The editor has enlisted a distinguished group of specialists to help her bring the dictionary up to date by deleting 200 obselete words and replacing them with 1000 new entries.

The text is good but the diagrams often leave a great deal to be desired regarding clarity and basic explanation. Noteworthy is the Latin or Greek etymology of most words. The appendix includes good sections on prefixes and suffixes, poisoning, urine testing and physiological normals.

This pocket dictionary is recommended to student nurses and, indeed, wouldn't be out of place on the medics' path-room tables.

I. D. Fraser

Paediatrics

The Essentials of Paediatric Surgery, by H. H. Nixon and Barry O'Donnell. 2nd Edition. Published by Wm. Heinemann Medical Books Ltd. Price 50s.

This excellent little book appears as a second edition. Paediatric surgery is now a recognised speciality and for the medical student and house officer this volume highlights the essential differences between the surgery of the very young and that of adults. Too often the general surgeon has in the past regarded the problems such as hernia as merely being adult surgery in miniature. This is a very readable book with a great deal of practical advice.

Undoubtedly it has had a wider appeal than was anticipated, but its distribution may well be limited by the fact that the cost is high for a specialist book of just over 300 pages. Many of the illustrations, though excellent, are bigger than they need be, particularly the X-ray reproductions: the chapter division is perhaps excessive with consequent waste of many blank half pages. The authors have clearly had difficulty in deciding on what to include and there are still some major deficiencies. More is required about fractures for the guidance of the many casualty officers who have to receive children as well as adults. A separate chapter on anaesthesia would be of value. While the electric alarm for the treatment of enuresis is mentioned again, there is no reference to the danger of electrolytic ulcers which have now been described on many occasions. There is no other comparable compact volume on this subject and it is highly recommended for students, potential paediatricians and general practitioners.

D. F. Ellison Nash

Child Health and Development, edited by R. W. B. Ellis, 4th Edition. Published by Churchill. Price 72s.

The last two decades particularly have been characterised by an increasing concern for the health and welfare of children, and this has led to a continuing reduction in mortality in infancy and childhood, but also to a more fundamental interest in normal development and the positive aspects of health. Quite apart from doctors working specifically in the field of preventive medicine one can look forward to a progressive increase in the General Practitioner's involvement in this aspect of paediatric care, and it is important that the student should at least have sufficient contact with the subject to arouse his interest.

The purpose of this book is to gather together some of the widely scattered information relating to the development and welfare of children, and it is divided into two parts. The first deals with normal development, ranging from genetics and prenatal development, through prematurity and the newborn, up to puberty and adolescence, with special chapters also on nutrition and feeding, behavioural and emotional development, and infection and immunity. The second is concerned with those social agencies having a direct impact on the child, covering the child health services themselves and also education, child guidance, punishment, the care of the underprivileged child, child health in the tropics, and finally family planning. The appendix provides a useful twelve page synopsis of legislation concerned with children.

Professor Ellis, whose death since this edition appeared must unfortunately be recorded, recruited a team of seventeen other authors, mostly from Scotland, and wrote five chapters himself. In spite of this diversity of authorship, the book as a whole has not lost the imprint of the editor's own personality and interests; the standard of the contributions is high, a number of sections have been completely rewritten, and there are probably only occasional instances where out of date material has been transferred from earlier editions, as in the table of frequencies of autosomal recessive abnormal conditions in the population, where the frequency of phenylketonuria may be understated, and the diagnostic terms used for some other conditions are no longer acceptable.

This book covers a wide field and it certainly fills a definite need; it is complementary to the usual textbooks and will, I hope, be used for reference by students doing Paediatrics. On the whole it will be of greater value to the postgraduate student, and there is a need for a shorter book in which the subject is presented in a more graphic and digestible manner, so as to bring home both the importance and the immense potential interest of the subject more clearly to the average undergraduate student.

P. J. N. Cox

Otorhinolaryngology

Diseases of the Ear, Nose and Throat, Vol I and II. Edited by W. G. Scott-Brown, John Ballantyne and John Groves. 2nd Edition. Published by Butterworth. Price £17 15s. 0d.

It is a pleasure to welcome a second edition of this well-known text book. Every effort has been made to bring it up to date and several new chapters have been added. One interesting addition is the provision of a symptom index. This will prove useful for candidates who are revising for higher examinations. A book of this type is very necessary for those starting a career in the speciality. It suffers from a lack of completeness but with such a grounding that it provides, together with an adequate bibliography, the embryo specialist is well and truly launched. It goes without saying that even at a price of £17 15s. 0d. per set, all trainees should be in possession of their own copy and that those who own first editions should replace them. The editors are to be congratulated on producing such a coherent work from a very impressive list of contributors. Misprints there will always be and some of these are unintentionally amusing, viz. the illustration of Mr. Pickard's assistant "taming the nystagmus" (fig. 142). This is of course apt wish fulfilment of all who deal with vertigo.

A. P. Fuller

SPORTS NEWS

SPORTS EDITORIAL

"Probably one of our more unfortunate legacies from the early nineteenth century is the phenomenon of organised sport." (Baker: *St.B.H.J.*, January, 1967.)

It was unfortunate that the correspondent in the January Journal should have chosen, whilst criticising the Rugby Club Ball, to attack out of hand all sportsmen. It is fair to say that a high proportion of student activity at Bart's is reported in this section of the Journal and that a correspondingly high proportion of students are involved in these activities. He accuses them all of being "figures whose only capacity to stand up as a man is when supported by the bar or by their fellow insecurees in the scrum" His capacity to do the same appears to be when he is supported by a piano stool or by his fellow musicians in an orchestra. It was even more unfortunate that having said all this he should proceed to the height of bad manners in castigating the organisers who worked so hard to produce the Ball. If indeed "the predictably bad cabaret and unimaginative dance music were no worse than one might have expected" one wonders why our correspondent ever thought of coming—or even, for that matter, how he came to procure a ticket, since several regular players were unable to get hold of one. Whilst one cannot condone the food fights—they are an unfortunate legacy of this function—it would seem to be the act of a puerile mind to take such an opportunity to launch an attack on organised sport and its followers.

To end on a brighter note we must congratulate Brian Rees on winning his first Welsh cap. At Murrayfield he had all our good wishes for a successful debut—we hope that there will be many caps to follow. Brian has already played for the London Welsh and United Hospitals since his arrival at Bart's.

RUGBY CLUB

2nd February; **Hospitals' Cup Second Round; Bart's** v. **The Westminster,** at *The London Hospital Ground.*

On a dry windy day, with a gratifying number of Bart's supporters, and a deceptively rolled Hale End quagmire, the scene was set for a battle between the Bart's forwards and the Westminster backs—or so the papers had informed us.

The game opened nervously with Lambert dropping a pass from Pope. From the resulting scrum the ball went along the Westminster line, only for each of the attackers to be chopped down by the merciless tackling of Jefferson, Savage and Hopkins.

Rutter tried an abortive drop kick, Griffiths cleared well with a good touch. The pack were now playing furiously, obtaining almost all the ball from tight, loose and line-out. Lambert and Pope were kicking well down the touch line keeping the pack on the Westminster line. Now, as throughout the game, Mason and Britton dominated the lines-out allowing Westminster only two catches in the first half. The front-row were also having a field day with Fairhurst taking many against the head, well supported by O'Kane and Furness. Yet despite all this good ball no scores were forthcoming. Jefferson nearly went over under the posts but he had three men on him.

Rutter Nearly Over

A good break by the dangerous Westminster threes led to one of their number touching down, however the referee noticed a knock-on and gave a scrum 5. Shortly after this Rutter dummied through four men but as he approached the line he appeared to be in a quandary and was well held up by McIntyre. From under the posts Smith broke through, passed to Britton who passed just forward to Mason with Hopkins outside him, and no defenders in sight.

At this stage Savage came limping off, for strapping to pulled hamstrings. After about five minutes he returned to the wing and Smith took over in the centre. Griffiths attempted a penalty six yards in but was just wide. In their 25 Smart picked up from the base of the scrum and tried to dummy through but was caught. Mason continued to jump well, and Pope converted his efforts into good touch kicks, but when the line was reached nobody seemed capable of crossing it. Thus half time was reached with the score 0-0 and Bart's on top.

From the kick off Westminster were awarded a penalty which Skirving kicked into the centre. Instead of clearing immediately Bart's dithered and were nearly caught under their posts. Rutter and Lewis for the Westminster tried to break through our defence, but time and again they ran the wrong way—usually into McIntyre. Griffiths was playing well, fielding the high ball under pressure and returning it with interest. After 14 minutes of the second half a perfect threes movement all along the line, saw fly-half Lambert dive spectacularly over the line, unfortunately it included a forward pass and was disallowed.

Five minutes later Skirving broke through and kicked ahead, the ball landed in front of the posts, Griffiths and Lambert fell for the ball, both missed it, and it was picked up and passed to Skirving who scored under the posts. He then missed the conversion.

Quick Reply

Bart's replied in 75 seconds, a good dummy-run and reverse pass by Pope saw the ball speed along the line to the winger Savage who gave a scoring pass for Bradley-Watson, who had done well to cover across, to dive over in the corner. Griffiths was just short with the conversion.

The game had now changed its character, as Bart's were playing it open, the forwards were still dominant, but this was just what Westminster wanted. From a scrum under the posts on the Bart's 25, the Westminster fly-half ran left, drew three men, and passed to the left winger who scored in the corner. *Score* 3-6. The defence in the centre was disorganised and Jefferson was playing with virtual loss of vision on the left, however he pluckily continued. Smart kicked high upfield, McIntyre followed up well, from the resulting scrum the ball went to the Bart's centres. Rutter intercepted a pass between the centres, ran the length of the field, chased by Pope, and scored under the posts. Again the conversion was missed. *Score* 3-9.

Last Efforts

The pack stormed back into the game taking play up to the line, a pushover try was attempted but the scrum collapsed. Jefferson was again in the wars with a scalp wound. On the other side of the posts a further pushover was attempted with the additional weight of the halves, however it was far too wet and the scrum again collapsed.

A penalty was awarded to Bart's on the opposition line to the extreme right. Pope threw a perfect long ball open, this was caught by Smith who accelerated up to the line, was stopped, but he passed to Hopkins who dived over 10 yards in. *Score* 6—9. Griffiths spurned the conversion, the time was up however, before we had further chance to score.

Although our injuries marred this game, it did not conceal the fact that we made three defensive errors and paid the price. Despite this everyone played well and should be congratulated on a hard fought game.

Mid Season Review

After an initial boost to the season from the 7-a-sides the 1st XV had little success until the last three games against Oxford, Warlingham and Rugby. A strong Oxford side narrowly won, whilst Warlingham were trounced and Rugby were beaten 8-3.

This year 32 players have been tried in the 1st XV, the best combination having only just emerged, this necessitates the Captain, Secretary and Treasurer playing for the 2nd XV. The side is now playing with cohesion and confidence, and three freshmen are playing regularly for the 1st XV—S. Smith, N. Fairhurst and A. Mason.

One of the more notable teams this season is the "Veterans", on paper they are the sixth side but they play to an "A" XV standard, their members consisting mainly of Housemen and Registrars.

Match Reports

3rd December; v. **Old Cranleighans, match lost 0-6.**

A scrappy game with neither side capable of producing good football. An early run by Smith on the left promised a possible way through, but the wings were later ignored, and many passes went to ground. Packer at full-back had a good game, showing himself capable of attacking from his own line. Two tries by the Cranleighans settled the game.

7th December; v. **University of London, match lost 0-15.**

The University had a stronger side out than usual, their Captain and fly-half having a particularly good game. The Bart's side again showed changes from the previous week and did not play as a unit. The Bart's threes' tackling was particularly weak, as the University broke through the centre, or made the man over. This match emphasised the point that the fly-half must either go straight up to his opposite number, or make a positive effort to cover-tackle.

10th December; v. **Old Askeans; match lost 3-13.**

A quagmire at Kidbrooke greeted the return of Gilmore from honeymoon and Smart from work. Playing downhill with the tide we started well when Smith produced a nice outside break to score in the right corner. Griffiths was unable to convert and Bart's, playing with more fire than previously, held their 3-0 lead until half time. In the second half Askeans counter attacked, using the short kick ahead to create panic in the Bart's defence. Although the forwards were storming uphill with successful foot-rushes we were unable to score again and two defensive errors let the Askeans in to score two quick goals and a penalty.

17th December; v. **Woodford; match won 13-11.**

This last game before Christmas was a good one with a narrow but well deserved win by Bart's.

Smart opened the scoring by peeling from the back of a line-out and walking over three defenders to touch down. From a loose maul Britton was well up to support Savage and score under the posts.

Again the Bart's threes' tackling was poor and Woodford made good use of this by scoring two tries through the centre. The game was won however by a movement between Savage, Baker and Johnson. Baker went over half way out, after a pass inside by Johnson. Griffiths succeeded with two of his three conversion attempts.

7th January v. **Old Rutlishians; match lost 3-21.**

The Christmas break seemed to be the undoing of Bart's. The confidence gained in the Woodford game was not evident and Rutlishians scored heavily in the first half. The second half was a draw at 3-3, Bart's played throughout with 14 men. This was no excuse as the pack did well to obtain a fair supply of the ball but it rarely reached the outside centre. Tackling and covering were at fault.

14th January; v. **Cambridge Town, match lost 0-8.**

Two tries within three minutes helped Cambridge to a half-time lead of 8-0. The game started well enough for Bart's with some promising three-quarter movements. After 23 minutes Pope intercepted well but he had too far to go and his winger Jackson died with the ball. From a scrum on the left near the half-way line Cambridge eventually scored. They kicked ahead for the winger to run outside and score, Butlin converting. Two minutes later again from a kick ahead the Cambridge centre just won the race for a doubtful touch-down.

Griffiths had a penalty attempt which went wide as Bart's tried to make a come-back. The Cambridge centre intercepted and was nearly through but Griffiths just managed to stop him as he was off balance.

Cambridge wasted their ball by kicking for the corners rather than trusting the backs to run with it. From the second half kick-off McIntyre nearly went over but he had no support.

25th January; v. **Warlingham, match won 51-0.**

A slightly weakened Warlingham side were trounced by Bart's. This was a game in which everyone enjoyed themselves, but of which the value was doubtful. The forwards were handling like threes and Furness scored his first try of the season. Savage was on top form with four tries and McIntyre and Smith had two each. Griffiths converted seven so it seems that we have a place-kicker, at last!

28th January; v. **Rugby,** at **Chislehurst; match won 8-3.**

With a very decisive win over Warlingham behind them Bart's went on to the field determined to find the form which had been lacking since the Centenary game. Rugby on the other hand, with an almost full strength side, had a formidable record of only four losses behind them. The Bart's forwards were soon working as a pack with much improvement in the tight and some very loose play. Some decisive running and passing by both forwards and backs from a loose maul in midfield sent McIntyre over for the first try. Rugby hit back, but could not score. Some of the line-out play was scrappy but one or two good balls did come back and it was one of these that sent Savage off on a fine run to score under the posts. Griffiths converted easily.

The second half was played uphill against slight wind and at times the Hospital were hard pressed. The tackling, especially amongst the forwards, deteriorated, and this was responsible for Rugby's try.

Fixtures for March, 1967

March 4th	Streatham-Croydon : Chislehurst	
March 11th	Westminster Bank : Away	
March 15th	Public School Wanderers : Chislehurst	
March 18th	Aldershot Services (10.30 a.m.) : Away	
WELSH TOUR		
March 24th	Glynneath : Away	
March 25th	Treorchy : Away	
April 1st	Treorchy : Chislehurst	
March 2nd	HOSPITALS' CUP FINAL : Richmond Athletic Ground	

Playing Record up to 3rd February:

Played	Lost	Drawn	Won	Pts. For	Against
27	18	4	5	179	302

D. B. Jackson.

GOLFING SOCIETY

The 31st Autumn meeting was held at Porter's Park Golf Club on Thursday, 6th October.

Over 100 members had been circularised, twelve replied that they would play and twenty-three attended. It was a rather damp but otherwise enjoyable afternoon.

A. B. Haigh, off a handicap of 13, achieved the remarkable feat of winning all the competitions. The laws of this democratic society do not allow that any one member shall win more than one cup and Fiddian and Akeroyd, who were runners-up for the Graham Trophy, agreed that Haigh should receive the Milsom-Rees Cup. The award of the Graham Trophy presented difficulties, partly because Messrs. Fiddian and Akeroyd had returned identical scores and partly because it was not there. Finally it was decided that Fiddian should be the winner. This decision was made by private arrangement and was perhaps influenced by the fact that it was Fiddian's birthday and there was also a slight misunderstanding on the part of Akeroyd about the number of clubs one is permitted to carry.

THE

MEDICAL PROTECTION SOCIETY

FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Senior Medical Secretary
Herbert Constable
MRCS, LRCP

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Dental Secretary
Frank Allott,
LDS

The results of the competitions were, therefore, as follows:

The Milsom-Rees Cup (*Handicap*)

Winner: A. B. Haigh, 39 points (13);

Runner-up: L. P. Garrod, 37 points (18).

Sealed Holes

A. B. Haigh, 8 points.

Graham Trophy

R. V. Fiddian, 26 points;

A. Akeroyd, 26 points;

(A. B. Haigh, 28 points.)

The Summer Meeting will be held at the Worplesdon Golf Club on 21st June, 1967.

J.O.R.

JUDO CLUB

The club has been regularly fielding four teams which have achieved quite encouraging results in the *Wednesday Inter-College Leagues.*

The first team is as yet unbeaten and has a good chance of coming top of the league. This would make the 1966-67 season a very successful one as we have already won the United Hospitals' Cup.

In early December gradings were held at the Budokai Club at which the noteable upgradings were:

A. Boatman, to Blue Belt;
A. Ruddle, to Green Belt;
J. Deerlove, to Yellow Belt;
J. Davies, to Yellow Belt.

This means that we now have one Blue, four Green and four Yellow belts in the club, which should enhance our chances of keeping the Inter-Hospitals' Cup. (The competition is to be held in the U.L.U. Gymnasium on Wednesday, 22nd March.)

One of our most enjoyable fixtures was at Oxford in November when we took part in a match with the Dark Blues, Cranwell and Reading University. We by no means disgraced ourselves in beating Reading and losing to the other two teams.

It is unfortunate that we have not got enough floor-space to have our mats permanently fitted, as this would enable us to have much more time for practice.

P. D. Clarke.

SQUASH CLUB

The club was successful in the first Cumberland Cup Match of the season versus the **Metropolitan Police,** beating them 3-2. Ussher and Edelsten won without difficulty and Shepherd, on the verge of being beaten in the 4th game, was sportingly given the game by his opponent who retired with a knee injury. Mitchell and Latham lost to their opponents.

The next match was also a Cumberland Cup Match played against **British Petroleum.** The team lost 2-3. Ussher had a very exciting and skilful game but lost to his experienced opponent, Mitchell had a convincing win, and the captain played well to defeat his opponent. Edelsten lost after an energetic match and the secretary lost in straight games.

The club lost the match against the **Old Paulines** 2-3. Mitchell and the captain had convincing wins, whereas Edelsten played well in the first game but deteriorated as the games proceeded and lost. The secretary and Shepherd lost.

The match versus the **Bar** was lost 2-3. Goss played a very determined game and eventually beat his more experienced opponent. Mitchell won without difficulty. The captain, secretary and Graham all lost their games.

The club sent two teams to **Guy's Hospital.** Without doubt the match of the evening was that played between Ussher and Newman (Guy's) both played hard and the gallery was treated to an unlimited variety of shots. Ussher lacked the experience of Newman however, and unfortunately lost. Edelsten, Chesney, the captain and the secretary all lost their games. With the second team the situation was nearly reversed, Shepherd, Goss, Graham and Moore won, but Purcell unfortunately failed to make it a 5—0 victory.

The Cumberland Cup Match versus the **National Provincial Bank** was lost 2—3. Mitchell and Ussher, both in devastating form, won. Edelsten, the captain and Shepherd lost to superior opponents. A weak team consisting of the secretary, Moore, Purcell, Molyneux and Burke lost 5—0 to **Westminster Hospital.**

The match against the **Privateers** was played at the new Crystal Palace Sports Centre. Ussher played well with a great variety of shots but unfortunately lost. Edelsten beat his opponent in an exciting game, and Burke, who had little opposition, also won. The secretary and Shepherd lost to give the match to the Privateers.

The club was convincingly beaten by **West London.** Team: Ussher, Mitchell, Shepherd, Burke and Moore.

The Cumberland Cup Match against **Lensbury** was lost 2—3. Ussher and Mitchell won without difficulty, and Edelsten, Shepherd and the secretary lost to more experienced and fitter opponents.

The club won the return match against the **Privateers** 4—1. Mitchell, Ussher, Edelsten and the secretary won, and Shepherd fought hard but lost to a cunning opponent.

The return match versus the **Metropolitan Police** in the Cumberland Cup was lost 2—3. Mitchell started off with great speed and skill but slowed down in the following games. In the 4th game his opponent retired with an avulsed achilles tendon. Ussher won in his usual good style. The captain was unable to get the ball past his 6ft. 6in. opponent and lost after a fierce battle. The secretary and Shepherd lost in straight games.

The next fixture against **Gallagher** was lost 2—3. Goss, determined not to lose, snatched victory from his opponent after an exciting struggle. Edelsten played well to win his game. Graham and the secretary lost.

In the U.H. Cup Bart's met **Middlesex** in the first round. Ussher started off well but allowed his opponent too much room in the later games; score: 1—3. Mitchell had an unexciting win in a very quick three games. The captain could not find his length and lost in three games. Shepherd played well and won in three games. The match rested on the secretary who lost 2—3 after a long struggle, thus giving the match to Middlesex.

The return match against **Roehampton** was lost 2—3. Ussher and the captain won. Mitchell lost after a two game lead, and Shepherd and Burke played hard but lost to more experienced opponents.

In the final round of the Donaldson Cup the captain lost to John Ussher, who now holds the cup.

C. L. McCaldin.

WHAT DOES

STAND FOR?

IT STANDS FOR **security and peace of mind from the day you qualify—until the day you retire—and after.**

IT STANDS FOR **the provision of advice on all your professional problems . . . . for legal assistance in any difficulty or proceedings of a professional nature . . . . for unlimited indemnity in respect of damages and costs in the event of an adverse verdict or a settlement out of Court.**

IT STANDS FOR THE MEDICAL DEFENCE UNION **the oldest and largest organisation of its kind in the world. Further particulars can be obtained from**

THE MEDICAL DEFENCE UNION

Tavistock House South Tavistock Square London WC1

Secretary: Dr. Philip H. Addison

Dental Secretary: A. H. R. Rowe, M.D.S., F.D.S.

HOCKEY CLUB

United Hospitals' Cup
Bart's v. St. Mary's, Lost 1-0

The weather and other agencies were instrumental in producing a spate of cancelled matches during December and early January. This inevitably lowered the level of fitness of the team which lost to St. Mary's. This, however, is not offered as an excuse for the defeat, since territorially Bart's were overwhelmingly victorious.

Several of our shots hit defenders, goal posts, or were disallowed and our defence in its turn were left almost undisturbed for the majority of the game. St. Mary's single, though telling goal, came from their only real break-through—this occurred in the last five minutes of play and was sufficient to take them through to the semi-finals of the United Hospitals' Cup.

University Cup
Bart's v. Queen Mary College, Won 4-1

Queen Mary College were unfortunate to lose their centre half (and captain) in the early stages of this game. He fell awkwardly and dislocated his shoulder. After this, despite sturdy opposition, our forwards had little difficulty in scoring. Again the defence was rarely troubled, and the game resulted in a convincing win to take us into the next round of the University Cup competition.

Bart's v. Guys Hospital, Match Drawn 0-0

The usual taut atmosphere pervaded this match at Honor Oak.

This was our seventh match against Guy's in three seasons and was our fifth goal-less draw (indeed only three goals have been scored in all these seven games, two for us and one against; one cup match last year had to be decided on corners). This surely is a triumph for dogged defence and "midfieldmanship".

Despite its intensity the match was very enjoyable, though some would deny the justice of the drawn result in view of the dominance of our forwards.

Bart's v. Erith Technical College, Won 2-1

The skilful and aggressive play of our forwards proved a little too much for the experienced Erith side. Their few, though spirited attacks were dealt with capably (almost nonchalantly) by Mike Rymer and Graham Benke—our two husky backs, leaving a grateful goal-keeper to do some undisturbed gardening in the goalmouth (it's getting almost overgrown these days!).

Bart's v. Aylesbury, Lost 4-2

Playing Record	P	W	D	L	F	A
Bart's 1st XI	19	8	5	6	32	26
Bart's 2nd XI	9	3	0	6	12	32

P. R. Jordan.

SWIMMING CLUB

After the West of England tour, the Mary's Pool seemed shorter and the Bart's team found that they were fitter than their opposition. This gave them time to concentrate on ball handling and working together as a team. This soon began to show in an almost unbroken run of victories for both teams. But on a couple of occasions we could not muster a full team and this is the main reason we did not win our leagues. With the flood of new members to the club, we tried to give those with an obvious aptitude a few games in the senior team. This gave them experience and showed us what they could do.

R. Jolly and D. Shearer have been swimming for the U.L.U. team and were invited to go on their annual tour to Dublin. R. Jolly is also playing regularly for the U.H. Water Polo team.

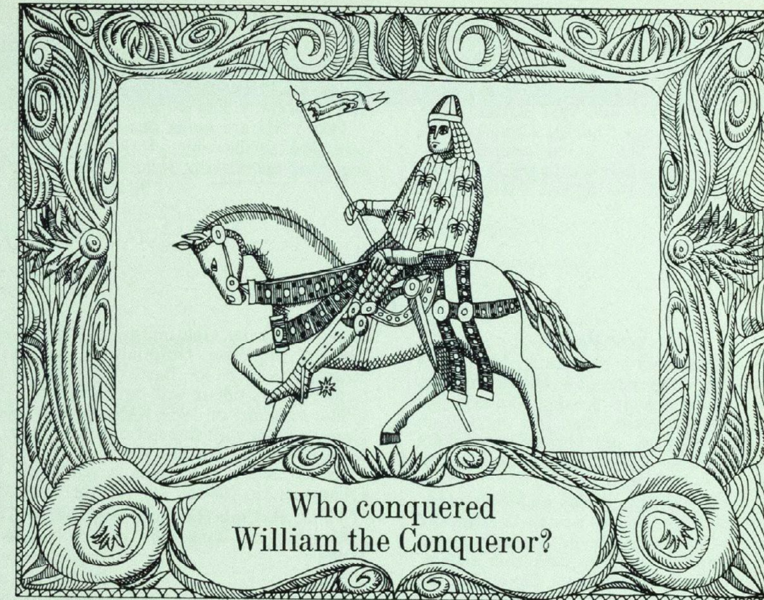
Training continues strongly with an ever increasing standard of fitness. But there is still room for more members.

Now in February we are starting the U.L.U. league with a group of individuals who know their own shortcomings and merits. They are working well together but must not become complacent with their victories.

P. Coburn and M. Weller have proved strong and constant members of the 1st team and with R. Jolly have been awarded their colours.

19th Jan. *West Ham*, Won 7—0.
26th Jan. *Royal Vet. College*, Won 8—0.

M. Knight.



No one.
But he still worried a lot.
About his acne.
It was unconquerable too.

Today, William's plight is still shared by many adolescents.
But now Neo-Medrone Acne Lotion
– the modern comprehensive acne control agent –
removes the frustration of uncontrolled acne.

Whenever you need a staunch ally
against acne, signify

Neo-Medrone Acne Lotion

Supplied: 25 cc. plastic squeeze bottles. **Upjohn** UPJOHN LIMITED · CRAWLEY · SUSSEX
REGISTERED TRADEMARK: NEO-MEDRONE GB3855.1

BOAT CLUB

U.L. Winter Eights: *2nd December*

The crews were unchanged from the previous Saturday's races against Guy's and both reached the finals. The first VIII played bridge all morning, St. Georges' having scratched, but returned to beat Q.M.C. in the semi-final by a ¼ length. In an exciting final Imperial College beat us by ¾ length. The second VIII enjoyed easy successes in the earlier rounds, but in the semi-final the margin was a canvas from L.S.E. In the final the U.C.H. crew—their first VIII with only two changes—won by four lengths.

Two VIIIs are going out twice a week this term and at the time of publication will be beginning the series of Head of the River races.

J. D. C. Martin

CROSS COUNTRY

New Year Report

On Wednesday, 29th November, four members visited the University of Sussex at Brighton for a triangular match. Scoring 4 a-side, we were beaten by Sussex but just won from Queen Mary College and also from Brighton Technical College, who turned up at the last moment.

The course, through woods and over grassland was pleasant, and it was to be regretted that more of our members did not make themselves available for such an enjoyable match.

On the second Saturday in December, we defended, but lost, the **Roehampton Cup** in the *University of London Championships*. With Thompson and Brooks only in the twenties and an unfit Graham Hesselden much further back, followed by our two other scorers, we were easily beaten by Goldsmiths, although we did hold off the other Hospitals. I feel that the potential is there for Bart's to return to their former glory, but it will be a long haul back to the standard of 1962 when we just lost 1st place to U.C., with three of our men in the first nine places, and our last scorer at 28. We shall it seems have a hard fight to retain the U.H. Championship for the 7th year in succession.

The **U.H. Club Handicap** was held at Chingford over six dangerous, icy miles on 7th January.

Result:—

		Time	Less H'cap
1.	D. Halestrap (Guys)	42min. 00sec.	41.00
3.	G. Hesselden	43min. 05sec.	37.35
6.	D. Tunstall-Pedoe	44min. 57sec.	41.37
8.	R. Thompson	48min. 38sec.	43.08
9.	F. Pagan	50min. 56sec.	45.26

R. Thompson

RIFLE CLUB

The first half of the season has seen some encouraging shooting in all sections of the club. The Novices B team is to be congratulated on its lead in Div. II of the University of London league with some excellent scores which, if continued, could maintain the team in this position.

Shoulder-to-shoulder matches have proved disappointing with only one in four of the matches in the Engineers Cup being won, and a heavy defeat by Leicester University (at Leicester) possibly due to "shooting whilst under the influence . . ." We will be fielding a strong side when Leicester return to us later in the season, when we hope to avenge this defeat. The first team has been encouraged by its win in the Lloyd Cup first round, with the highest score of all the hospitals and averaging over 96 per man. There is no reason why we should not remain at the top of this league.

Ian McLellan is to be congratulated on his win in Div. B of the Tiger Trophy Competition—a National Pistol competition—with a score of 270 ex 300. In the University competition, the pistol A team is again lying second to University College A, and in division II our B team is first with the C team not far behind.

As we have now been re-issued with a Range Safety Certificate, the range is, at last, being opened again, and we are in a position to practice for all our forthcoming matches. The full-bore season is almost here for those who wish to try a different aspect of the sport.

S. G. Crocker.

The Business Houses' Discount Buying Service

49 BOW LANE, CHEAPSIDE, LONDON, E.C.4.
Telephone: CENtral 7225

Authorised Suppliers of BRANDED MERCHANDISE to Staff Associations and members of Approved Organised Groups.

DISCOUNTS AVAILABLE LISTED ALPHABETICALLY

Item		Discount
Batteries (car)	UP TO	17½%
Bicycles	„ „	17½%
Branded Shirts	„ „	20%
Beds	„ „	17½%
Bedding (sheets, blankets, b/spreads)	„ „	17½%
Bathroom fittings	„ „	17½%
Blankets (electric)	„ „	17½%
BRANDED CARPETS	„ „	30%
Cars	„ „	10%
Car radios	„ „	17½%
Camping equipment	„ „	17½%
Car accessories	„ „	17½%
Clocks	„ „	17½%
Cookers (large)	„ „	10%
Cookers (small)	„ „	15%
Curtain fittings	„ „	17½%
Cutlery	„ „	33⅓%
Dressing table sets	„ „	30%
Electrical appliances	„ „	17½%
Furniture		
Bedroom	„ „	17½%
Kitchen	„ „	17½%
Lounge	„ „	17½%
Office (re-conditioned)	„ „	HALF-PRICE
Fridges	„ „	12½%
Gardening and General tools	„ „	17½%
Glassware	„ „	20%

Item		Discount
Hi-Fi equipment	„ „	20%
Kitchen equipment and gadgets	„ „	17½%
Lawn mowers (hand)	„ „	17½%
Lawn mowers (power)	„ „	12½%
Leather goods	„ „	20%
Light fittings	„ „	17½%
Nylons (assorted)	„ „	30%
PHOTOGRAPHIC EQUIPMENT INCLUDING FILMS	„ „	17½%
Pen sets	„ „	10%
Perfume (French)	„ „	20%
Radios	„ „	17½%
Radiograms	„ „	20%
Record players	„ „	20%
Suitcases	„ „	17½%
Tape recorders	„ „	20%
Television sets	„ „	20%
Table lamps	„ „	17½%
Tyres (FITTED FREE)	„ „	17½%
Tools (POWER) and accessories	„ „	17½%
Typewriters	„ „	12½%
Towels	„ „	17½%
Venetian blinds	„ „	20%
Watches	„ „	17½%

This list is intended only as a guide to the range of merchandise we are able to offer. In addition to items listed, there are many others available at comparable discounts. The company reserves the right to amend prices and discounts without notification.

A DIVISION OF
THE RYAMS ORGANISATION (Southern) LTD

SAVE up to 7/6 in the £

off the basic price on all your purchases

Almost anything can be supplied at most favourable discounts and delivery can be arranged anywhere in the country.

Furniture, Carpets, Watches 25%. Cutlery, Venetian Blinds 20½%. Tape Recorders, Projectors 20%. Record Players, Binoculars 20%. Radio, TV, Sewing Machines 20%. Screens, Lenses, Enlargers, etc. 20% Electrical Goods, Oil Heaters, Washing Machines, Spin Driers, Razors, Heaters, Food Mixers, etc. 17½% to 15%. Refrigerators, Mowers, Power Tools 12½% to 15%. Gas Appliances 12½%. Cars 10%.

All goods supplied are brand new and fully guaranteed

Reading Warehouses Ltd.

(Dept. BM)

TADLEY, HANTS.

Phone: TADLEY 3704

A SPRING MARKET

is to be held by

BARTS' WOMEN'S GUILD

on **March 15th** from **11 a.m. to 5.30 p.m.**

in the

Gloucester Hall Nurses' Home

PROCEEDS ARE TO PROVIDE ADDITIONAL COMFORTS FOR PATIENTS & TO CONTRIBUTE TO THE BENEVOLENT FUND OF THE LEAGUE OF ST. BARTHOLOMEW'S NURSES.

ALL ARE WELCOME

Engagement Rings

From Craftsman to Wearer

25% DISCOUNT

"FINEJEWELS"

88-90 HATTON GARDEN, E.C.1.

Telephone: HOLborn 8058

Weekdays 9.30-5.30, Sat. 9.30-1

AIDS TO LABORATORY DIAGNOSIS

Catalogues and lists available

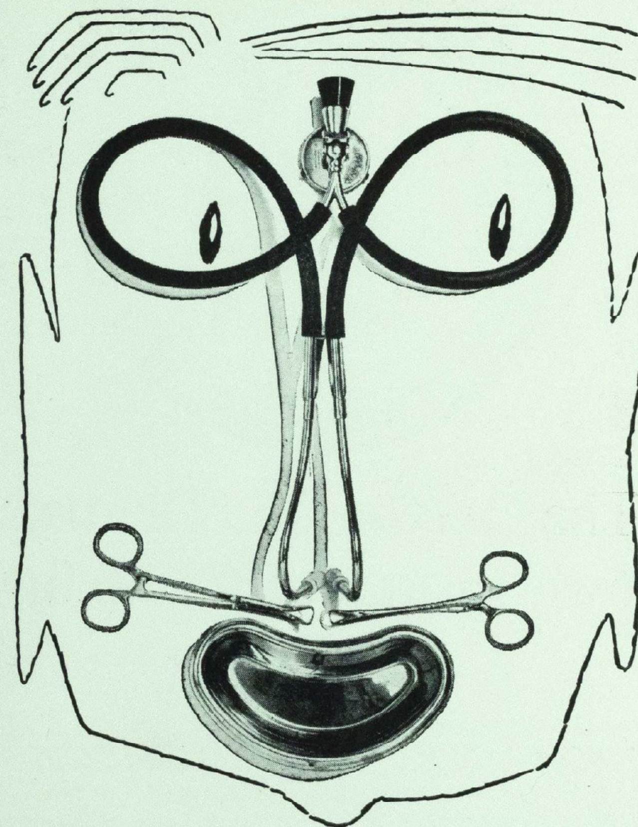
- ★ Biological Stains and Reagents, list L.
- ★ Instruments and Accessories for Microscopy.
- ★ "WELLCOME" Diagnostic Reagents and Materials.
- ★ "WELLCOME" Transaminase Regents.
- ★ Service Bulletins.

Specialists in Biological Stains Since 1915

GEORGE T. GURR LTD.

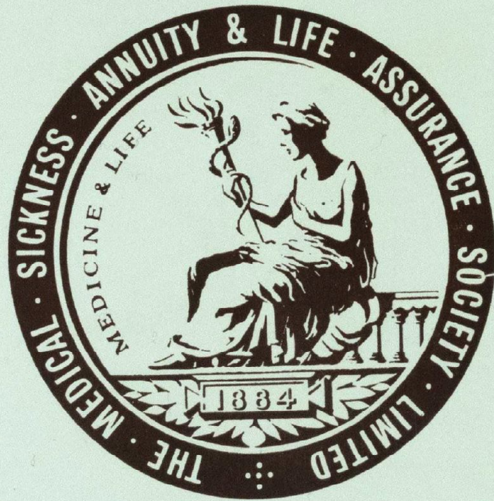
136-144, New King's Road, London, S.W.6.

Cables: Microstain: London, S.W.6. Tel: RENown 5282/4



the bank for friendly service

The St. Bartholomew's Hospital Office, which is opened for your especial use, is under the management of Mr. R. B. Harrison, West Smithfield Branch, 59 West Smithfield, E.C.1 and enquiries will be welcomed.



The Doctors and Dentists own Insurance Company

Sickness and Accident Insurance
Permanent Policies to meet the special needs of the Medical and Dental Professions.

Family Provision Assurance
A tax free income for your family in the event of death.

Life Assurance
Capital for retirement and security for dependants in the event of death.

The Combined Policy
Three Policies in one—Permanent Sickness and Accident Insurance, Life Assurance and Family Provision Assurance.

Foundation Policy
A foundation on which students and newly qualified Doctors and Dentists can build to obtain a combined policy. Cover against incapacity and death at very low cost with the right to convert to a normal policy later.

The Medical Sickness Annuity and Life Assurance Society Limited

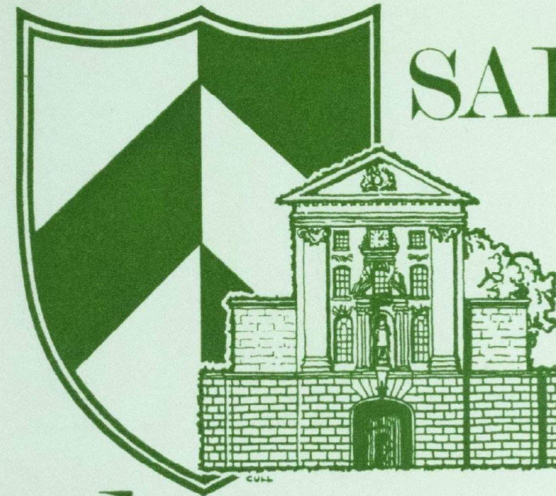
P.O. Box 449, 7-10 Chandos Street, Cavendish Square, London. W1. Tel: Museum 1686

Member of the British Insurance Association.

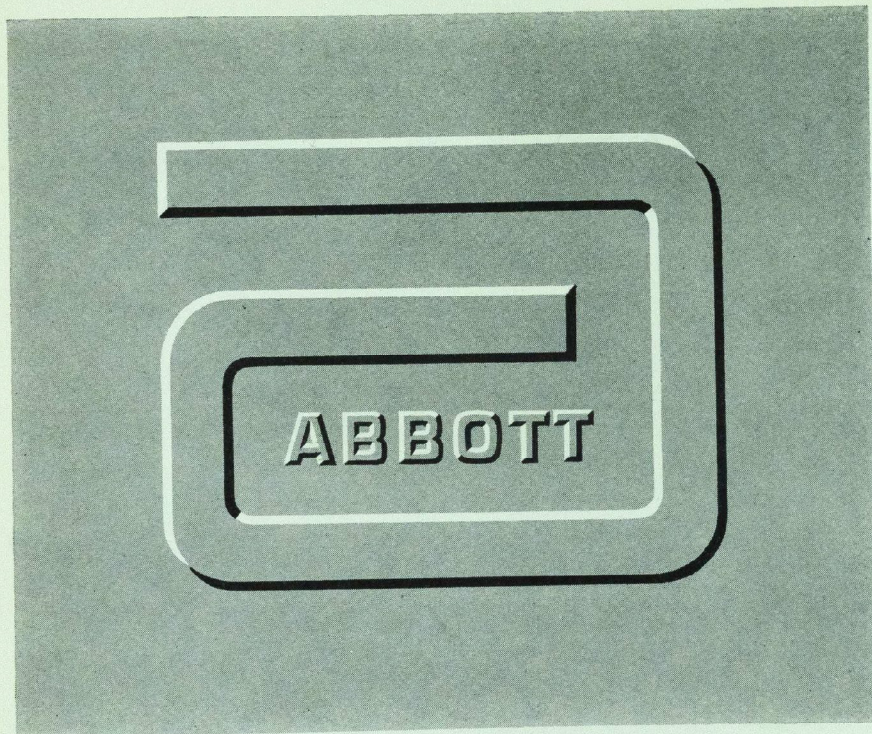
Printed by Dramrite Printers Ltd., 91, Long Lane, London, SE1. j 1512

The Zambia Flying Doctor Service

SAINT · BARTHOLOMEW'S · HOSPITAL · JOURNAL



VOL. LXXI No.4 APRIL 1st, 1967



The symbol of better health

Just as a patient needs to have complete confidence in the doctor, so the doctor needs to have confidence in the products he prescribes. Ultimately, this means confidence in the manufacturer of pharmaceuticals. Such confidence can only be built up over the years, by the profession as a whole, when it has used the products and found them not only effective, but also convenient and consistent in use. Confidence is a complex phenomenon, but easy to recognise—like the Abbott symbol.

Abbott pharmaceutical products include: Aerotrol · Calcidrine · C.V.K. · Dayamin · Desbutal · Di-Paralene Enduron · Enduronyl · Erythrocin · Erythroped · Eutonyl · Ferro-Gradumet · Ferrograd C · Harmonyl · Iberol · Nembudeine Nembu-Donnal · Nembutal · Norisodrine · Paradione · Peganone · Penthrane · Pentothal · Phenurone · Selsun Serenesil · Tridione · Vi-Daylin

ABBOTT LABORATORIES LIMITED QUEENBOROUGH KENT

ABPR19/1

FIRST FOR CARPETS

Dodson Bull

UP TO 30% DISCOUNT ON BRANDED CARPETS

Wiltons • Axminsters • Orientals • Tufted

£200,000 Carpets on display

in our extensive London and Northern Showrooms

- All makes available with full Manufacturers Guarantees.
- Free Delivery U.K.
- NO IMPERFECT GOODS SOLD
- Expert fitting service available most areas

Write stating requirements or for introduction to showrooms in most main cities

Open 9.30 to 5.30 Mon. to Fri. 9.00 to 12 noon Sats.

DODSON-BULL CARPET CO LTD

2, 4 & 5, Little Britain London EC1 (1 min St Paul's)
Tel: MON 7171 (10 Lines)

LONDON'S LEADING SPORTS OUTFITTERS

OFFICIAL OUTFITTERS TO

ST. BARTHOLOMEW'S HOSPITAL STUDENTS' UNION

BLAZERS - SWEATERS - TIES - SCARVES

10% Discount allowed to all ULIESA Students off Sports Equipment.

JACK HOBBS

59 FLEET STREET, LONDON, E.C.4

Tel: FLEet Street 2139

R. E. F.

PHOTO SERVICE

Wedding Specialists

Covering England

10% DISCOUNT

TO ALL HOSPITAL STAFF

Enquiries, full details;

13 HORNSEY RISE GARDENS N.19.

ELEGANT HAIR STYLES at

JOSEPHINE

of REGENT STREET

CITY

BRANCH

ST. BARTHOLOMEW'S HOSPITAL VOUCHER FOR

20% DISCOUNT AT

JOSEPHINE

TEL: CLE 0464-3

MONDAY—THURSDAY incl.

30 GOSWELL ROAD, E.C.1.

Valid for April 1967

ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE

The Wine Committee

(*President: Mr. George Ellis*)

announces that the Fifth Annual

Barbecue Ball

(incorporating the View Day Ball)

will be held at **Charterhouse Square**

on **Friday, 9th June, 1967**

Attractions and distractions include:

FIVE BANDS

CABARET

not to mention BARBECUE

also

Too much cheap drink; too many bars

Marquee with dance floor big enough for the whole family

More than ample sumptuous buffet

AND the usual high standard of Wine Committee decoration

Double Tickets: 4 *guineas* (*Students* 3 *guineas*) *are available from the Wine Committee.*

SAVE up to 7/6 in the £

off the basic price on all your purchases

Almost anything can be supplied at most favourable discounts and delivery can be arranged anywhere in the country.

Furniture, Carpets, Watches 25%. Cutlery, Venetian Blinds 20½%. Tape Recorders, Projectors 20%. Record Players, Binoculars 20%. Radio, TV, Sewing Machines 20%. Screens, Lenses, Enlargers, etc. 20% Electrical Goods, Oil Heaters, Washing Machines, Spin Driers, Razors, Heaters, Food Mixers, etc. 17½% to 15%. Refrigerators, Mowers, Power Tools 12½% to 15%. Gas Appliances 12½%. Cars 10%.

All goods supplied are brand new and fully guaranteed

Reading Warehouses Ltd.

(Dept. BM)

TADLEY, HANTS.

Phone: TADLEY 3704

'The advantage of the Concise Medical Textbooks is their low price which makes their addition to the student's library easy . . . to this are added clear writing . . . and sound teaching.'

British Medical Journal.

CONCISE MEDICAL TEXTBOOKS

The following are the books now available in this popular series. Further titles are in preparation.

Bacteriology by C. G. A. Thomas. 312 *pp.* 21*s.*

Biochemistry by S. P. Datta and J. H. Ottaway, 379 *pp.* 82 *illus.* 25*s.*

Dermatology by R. M. B. Mackenna and E. Lipman Cohen, 288 *pp.* 1 *plate* 21*s.*

Embryology by M. B. L. Craigmyle 199 *pp.* 86 *illus.* 16*s.*

Gynaecology by J. M. Holmes 228 *pp.* 29 *illus.* 18*s.*

Obstetrics by J. M. Holmes 264 *pp.* 37 *illus.* 18*s.*

Ophthalmology by Kenneth Wybar 360 *pp.* 79 *illus.* 25*s.*

Organic Chemistry by G. P. Maw. 214 *pp.* 18*s.*

Pathology by J. L. Pinniger 270 *pp.* 6 *illus.* 18*s.*

Psychiatry by E. W. A. Anderson. 304 *pp.* 21*s.*

Public Health and Preventive Medicine by J. B. Meredith Davies 318 *pp.* 5 *illus.* 25*s.*

BAILLIÈRE, TINDALL & CASSELL

7 & 8 Henrietta Street, London, W.C.2

H. K. LEWIS & Co. Ltd.

BAILEY & LOVE'S SHORT PRACTICE OF SURGERY
Thirteenth Edition revised by A. J. Harding Rains, M.S., F.R.C.S., and W. Melville Capper, F.R.C.S. Consulting Editor: McNeill Love, M.S., F.R.C.S. With 1677 illus. (286 coloured). 9¾ in. x 6⅝ in. **£4 4s.**, postage 6s.

RAWLING'S LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY
Ninth Edition revised by J. O. Robinson, F.R.C.S. 8½ in. x 5½ in. 38 illus. **17s. 6d. net**, postage 1s. 1d.

BASIC PRINCIPLES OF ACCIDENT SURGERY
By M. C. T. Morrison, F.R.C.S. 8½ in. x 5½ in. 29 illustrations. **£1 1s. net**, postage 10d.

ELEMENTARY PATHOLOGICAL HISTOLOGY
By W. G. Barnard, F.R.C.P. Third Edition. With 185 illustrations. 9¾ in. x 7¼ in. **17s. 6d. net**, postage 1s. 1d.

THE DIAGNOSIS OF THE ACUTE ABDOMEN IN RHYME
By "Zeta." Fourth Edition, with drawings by Peter Collingwood. 7¼ in. x 4¾ in. **10s. 6d. net**, postage 10d.

ROXBURGH'S COMMON SKIN DISEASES
12th Edition by Peter Borrie, M.A., M.D., F.R.C.P. 8½ in. x 5½ in. 239 illustrations. **£2 10s. net**, postage 3s.

OBSTETRICS AND GYNAECOLOGY Combined for Students
By Elliot Philipp, M.A., M.B., B.Ch., F.R.C.S., F.R.C.O.G., 9¾ in. x 6⅝ in., 203 illustrations. **£3 15s. net**, postage 3s. 3d.

POCKET BOOK OF PHYSICAL SIGNS IN MEDICINE
By H. Fuld, M.D., F.R.C.P. 8½ in. x 5½ in. **£1 5s. net**, postage 1s.

NOTABLE NAMES IN MEDICINE AND SURGERY
By Hamilton Bailey, F.R.C.S., and W. J. Bishop, F.L.A. Third Edition. With 241 illustrations. 8½ in. x 5½ in. **£1 15s. net**, postage 1s. 3d.

THE MECHANISM OF LABOUR FOR STUDENTS
By D. B. Bower, F.R.C.S., M.R.C.O.G., D.Obst. With 36 illustrations 7¼ in. x 4¾ in. **(Nearly Ready)**

136 GOWER STREET, LONDON, W.C.1
Telegrams: "Publicavit, London," W.C.1 Telephone: EUSton 4282 (7 lines)

UNIVERSITY EXAMINATION POSTAL INSTITUTION

G. E. OATES, M.D., M.R.C.P., London

POSTAL COACHING FOR ALL MEDICAL EXAMINATIONS

Carefully designed courses under the supervision of specialist tutors. Advice on reading, guidance notes to each lesson and solutions to all test papers are provided.

PROSPECTUS AND LIST OF TUTORS
on application to

Dr. G. E. OATES,
17 Red Lion Square, London, W.C.1
Telephone: HOLborn 6313

JEWELLERY AND WATCHES

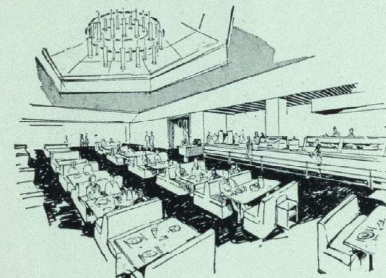
20%-25% DISCOUNT TO ALL BARTS STAFF
ON OUR OWN MANUFACTURED GOODS
DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings,
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. -Teasets & Plate.

10%-20% DISCOUNT TO ALL BARTS STAFF
on all Branded Goods — ALL SWISS WATCHES, Clocks, Cutlery, Pens, and Lighters and on Second-hand Jewellery.

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTON GARDEN, E.C.1
HOL 0700 or 6431
OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00
Special attention to order by post or phone

Have you tried it yet?

GAMAGES
NEW "CRYSTAL DOME"
Self-Service Restaurant
With Table Licence



GAMAGES HOLBORN E.C.1

Completely redesigned and fully re-equipped. Finished in an attractive contemporary decor.

Enjoy perfectly cooked, appetising meals in luxurious comfort. A widely varied Luncheon Menu available from 11.30a.m.-3.30 p.m. Morning Coffee, Snacks, Teas, etc., available during Store hours.

The "Crystal Dome" adjoins the Cocktail Bar and Sandwich Lounge on the 3rd Floor and is served by three direct lifts

NO WAITING. POPULAR PRICES. Why not try it? NOW!

9 a.m.-5 p.m. (Thursdays 7 p.m.) Sats. 1 p.m.

A wise move . . .

Insurance—*Life, Sickness, Accident, House, Surgery and Motor*—**features prominently in professional life. There are many Insurance Societies transacting business with wide variation in terms and conditions from which to choose and it is a wise move to obtain the best contract possible.**

Founded almost 60 years ago the function of the Medical Insurance Agency is to act as Insurance Brokers and, with its wide knowledge of conditions in medical and dental practice, it is able to render a valuable service on Insurance and many financial problems.

All surplus is devoted to the endowment of Scholarships and in donations to existing charitable funds of the Medical and Dental professions.

MEDICAL INSURANCE AGENCY
Limited (By Guarantee)
Chief Office: **B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1**
TELEPHONE: 01-387 6031/9
Branches throughout the country

Transform the Parkinsonian patient with

'KEMADRIN'

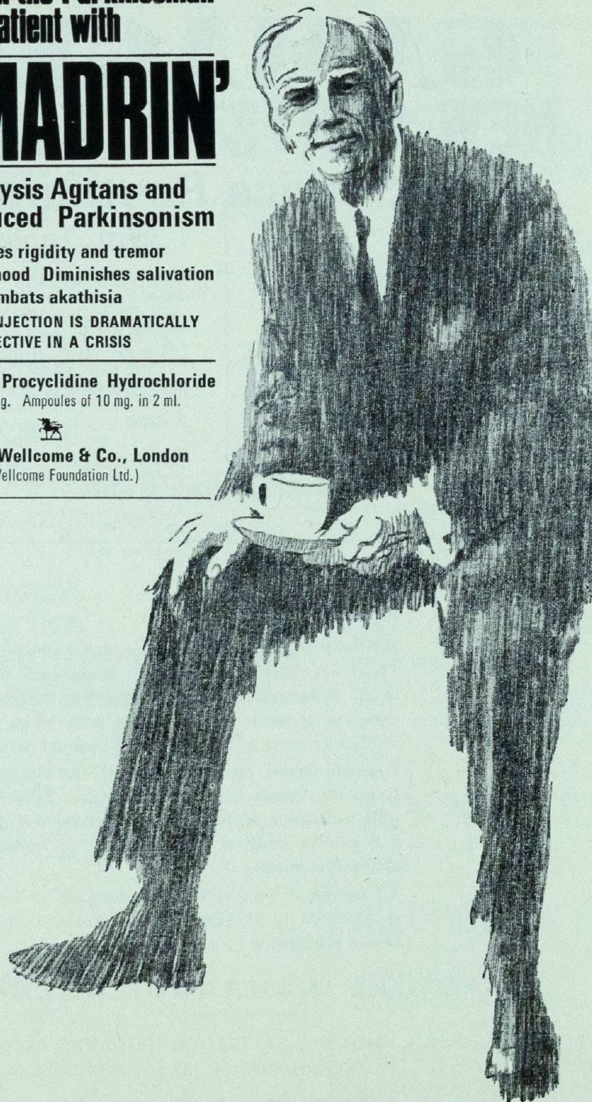
in Paralysis Agitans and Drug-induced Parkinsonism

Decreases rigidity and tremor
Elevates the mood Diminishes salivation
Combats akathisia

'KEMADRIN' INJECTION IS DRAMATICALLY EFFECTIVE IN A CRISIS

'Kemadrin' brand **Procyclidine Hydrochloride**
Tablets of 5 mg. Ampoules of 10 mg. in 2 ml.

Burroughs Wellcome & Co., London
(The Wellcome Foundation Ltd.)



Saint Bartholomew's Hospital

JOURNAL

Vol. LXXI No. 4 — 1st April, 1967

CONTENTS

The Iniquitous Drag ... 124
Letters to the Editor ... 125
News ... 126
London Medical Group ... 127
Abernethian Society ... 127
Retirement: Arthur Westwood ... 128
The Zambia Flying Doctor Service, by James Lawless ... 129
Prospect ... 134
Two Cases of Cavernous Sinus Thrombosis, by Derek Browne ... 135
Drama Society: The Birthday Party ... 140
A Case of Cigarette Angina, by Geoffrey Bourne ... 142
The Ninth International Cancer Congress via Siberia, by Malcolm Donaldson ... 143
Medicine in Literature ... 146
Tuna Fishing in Newfoundland, by Michael Keighley ... 147
The Boat Club Ball ... 150
Epicurus ... 151
Reviews, Penguin ... 152
Medical Books ... 156
Sports News; Sports Editorial ... 159
Hockey Club ... 159
Boat Club ... 160
Golf Club ... 160
Soccer Club ... 160
Cross Country Club ... 162

THE JOURNAL STAFF

Editor: **J. A. Sills**
News Sub-Editor: **Miss E. A. Macdonald**
Reviews Sub-Editor: **I. D. Fraser**
Social Sub-Editor: **R. C. D. Staughton**
Sports Sub-Editor: **R. H. Soper**
Photographic Sub-Editor: **C. G. Fagg**

Manager: **J. P. D. Reckless**
Assistant Managers: **C. S. B. Roch-Berry**
N. T. Goodchild
M. Castleden
Charterhouse Representative: **Miss J. Hall**
Nurses' Representatives: **Miss E. Ferreira**
Miss P. M. Kilshaw

THE INIQUITOUS DRAG

One of the less agreeable modes of transport during rush hours is the 'tube' train, and one of the most irritating situations, for one who does not indulge in the habit of smoking tobacco, is to find circumstance directing one into a 'smoking' compartment. There one is subjected to the massed fumes of the packed inmates, among whom, to be pitied particularly are the bronchitics with dyspnoea at rest, sucking feverishly at half an inch of cigarette, held in nicotine-stained fingers. Even in hospitals similiar phenomena are not uncommon, though one difference is the silent presence of the *Bird* respirator.

It is now some five years since the publication of the *Royal College of Physicians Report on Smoking and Health*, but apparently the message has yet to permeate the populace. The evidence linking the smoking of tobacco with ill-health is well documented; it is strongly associated with the first stage of Chronic Bronchitis (cough and sputum) and it is a well known fact that abandoning the habit of smoking aids remission of more severe states. Lung Cancer (squamous cell and oat cell carcinomas) correlates very closely with cigarette smoking, but as the word 'cancer' is still emotionally charged, people are prone to introduce irrelevant arguments to attempt to deny the causal relationship, presumably for their own peace of mind.

The classic Framingham study in the United States showed that there is an increased risk of myocardial infarction in people who smoke, and on page 142 of this *Journal* Dr. Geoffrey Bourne reports a case of angina due to cigarette smoking. Peptic ulceration, atherosclerosis and thromboangitis obliterans are all associated, even the foetus according to recent evidence is not immune from the effects; one survey has shown that children born to mothers who were smokers, tended to be smaller and were more likely to be born prematurely.

Unfortunately tobacco is big business, and the annual tax revenue is in the region of £1,000 million, compared with the cost of the N.H.S. of around £1,350 million. The average adult consumption of cigarettes in 1965 was 2,680 per head, and it is estimated that some 72 per cent. of men and 39 per cent. of women over the age of sixteen are classed as smokers. This has its effect in the sickness rates; for example the highest single cause of working day loss in 1961-62 was bronchitis with 123 days lost per 100 men, a similar figure for acute upper respiratory tract infections was 52 and for arteriosclerotic and degenerative heart disease 36. In contrast, the estimated comparative figure for days lost by industrial action is about 15 days per 100 men.

It appears, sadly, that it is well nigh impossible to dissuade the long-standing smoker from continuing the habit, and so it is important that efforts are now directed instead at prevention. The emphasis must be on convincing people of the potential dangers of the habit and on the essentially dirty nature of the habit. As Mr. Donaldson points out on page 145, all cigarette packs on sale in the United States are required to carry a warning of the health hazard, as yet this is not the case in Britain. In fact Government anti-smoking propaganda appears at present to be merely token and the annual expenditure on this cannot compare with the £18.8 million spent on advertising by the tobacco industry in 1964.

As members and future members of the Profession of Medicine we must, even more perhaps than others in positions of authority and respect such as parents and school-teachers, be prepared to set an example and give firm advice to the public and in particular to dissuade the younger members of our society from even starting the habit. Some people may require examples to back up the advice, and it may be helpful to quote the fact that this Profession seems to have accepted the link between smoking and lung cancer, for there has been a fall in the numbers of Doctors smoking and a coincidental fall in their mortality from that condition.

It is surely up to us to see that this fall becomes generalised throughout the population.

LETTERS TO THE EDITOR

FEBRUARY EDITORIAL

Sir,—May I have the opportunity of correcting an error of fact on which is based the theme of your Editorial "A New Era?", which dealt with intra-uterine exchange transfusion. The team did not arrange to publicise this operation. The fact is that within three hours the Press had got hold of the name of the surgeon and rough details of the operation, which they intended to publish. It seemed right, therefore, that they should be given a more accurate report. In the event one paper saw fit to ignore this. We decided to give the information direct to the Press in an endeavour to avoid the misrepresentation which occurred on the last occasion when publicity affected this Department. It is particularly distressing that just this should occur now in our own *Journal*.

Yours sincerely,
C. N. HUDSON,
Resident Assistant Physician Accoucheur,
St. Bartholomew's Hospital,
13th February. E.C.1.

The *Journal* welcomes this letter and offers its apologies for the misrepresentation. It would like to suggest however, that it did not act completely irresponsibly; before publication a copy of the typescript of the Editorial was submitted as a courtesy to the Surgeon. Unfortunately the reply which would have provoked alterations was delayed in postal transit and did not reach the *Journal* until after the publication of the February issue.

STATISTICS

Sir,—It is sad to read in Paul Turner's interesting article on Clinical Pharmacology (*Journal*, February, 1967) that Bart's which since 1948 has been the only London undergraduate teaching hospital with its own Department of Medical Statistics, now has to turn to a drug firm for statistical advice.

Yours faithfully,
M. P. CURWEN,
10 Southwood Lane,
8th February. Highgate, N.6.

Sir,—A Department of Clinical Pharmacology needs not only statistical advice but actual assistance in the analyses of results. Modern statistical methods involving analysis of variance or dispersion may require computer time with elaborate programming procedures. This is more than the Hospital's Department of Medical Statistics can provide at present, in view of its other commitments.

Until the time comes when this Department has its own full-time statistician and access to a computer, we are more than grateful for the outside assistance we receive.

Yours faithfully
PAUL TURNER,
Dept. of Clinical Pharmacology,
St. Bartholomew's Hospital,
13th February. E.C.1.

Engagements

GRANT—GLYN WILLIAMS.—The engagement is announced between Dr. Travers Grant and Miss Shirley Glyn Williams.

JOHNSON — IMRIE. — The engagement is announced between Stafford Martin Johnson and Miss Elisabeth Imrie.

VANNEGAN — MORGAN. — The engagement is announced between John A. D. Vannegan and Miss Gillian M. Morgan.

Marriage

BALDWIN—ROBERTS.—On January 21, Dr. R. W. M. Baldwin to Marion Roberts.

Births

GILLESPIE.—On February 9, to Anne (née Victory) and Dr. H. M. Gillespie, a son (Christopher Michael).

GORDON.—On February 3, to Sissel and Dr. Alistair Gordon, a son (Morten Alexander).

Deaths

PALMER.—On February 9, Dr. P. J. E. B. Palmer, M.R.C.S., L.R.C.P., Qualified 1939.

April Duty Calendar

Sat. & Sun. 1st & 2nd.
Mr. Ellison Nash
Dr. Black
Mr. Manning
Dr. Gillett
Mr. Dowie

Sat. & Sun. 8th & 9th.
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Bowen
Mr. Fuller

Sat. & Sun. 15th & 16th.
Mr. Tuckwell
Dr Oswald
Mr. Aston
Mr. Ellis
Mr. Cope

Sat. & Sun. 22nd & 23rd.
Prof. Taylor
Prof. Scowen
Mr. Burrows
Dr. Ballantine
Mr. McNab Jones

Sat. & Sun. 29th & 30th.
Mr. Hunt
Sir Ronald Bodley Scott
Mr. Aston
Dr. Jackson
Mr. Dowie

Physician Accoucheur for April is Mr. D. Williams.

Honours

University of London

Prof. O. J. Lewis has been appointed to the Chair of Anatomy, in the Medical College.

University of Cambridge

H. B. Stallard, Gonville and Caius College; M.Chir.

Sims-Black Travelling Professer

Mr. D. B. Fraser has been elected to this Professorship for 1968.

Announcement

The May issue of the Journal will not be published until View Day, Wednesday 10th, May.

Erratum

We regret that in 'A Case of Hydranencephaly' by M. R. B. Keighley in the March Journal, the bottom line of the right hand column of p. 98: *'and middle cerebral vessels are present.'* was transposed to the top of the left hand column.

Department of Psychological Medicine;
December Clinical Meeting,

"Aviation Medicine"
Dr. W. A. H. Stevenson

Dr. Stevenson, a Psychotherapist in the Department of Psychological Medicine, is also a civilian Consultant Psychiatrist to the Ministry of Civil Aviation, and Clinical Consultant Psychiatrist to the combined Medical Board of British European Airways and the British Overseas Airways Corporation.

On the 8th December, he read a short paper on the psychiatric aspect of "Aviation Medicine" especially in its relation to passengers, air crew and ground staff. He made the comment that an aeroplane stands up on three legs, its crew, engines and the ground control staff, and said that it was essential for all personnel to function harmoniously and with the greatest possible reliability.

He discussed the various ways of maintaining the health and morale of personnel at peak efficiency, and also relating to passenger comfort and safety.

London Medical Group

Symposium on ABORTION

The London Medical Group, sponsored by the Institute of Religion and Medicine, holds meetings mainly on ethical matters, open to all connected with the medical services. The meetings are held in rotation at different Medical Schools, and on 16th February, Bart's were hosts at a symposium on Abortion.

Mr. D. B. Fraser, the Chairman of the Meeting welcomed the speakers, and defined the meaning of abortion as the termination of a pregnancy before the 28th week of intra-uterine life.

The first speaker was the Rt. Rev. Robert Mortimer, Bishop of Exeter, who sat on the recent Church Assembly Committee on Abortion. He explained that the Roman Catholic view is that life begins at the moment of conception, whereas the Anglican Church considers that the foetus up to the 28th week is a potential life, which has the right to live. If the rights of the mother conflict with those of the foetus, then it may be justifiable to sacrifice the potential life.

Lord Silkin, the next speaker, is well known as an advocate for reform of the Abortion law, for it was he who introduced a Bill of reform in the House of Lords two years ago, although he explained that his involvement had arisen more or less by accident. He said that abortion was available on a very limited scale under the Health Service, although anyone with fair reason could have an abortion performed by a reputable surgeon if they could afford to pay. At the same time it is estimated that about 20,000 illegal abortions are carried out every year. The present legal situation is entirely dependent on the precedent set by the celebrated Rex *v.* Bourne case of 1938. Statutory law was needed with the indications widened to include the following cases: rape, a foetus liable to be deformed, a mentally defective mother, the health of the mother likely to be adversely affected, and certain other cases in which the addition of a further child was likely to be detrimental to the family.

Dr. G. F. Abercrombie, a distinguished general practitioner and former President of the College of General Practitioners, spoke on abortion as it concerned his profession. Broadly there were two groups of patient who came into the G.P.'s surgery requesting abortion: one was the single girl unknown to the doctor, and the other, the married woman threatening to go to an illegal abortionist if nothing were done. In all his professional life he had only had to refer a handful of women for therapeutic abortion. He could see no good reason for making the law more specific, especially as the medical indications for abortion were becoming fewer and fewer.

Some lively questioning followed with Lord Silkin rigorously defending the case for reform, but the Chairman never let him off the hook and occasionally he floundered. The Bishop stuck firmly to the Church line, and seemed unwilling to elaborate on its rather vague rulings, and Dr. Abercrombie was brief and sensible. The Chairman's poignant wit shone through, but his wisdom, although somewhat dogmatic, was not concealed.

One got the impression that the argument for change in the present case law is slight. Although not much new was said, the symposium seemed to stimulate discussion over the coffee table, which presumably was its object. But whatever is done, as Dr. Abercrombie so aptly said: "Love will find a way".

M.E.S.

Abernethian Society

Thursday, 23rd February:

A Symposium on Myasthenia Gravis

The President, welcoming the speakers, said that this form of meeting was the exception nowadays, although in the early 19th Century it had been the rule; in those days a fine of one shilling was imposed on all who failed to attend, but he assured the speakers that the large audience present had had no such encouragement. Three of the speakers were well known to Bart's—Dr. Aldren Turner, Mr. Tubbs and Dr. Boulton; the fourth, Dr Parkes had formerly worked in the Physiology Department and was now Neurological Registrar at King's College Hospital.

Dr. Aldren Turner, speaking first, gave a characteristically urbane discussion of the clinical features and history of *Myasthenia.* Thomas Willis, of Oxford, is credited with the first description of the disease in his book, De Annima Brutorum, published in 1672. For 200 years there were no further descriptions in the literature until Wilks of Guy's reported a case, and then in 1895 Jolly named the disease *Myasthenia Gravis pseudoparalytica.* The great breakthrough in treatment came in 1934, when it occurred to Dr. Mary Walker, working at St. Alfege's, Greenwich, to try the anti-curare

substance Physostigmine on a Myasthenic, and the result was a dramatic relief of the weakness.

The relationship between the Thymus and Myasthenia was observed by Sauerbruch, when he removed the thymus of a thyrotoxic patient, with relief of the coincident Myasthenia, but not the thyrotoxicosis. Blalock in the United States and Keynes in this country developed the treatment of Myasthenia by thymectomy, and later thymic irradiation.

Dr. Parkes then spoke on the possible mechanisms of the disease. There were two principal aetiological theories. The auto-allergic theory supposed that a disturbance in the antibody producing mechanism resulted in an antigen-antibody reaction at the neuromuscular junction. The other theory was that there is a circulating toxin, possibly produced by the thymus, which blocks neuromuscular transmission. Dr. Parkes weighed up the evidence for the two theories: he had been able to demonstrate a factor in the serum of Myasthenics, which produced neuromuscular fatigue when injected into rats, but the factor had not been identified. Although antibodies have been demonstrated in Myasthenics, he felt that these reflected rather than caused the disease. He then showed a delightful short film of a myasthenic dog, Topper, and its remarkable response to anti-cholinesterases.

Mr. Tubbs, speaking on the surgery of the Thymus, emphasised that thymectomy must only be carried out on a carefully selected group of patients—young patients whose disease was of short duration, and the desperate cases which had failed to respond to other treatments. When a thymoma, and not just hyperplasia was present, radiotherapy possibly with subsequent thymectomy was the treatment of choice. He preferred to leave the selection of cases and timing of operation to the neurologist.

Finally, Dr. Boulton in a talk illustrated with admirable "pop-art" slides gave what he called his "simple man's guide" to Myasthenia. Undaunted by Dr. Parkes' preference for a circulating toxin theory, he defended the auto-allergic mechanism. He went on to summarise the available treatments, stressing the value of complete rest of the neuromuscular junction by treating the patient on a respirator for a short time, even under curare. He then discussed the results of recent thymectomies here, and showed convincingly the value of routine post-operative positive pressure respiration in these cases.

Some interesting points arose, both from the floor and the panel in the ensuing discussion, after which Dr. Griffith of the Physiology Department thanked the speakers for an entertaining and fascinating meeting.

M.E.S.

Retirement

ARTHUR WESTWOOD

Arthur Westwood came to the medical college in 1920, and will be remembered by many years of Bart's men. Most of his work was in the anatomy department where he served under several professors, coped with numerous demonstrators, and ruled countless students with great deference.

The method he developed for preparing cadavers was something of a closely guarded secret and the envy of his colleagues. There was little in the Department of Anatomy to which he could not turn his hand, and before technicians were recognised and graded, Arthur's prowess in the preparing of specimens and slides and photomicrographs eased many a student's task. At the outbreak of war he moved with the preclinical departments to Cambridge, and though his empire in the Anatomy School there was smaller, it was run with the same efficiency and enthusiasm, though he was never known to wax as eloquently as the current Professor on the beauties of a human specimen that crowned the ovum hunting period. Arthur saw the interregnum when a surgeon was in charge of the department, he returned to Charterhouse Square after the war; but conditions changed and in February 1962 he moved to the clinical side of the school and on Hughes retirement became Lecure Attendant, thus returning to his original "rooms".

It is in this role of the incorruptible keeper of lists and the unflappable projectionist that the present generation of students remember him. It was a quiet job compared with his previous one, but Arthur carried it out with the same dignity and efficiency that we had come to expect from him over the years. He never seemed to change, and like the true College servant appeared ageless so that one never expected him to retire. Then quite suddenly and without any fuss he was gone with the turn of the year, and all that was left was to wish him a happy retirement.

I.M.H.

The ZAMBIA FLYING DOCTOR SERVICE

by James Lawless

Zambia is a large country with a small population and poor communications. In area it is over three times the size of Great Britain yet with a population of only four million. The one railway line runs more or less north-south joining the main centres of population found at Livingstone, Lusaka, Broken Hill, with the towns of the *Copperbelt*. Seven towns make up the network of the Copperbelt all connected by good tarred roads and with a combined population of over half a million people. Away from the railway, small concentrations of populations form around administrative centres joined by gravel roads. Two-thirds of the population live more than 15 miles from any town, or centre of any kind. The majority of these people live several days journey away from the nearest four-wheel drive track. They live for the most part in very small villages of usually less than a dozen houses.

Aircraft are capable of covering long distances in a short time and furthermore they require no roads, it is for these reasons that they are of particular advantage in large sparsely populated countries. In most underdeveloped countries and particularly in Zambia the problem of getting medical attention to the majority of the population is, to a large extent, one of communications. It goes without saying that you cannot practise medicine without first meeting the patient and even the most effective drugs are of no use unless prescribed and given. The physical accessibility of medical attention has become one of the criteria with which to judge the good society. The concentration of population—the tarred road—the telephone, and the motor car may have contributed more to the effective treatment of the sick than we shall ever know. The crowded surgery, however inconvenient it may at times appear, is one of the more noble achievements of mankind.

The Flying Doctor Service is one way of providing medical care to people who would otherwise have nothing. There are many Flying Doctor Services. The Royal Flying Corps in the First World War trained some doctors as pilots, the famous Australian Service started in 1927 and there are other Services in East Africa, Nigeria, South America and, nearer home, in Scotland, where for many years British European Airways have operated a service to the islands off the West and North coasts.

The Zambia Service is the youngest of all these—the decision to operate it for a trial period, only being taken in March 1965. Since that time 8,500 patient visits have been recorded and 110 patients flown to hospital.

In the design of the project several principles were kept in view.

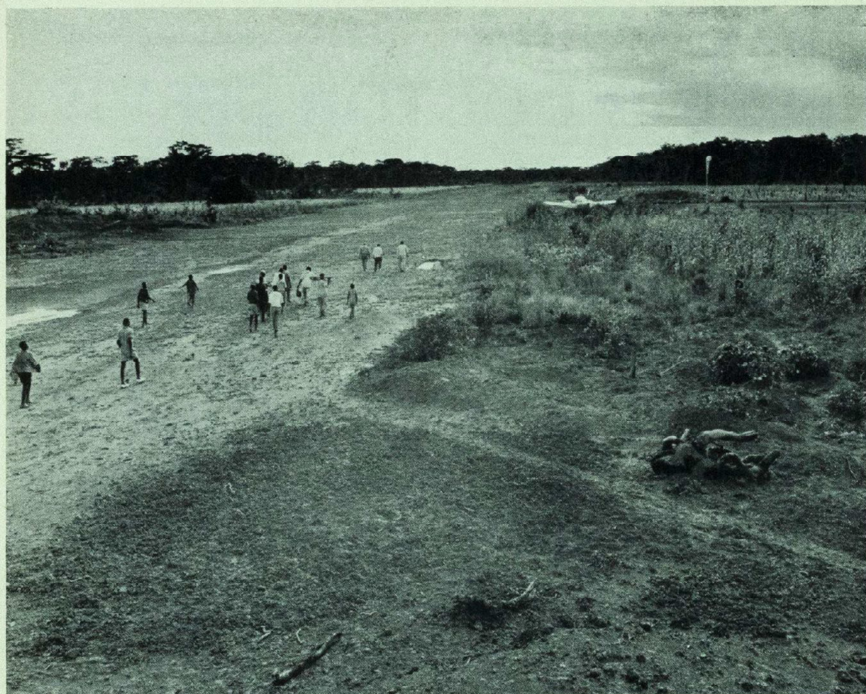
First; it was not simply to supplement existing facilities, but rather to go where none existed. This meant the construction of airstrips.

Second; it was known from work done in India and East Africa that the absolute maximum distance normally travelled on foot or bicycle by patients seeking medical attention was about twenty miles.

Third; regular visits at fixed times, three times a week, by a doctor and nurse to each airstrip were envisaged. It was felt that by this means, even quite ill patients could be successfully treated at the airstrip clinics.

Finally; locally constructed traditional mud and wattle buildings with thatched roofs were to be used.

The scheme proposed the construction of airstrips a thousand yards long by a hundred yards wide every seventy miles throughout the country. At each airstrip there would be a clinic building and a long range high frequency radio in communication with the service centre at Ndola Airport. Round each airstrip in a circle, and at a theoretical distance of 26 miles, short range V.H.F. radio sets were to be set up in convenient villages. These sets were to be in communication with the airstrip clinic and there were to be six of them to each airstrip. By this means it would be impossible for anyone to be more than fifteen miles from a radio in the area covered. The unit of an airstrip plus its six satellite radios was called a *cell* and covered a circle 52 miles in diameter. The whole country could be covered with 69 cells. As a start it was proposed to establish



The Airstrip at Mushingashi

16 of them within 150 miles radius of Ndola.

This number of units would provide the desired coverage in an area 300 miles in diameter containing a purely rural isolated population of 417,000 people.

A committee including the Minister for Health, Mr. Peter Matoka, was formed and His Excellency Dr. Kenneth Kaunda, President of the Republic, agreed to act as Chairman.

The First Airstrip

In order to test the concepts behind the proposals and obtain an idea of the likely costs it was decided to set up one cell in a remote area and operate it for a period as a trial. A very remote area 110 miles west of Ndola and the Copperbelt was chosen. The nearest all weather gravel road was 50 miles away and the nearest four-wheel drive track, often impassable in the wet season, 35 miles away. After several preliminary reconnaisance flights, a survey party landed by helicopter on 21st May, 1965. The scheme was explained to the people—many of the women and children had never seen a white man before—they were most enthusiastic and agreed to start the construction of an airstrip. (Helicopters, because of their low speed and high operating costs are not suitable for regular use in this type of project).

Airstrip construction in this part of the world, particularly in remote areas, and without the use of heavy machinery poses considerable problems. The country is heavily wooded and trees have to be cut, moved, stumped and burnt. In addition, and forming the biggest problem, there are many very large ant hills sometimes over 20 feet high and 25 yards in

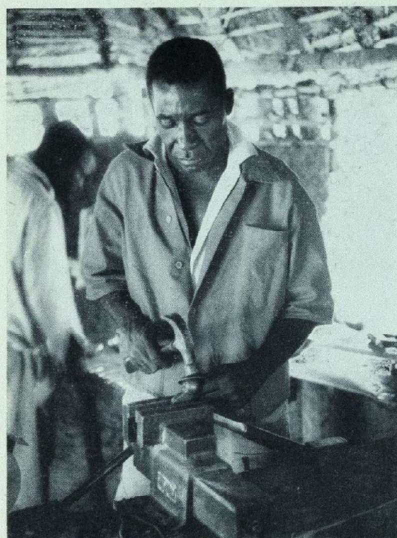
A patient boarding one of the aircraft

diameter. In some areas the frequency of these ant hills reaches 12 to the acre. The demolition of even small ones is a laborious and time consuming task. In the dry season, May to November, they become rock hard and this adds to the difficulty. The very largest type of bulldozer will take a whole day to move one, and with hand labour 20 men will take many weeks on the same task. Because we wished to employ as many people as possible, hand labour plus about four tons of explosive were used.

A small aircraft, a *Cessna* 180, was able to land on the first day of July, 1965, and a much larger twin engined *Piper Aztec* by the end of July. Eighteen months later construction work is still in progress and this gives some idea of the labour involved in clearing and levelling 28 acres and clearing a further 30 acres.

By November the radios had been installed by Philips, and an 11 ft. by 36ft. clinic building constructed out of traditional materials for an outlay of only £15. Two local carpenters were asked to make the necessary twin examination couches, tables and shelves and the cost of these furnishings came to about another £20. The total cost of the clinic building and furnishings was therefore £35. The actual structure cost was about 6d. a square foot. So far 8,500 patient visits have been recorded in the clinic, just over 4,500 new patients having been seen. The capital invested in the structure and furnishings of the clinic itself amounts to 1.68d. per new patient seen. Assuming the building will have a life of four years the original capital outlay required works out at only 0.4d. per head of patients seen.

Taking mankind as a whole it is tempting to speculate that whereas very little of the decrease in mortality has been due to the type of hospital or clinic structure employed—a very large part of the fearful mortality rate still



Kapolobwe hand beating a stainless steel spoon

existing is due to the fact that no hospital or clinic accommodation is provided at all. In other words penicillin and 6d. a square foot will produce a tenfold reduction in mortality. Penicillin and £8 a square foot perhaps a 10.1 fold improvement. However, these thoughts are hardly applicable to London where building for 6d. a square foot became impossible a thousand years ago and where now even a humble coal shed must cost several pounds a square foot to construct.

The very first patient to be flown out was an elderly man who had an abdominal mass that proved at laparotomy to be a gastric carcinoma in an advanced stage. A palliative gastro-enterostomy was done. Following this there was a tremendous improvement in his condition—he took up hunting again and successfully killed a leopard some three months after his operation!

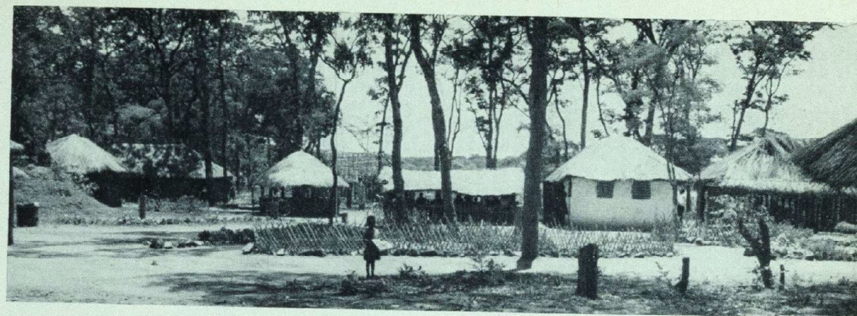
Regular visits were made on Mondays, Wednesdays, and Fridays, in the *Piper Aztec* owned by the Service. This aircraft will seat five passengers in addition to the pilot and cruises at just under 200 miles an hour. In this, the 110 mile journey takes 35 minutes compared with the overland time of three days (one day by Land-Rover, two days by bicycle). At first the villagers could not comprehend the speed of the aircraft and used to insist on bringing food for the journey. However, they are now very used to the aeroplane, though curiously enough it is known in their language by the name for butterfly and not, as one would expect, by the name for bird.

With a visit virtually every other day and radio contact at all other times it was found possible to treat even patients seriously ill with medical complaints at the airstrip clinic. Some large houses were constructed for those patients and their relatives who travelled long distances, food and if necessary, blankets being provided. It was found in fact, that patients frequently travelled 20 to 30 miles to attend the clinic, and sometimes much longer distances, a number having come over 80 miles for attention. One man mauled by a wounded buffalo was carried for seven days by his companions—runners going on ahead to warn us of his arrival. The horns of the enraged animal had penetrated deeply into his neck and into his chest cavity in two places. In spite of this he made a complete recovery.

Rural Development

As well as being a purely Flying Doctor Service it was always envisaged that every attempt would be made to encourage rural development in its widest sense. The first airstrip and radio immediately became the focal point of the area and a spontaneous concentration of population began to occur. It is the custom in Central Africa for the small villages to be abandoned and new ones built every four or five years as the fertility of the surrounding land becomes exhausted. This constant movement plus the very low average population density of only about three people per square mile, makes organised development very difficult. Attempts to persuade the villagers to live in bigger groups have not always been successful and the fact that they have started to do this spontaneously is a very encouraging aspect of the scheme.

Rural industries including carpentry, a bakers shop, a dress maker, and a market gardener, have been established at the airstrip which is rapidly becoming a small thriving community. A few months after work was started some very fine hand beaten spoons made out of cartridge cases were brought to us by one of the villagers. They were made by a man called *Kapolobwe,* entirely self taught and who could neither read nor write. We persuaded him to come and work at the airstrip, a small workshop was built for him, improved tools obtained, and regular supplies of 12 gauge brass and stainless



The Airstrip Clinic

steel flown in. He is a most brilliant and gifted metal worker and there is now an almost limitless demand for his products. These range from brass teaspoons to stainless steel carving knives and forks. He is now teaching apprentices and there is hope that this will become a staple industry of the area.

The capital outlay directly involved in establishing these small industries is very small. The baker for instance was set up in business for a total outlay of only about £15 including the building of his shop (£4), house (£4), and the purchase of small scales and baking tins. He built the oven himself. He now makes about eight shillings profit a day and whilst this may not seem much, it is a substantial sum for the area and a very good return on the capital investment made.

A Narrow Escape

During the trial many different types of aircraft were demonstrated to us by the respective manufacturers. On 17th January, 1966, one of these machines, a British *Beagle* 206, crashed immediately after take-off at the airstrip. The aircraft was completely destroyed but fortunately there was no fire and the four occupants survived with only minor injuries. The author and his wife, also a doctor, were in rearward-facing crash stressed seats, and this undoubtedly saved their lives. The pilot and engineer were in full tightly fitting shoulder harness and only survived because of this and the great strength of the structure. The aircraft hit the ground wingtip first, cartwheeled, and eventually finished upside down with a wing sheared off by a tree, while one of the engines had torn off and partly penetrated the cockpit. In spite of this the cabin remained more or less intact and the occupants were able to crawl out in a philosophical frame of mind. As it was already evening they had to spend the night at the airstrip and the author was able to while away the time stitching up his travelling companions. A relief aircraft and pilot arrived at dawn the next day—there was no rush to get on board. It felt as if every bone had been broken, even quite ordinary movements like breathing or laughing weakly, caused excruciating pain. "Shaken", the word commonly used is a masterpiece of understatement. It should be replaced by a more accurate, precise diagnosis along the lines of "generalised tendo-ligamental rupture with pulverisation and marked tendency to introspection".

However, with real genuine difficulty the party was dissuaded from walking the 110 miles and eventually flew back to Ndola. No clinics were lost because of the incident, and parts of the crashed aircraft have now been added to the workshop for the local metal worker.

Expansion of the Service

By April sufficient information had been gathered to enable a report and phased estimates for expansion to be presented to the Zambia Government. These proposed a country wide coverage using 69 airstrips with about 70 H.F. radios and 480 V.H.F. ones and with something in the region of 15 aircraft and 22 doctors. The rural population covered would be 2.7 million people and the cost about £986,000 a year or about seven shillings and twopence per head of the population covered. This would include all salaries and wages, all aircraft and radio operating costs, drugs, and airstrip maintenance. The capital for all costs involved in

purchasing aircraft, radios, and building airstrips would be just under a million pounds.

As a first stage it was proposed to build 16 airstrips to provide a coverage for the 417,000 rural people living within 150 miles of Ndola. Four aircraft and about five doctors would be required for this stage. The annual costs would be £222,000 and the capital costs £218,000. On a per capita basis the annual costs work out at 10/7d. per head of the population benefitting.

Following the presentation of these estimates there were many meetings with the Zambia Government and the Minister for Health, Mr. Peter Matoka announced in Parliament on 9th September, that the project would go ahead. Discussions on the phasing of the scheme are in progress and it is expected that a decision on this will be made public shortly. In the meantime, Mushingashi as the trial strip is now named, continues in operation.

It is hoped that it will be possible to make arrangements for doctors and nurses to come and work with the Flying Doctor Service for short periods of six months to a year or so, possibly seconded from existing hospitals in Britain or elsewhere. Ndola is only 14 hours journey from London by direct V.C.10 aircraft and this should facilitate the provision of staff when the time comes.

The scheme has shown that it is possible and practical to provide a medical service to the rural areas of underdeveloped countries much more quickly than was previously thought possible. It does not take up any of the hard pressed building construction capacity of these countries and the scheme can easily be developed and modified to suit changing local conditions.

Penicillin and chloroquine are two of the greatest achievements of mankind and yet many years after their discovery there are still immense numbers of our fellow men who are not able to benefit from these drugs simply because there is no source of supply near enough. Flying Doctor Services can go a long way towards overcoming this tragedy.

(Photographs by courtesy of Roan Selection Trust)

Prospect

"Bis dat qui cito dat".

He gives twice who gives quickly.

During the mornings spent in out-patients, which it is generally agreed is one of the less fruitful appointments of the course, the social rather than the medical aspects have frequently proved the more interesting. Perhaps one is more aware of social background in an out-patient clinic because the patient has more immediately emerged from it. The patient brings with him its symbols. He wears his own clothing instead of standard pyjamas and often brings a relative for moral support. I find it is the effect of disease on his small world rather than the clinical condition itself which gains my sympathy. And I wonder if we could not do more in the realms of prophylaxis.

Prevention of various diseases is the subject of much research; but could we not do more to forestall severe degrees of disease for which there is as yet no prophylaxis. Women are becoming increasingly aware of the significance of lumps in the breast and have the good sense to keep a constant check and even more important, report their findings. Fewer cases are now seen with a swollen arm as the presenting symptom. There are, however, many other symptoms the significance of which are unknown to the general public. For example, the stain of blood in sputum may be afforded scant note by the layman, but can indicate a great deal more to the clinician. It is easier to understand why frank blood in the stools may pass unnoticed. If symptomatology was more widely understood the covert processes of disease would be revealed at earlier stages.

It might be helpful to start with the publication and wide circulation of a pamphlet designed to describe to the general public roughly what may be considered as significant and what trivial. A lot of interest and publicity would undoubtedly be aroused. Medicine is news these days.

Without doubt there would be a flood of new patients at clinics and surgeries, and a lot of work involved; but in the end the medical profession would save not only lives but also time and money since early disease, particularly malignant disease, involves shorter stays in hospital and therefore less of a demand on staff. There might also be fewer trivial complainers in the queue.

It is, of course, impossible to assess whether one symptom is of serious significance when it is considered alone, but at least the public could acquire a greater sense of proportion. Surely they have the right to be a little more in the picture?

E.A.M.

Two Cases of Cavernous Sinus Thrombosis

by Derek Browne

Duncan (1812) was the first person to report his observations on thrombosis of the cavernous sinus as seen in the post mortem room, the earliest clinical account was by Bright in 1831. Before the introduction of antibiotics, Grove (1936) considered that the disease was usually fatal, and Yarrington (1960) reported that even with modern therapy there was a high morbidity, including total blindness, ocular palsies and hemiplegia. It is still a serious and often fatal condition.

Thrombophlebitis of the cavernous sinus may be caused by septic conditions of the face, middle ear, mouth, tonsils and the brain; and associated with diverse aseptic conditions, such as tumours and fractures of the face, and following surgery to the face and middle ear.

Spread of the thrombophlebitic process from the primary site of infection may be sterile, infective or embolic.

Eagleton (1926) described six diagnostic criteria for cavernous sinus thrombosis based on the pathology of the condition:

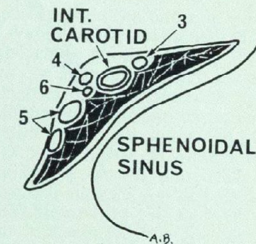
1. *A known source of infection.*
2. *Blood stream spread.*
3. *Early obstructive signs, e.g. fullness of the veins.*
4. *Lesions of the third, fourth, fifth and sixth cranial nerves.*
5. *Neighbourhood abscesses from retrograde thrombophlebitis.*
6. *Symptoms and signs of complicating diseases, e.g., headache and papilloedema from basal meningitis.*

A knowledge of the anatomy of the cavernous sinus is helpful in understanding the clinical features of thrombosis of the sinus.

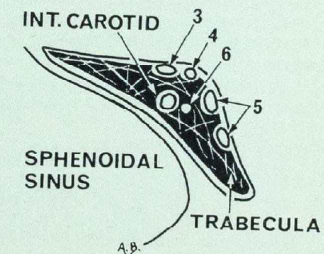
Anatomy

The cavernous sinuses are situated on each side of the sella turcica, between the supraorbital fissure anteriorly, and the apex of the petrous temporal bone posteriorly. The sinus is formed by the separation of two layers of dura mater. It consists of a variable number of laminae, which are best described as trabeculae and not as walls of adjacent veins. (Bedford 1966)

Tributaries. The sinus receives the superior and middle cerebral vein, some inferior cerebral veins and the sphenoparietal sinus. Posteriorly the sinus drains into the transverse sinus through the superior petrosal sinus and communicates with the internal jugular vein by the inferior petrosal sinus. Communication is also established with the pterygoid venous plexus via the foramen lacerum, the foramen ovale and the sphenoidal foramen. The two sinuses are connected by the anterior and posterior intercavernous channels to form a venous circle around the hypophysis cerebri.



Cavernous Sinus showing internal Carotid Artery in lateral wall



Cavernous Sinus showing trabeculae and internal Carotid Artery on medial wall (after Bedford).

Relations. The sphenoidal air sinuses and the hypophysis cerebri form a medial relation to the sinus. The internal carotid artery surrounded by its sympathetic nerve plexus, passes through the sinus with the sixth cranial nerve on its lateral side, and forms a variable relation to the medial and lateral walls of the sinus (Bedford 1966). The third and fourth cranial nerves and the first and second division of the fifth cranial nerve, in that order, from above downwards, lie in the lateral wall of the sinus, with the uncus of the temporal lobe of the brain as a more lateral relation.

As the veins supplying the cavernous sinus are devoid of valves, infection may enter by several routes:

1. *From the face along the angular and ophthalmic veins.*
2. *From the middle ear, along the lateral sinus and the petrosal sinus.*
3. *From dental infections, tonsillar abscesses and osteomyeletis along the pterygoid venous plexus.*
4. *Following infections of the sphenoidal air sinuses and following operations on the nasal septum and turbinate bones, through the sphenoidal roof.*

CASE REPORTS

Two cases of cavernous sinus thrombosis are described in patients who were admitted to the Luton and Dunstable Hospital within a period of three months. Each demonstrates the seriousness of the condition.

CASE 1.

P.G., a sales assistant, aged 26, was admitted to the hospital on 27th May, 1966, with a week's history of a boil on the right side of his face which he had squeezed. Two days before his admission, he had a severe headache, vomited and noticed that the right eye was swollen. On the day of admission, the headache was more severe and accompanied by vomiting and diplopia. On admission, the patient was febrile, with a temperature of 104°F. (40.0°C.), and he had a pulse rate of 100 per minute. A "mature" boil, half an inch in diameter was present on the right side of the nose. The right eye was proptosed with chemosis of the conjunctiva. There was a partial paralysis of the superior rectus muscle and complete paralysis of the lateral rectus muscle. Both pupils reacted to light and to accommodation. The right fundus showed venous engorgement. From the history and physical signs, a diagnosis of cavernous sinus thrombosis was made.

Investigations

Haematology: Hb. 86% W.B.C. 15,400 cells/cu.mm., polymorphs, 80%, lymphocytes 17%, Urea 52/mg/100mls.

Urine: Heavy deposit of albumin, with some red and white blood cells.

Lumbar puncture: Pressure 230 mm. C.S.F. Free rise and fall. W.B.C. 276 mainly polymorphs. No red cells. Protein 160 mg./100 mls.

Blood culture showed a growth of Staphylococcus aureus sensitive to benzylpenicillin.

Treatment

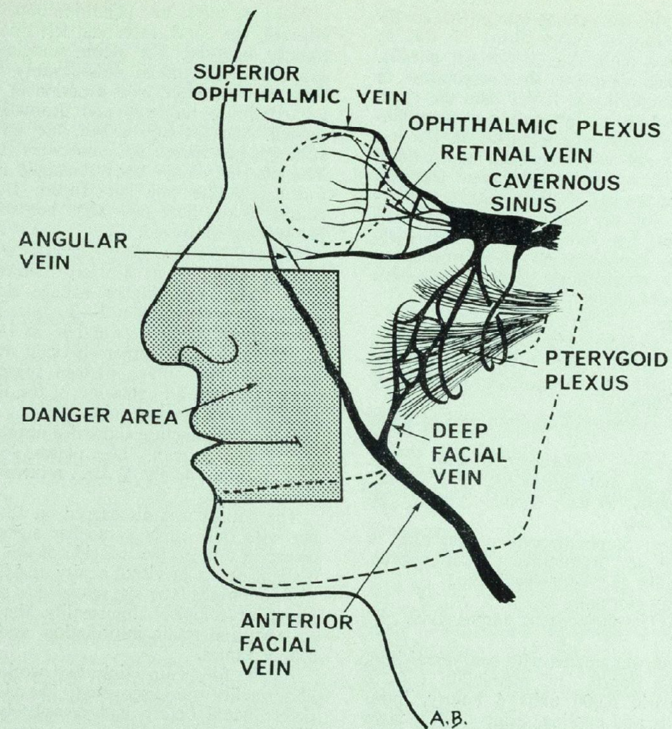
The patient was treated with benzylpenicillin, 2 mega-units 2 hourly. Methicillin 500 mg. orally 6 hourly, Heparin 10,000 units 6 hourly, intravenous fluids and cooling, the latter by applying cold sponges to the body and using electric fans.

Progress

Six hours after admission the patient developed severe respiratory distress and coughed up frothy blood-stained sputum, thought to indicate haemoptysis and pulmonary oedema. The cause of the pulmonary oedema was obscure, but was probably associated with multiple staphylococcal abscesses in the lungs. The extent of the haemoptysis with the pulmonary oedema was related to the fall in the heamoglobin concentration from 86% to 64%. It was therefore decided to reverse the anticoagulant effect of heparin with protamine sulphate, 5 mls. of 1% solution. The patient also coughed up a "membrane", which on histological examination was seen to be composed of degenerate lung tissue. A chest X-ray confirmed the diagnosis of pulmonary oedema, and multiple abscesses.

Six hours later the patient's breathing improved, but certain signs appeared that suggested that the thrombotic process had extended to the left cavernous sinus, these being: paralysis of the third, fourth and sixth cranial nerves on the left, dilatation and fixity of both pupils, with absence of corneal reflexes.

Twenty-four hours later the temperature fell, the patient became semi-comatose, restless, confused, dyspnoeic and cyanosed. The urine output decreased, the blood urea rose to 476 mg/100 mls., the potassium rose to 6.2 m.eq/l. The heart stopped, but began beating again after external cardiac massage and administration of oxygen.



The Cavernous Sinus and its connections (after Bailey and Love)

Further Treatment

A tracheostomy was performed, and positive pressure respiration started. Peritoneal dialysis was instituted because of the progressing oliguria, increasing blood urea level, rising potassium level and the acidosis. The blood urea fell to 340 mg./100 mls. and the potassium fell to 5.1 m.eq/1.

A further blood culture showed that the staphylococcus was resistant to benzylpenicillin but sensitive to cloxacillin. The antibiotic was therefore changed to cloxacillin.

Two hours later, the heart stopped beating, but responded promptly, to external cardiac massage. During the course of half an hour, the blood pressure fell to 65/0, and failed to respond to vasopressure therapy. The patient died on 3rd June, 1966.

CASE 2.

G.P., a school girl, aged 14, was admitted to hospital on 6th August, 1966. Five days previously she had noticed a septic spot on her nose which had been treated by squeezing instead of applying hot fomentations as she had been advised. Next day she complained of a generalised headache, and felt feverish. Two days later the temperature was taken by a neighbour and found to be 105°F. (40.5°C.), an observation noted, it is said, "with interest". Twenty-four hours later, she was anorexic, delirious and resisted any attempts to disturb her. The following day her general condition remained the same, but the left eye was painful and swollen, and she was unable to see out of it.

On admission, the patient was prostrate, delirious and had a temperature of 105°F. (40.5°C.) and a pulse rate of 126 per minute. Although unco-operative she responded to pain. The left pupil was larger than the right. Both pupils reacted to light and to accommodation, but the vision was impaired in the left eye. The left eye was proptosed and painful with chemosis of the conjunctiva. External movements of the left eye were absent, indicating paralysis of the third, fourth and sixth cranial nerves. The left fundus showed early papilloedema. There were no other neurological abnormalities. A diagnosis of cavernous sinus thrombosis was made.

Investigations

Haematology: Hb. 72%, R.B.C. 6,000,000, W.B.C. 18,000., 90% polymorphs. Urea 74 mg./100mls., Electrolytes: Na. 130, K 3.6, Cl 100 m.eq/l

Urine: Heavy deposit of albumin, and granular casts.

Lumbar puncture: Pressure 200 mm. C.S.F. Normal rise and fall. W.B.C. 355, mainly polymorphs. R.B.C. 1,500. Protein 180 mg./100 mls.

Blood culture: Staphylococcus aureus type 29 sensitive to Streptomycin, Tetracycline, Methicillin and Benzylpenicillin.

Chest X-ray: Normal.

Nasal swab: Staphylococcus aureus, type 29.

Treatment

The patient was treated with benzylpenicillin, 2 mega-units hourly i.m. methicillin I G. 6 hourly, heparin 6,000 units 6 hourly, intravenous fluids and cooling, using cold sponges applied to the body and electric fans.

Progress

During the first 24 hours the patient became hyperkinetic with twitching of all four limbs suggesting cerebral irritation. Kernig's sign was positive. There were indications that the thrombotic process had spread to the right cavernous sinus, because the right eye was proptosed and oedematous, and the fundus showed early papilloedema. She became comatose, and the planter responses were extensor.

The occurrence of melena necessitated the reduction of the original dose of heparin to one half.

The general condition improved during the next four days, and the temperature subsided, but she still was deeply comatose. On the fifth day a macular rash developed on her arms which was probably due to penicillin sensitivity, so that Cephaloridin in a dose of 1 G. 4 hourly was therefore substituted.

After 20 days, her condition remained unchanged, the coma, fever and left sided spastic rigidity persisted. The gloom surrounding this sad case was almost unbelievably dispersed when, a week later, over a period of two days her condition suddenly and dramatically improved. She sat up in bed, ate and talked, although her speech was somewhat dysarthric. The left side of her body remained rigid. Unfortunately she was left-handed. During the course of the next few days, her speech and her writing improved.

An E.E.G. recording showed a medium voltage α-rhythm at 8 c/sec., slowing down to 7 c/sec., with higher voltage slow waves in the occipital region at 2—3 c/sec. There was diffuse intermediate slow activity at 4—6 c/sec., mainly in the left tempero-parietal region. The nature of the voltage pattern suggested that there had been an extension of the thrombotic process to the cortical veins.

A lumbar puncture showed a normal pattern, and sterile growth. The plasma electrolytes were normal and the W.B.C. returned to 7,000 cells/cu.mm.

The patient was discharged on 18th September with only slight cerebellar signs, with increase in tone of the left side of the body, and a slight defect in visual acuity at 6/9.

Two months later she returned to school having no neurological abnormality. She was quick to learn and retain information, and joined in school games.

At the follow-up clinic two weeks later, no abnormality was discovered. The visual acuity defect noted before had completely resolved. Since the patient had never menstruated, it was impossible to ascertain if this function had been affected in any way.

DISCUSSION

Cavernous sinus thrombosis is a rare clinical condition. The incidence is declining as a result of adequate and successful antibiotic therapy. The commonest organism incriminated is the Staphlyococcus aureus. Penicillin resistant strains are becoming more frequent. (Barber and Rozwadowska-Dowzenko, 1948). Treatment must be started immediately the diagnosis is made and blood cultures and sensitivities of the organisms investigated.

Latent Period. Shaw (1952) emphasised the variable latent period from 1—25 days, with an average of 5.5 days between the appearance of the primary lesion and the onset of the physical signs suggesting involvement of the cavernous sinus. The onset is acute, with a

high temperature, and ophthalmic signs:—chemosis, ophthalmoplegia, proptosis and dilatation of the retinal veins. There is often a spread of the thrombotic process to the contralateral sinus. This occurred in both the cases described.

Complications. Complications are common. These include: septicaemia, pyaemia, ophthalmoplegia, and spread of the thrombotic process to the other sinuses in the brain.

Differential Diagnosis. Orbital cellulitis, infected accessory sinuses, e.g. frontal, ethmoidal and maxillary. Cellulitis of the cheeks, exophthalmic goitre and lymphoma.

Treatment

1. *ANTIBIOTICS.* Prolonged antibiotic therapy is the most important treatment of cavernous sinus thrombosis. Johnstone (1945) recognised that there was a distinct tendency for apparent cure to be followed by relapse, and suggested that therapy should be continued for several weeks after the temperature and white cell count had returned to normal.

2. *ANTICOAGULANTS.* Lyons (1941) was the first person to use anticoagulants in the treatment of cavernous sinus thrombosis by continuous intravnous heparin. Ershler and Blaisdell (1941), however, argued against its use by reporting a case of uncontrollable haematuria, but in the cases the dosage used was probably excessive. Pishey (1950), after reviewing the world literature, came out in favour of anticoagulant therapy. The controversy revolves a round the belief that some authors believe that the thrombotic process is a protective mechanism, and that anticoagulants by interfering with the natural cellular defence barrier, prevent the localisation of the infection. The advocates of the use of anticoagulants consider that extension of the thrombotic process to the cortical sinuses is prevented. In the first—P.G. —there was a massive haemorrhage into the lungs, which necessitated the reversal of the heparin with protamine sulphate. In the second case—G.P.—a melena stool was passed indicating haemorrhage into the intestinal tract. The dosage of heparin in this case was then reduced to half the original dose. Even so, the thrombotic process extended to the cortical sinuses. It should be noted that G.P. made a complete recovery, and that the cortical thrombosis resolved.

3. *NURSING.* First class nursing attention is imperative. This is especially so in the case of the unconscious patient with reference to bladder catheterisation, naso-gastric feeding, fluid balance and the care of the skin to prevent pressure sores. Cooling the patient with electric fans or cold sponges is often helpful. Tact and encouragement should be used when talking about the prognosis and treatment in front of the patient, since although G.P. was apparently "decerebrate" she heard every word that was spoken at the bedside which she was later able to recall.

4. *PREVENTION.* Thrombosis of the cavernous sinus is a preventable disorder. Infections of the face, throat and middle ear, should be treated promptly and adequately. Patients should be dissuaded from squeezing pimples and boils around the danger areas of the face.

Summary

Two cases of cavernous sinus thrombosis are described; both were caused by squeezing a boil on the nose. The first case was fatal, the patient dying of fulminating septicaemia and renal failure after being treated with antibiotics, anticoagulants and peritoneal dialysis. The second case made a complete and dramatic recovery, after being comatose for three and a half weeks.

A survey of the anatomy, aetiology and the treatment of cavernous sinus thrombosis is given.

Acknowledgements

I wish to thank Dr. T. Parkinson, F.R.C.P., Consultant Physician at the Luton and Dunstable Hospital for permission to publish these cases which were under his care, and also Dr. D. Colin Jones and Dr. A. H. Knight for their help and encouragement, and to Mrs. Anne Barrett for the medical illustrations.

REFERENCES

Barber, M. and Rozwadowska-Dowzenko, M. (1948): *Lancet*, **2**, 641.
Bedford, M. (1966): *Brit. J. Ophthal*, **50**, 41.
Bright, R. (1831): Reports on medical cases, London, Longmans.
Duncan, A. (1821): *Edin. med. Soc. J.*, **17**, 319.
Eagleton, W. P. (1926): Cavernous sinus thrombosis, New York, the Macmillan Company.
Ershler, I. L. and Blaisdell, I. H. (1941): *J. Amer. med. Ass.*, **177**, 927.
Grove, W. E. (1936): *Arch. Otolarying., Chicago*, **24**, 29.
Lyons, C. (1941): *Ann. Surg.*, **113**, 113.
Johnstone, D. F. (1945): *Lancet*, **1**, 9.
Pishey, W. P. (1950): *Arch. Otolaryng.*, **51**, 917.
Shaw, R. E. (1952): *Brit. J. Surg.*, **40**, 40.
Yarrington, C. I. (1960): *J. Amer. med. Ass.*, **173**, 506.

DRAMA SOCIETY

Main Production

The Birthday Party

by Harold Pinter

"The milk's not off Stan. Petey ate his"

"I've always liked older men. They can soothe you."

Stanley Webber is a down and out. He once played the piano in the summer show on the pier. Now he is a recluse; disillusioned and weak. He lives in the house of Petey and Meg Boles where he is the permanent and only guest.

Petey Boles is ordinary. He personifies all that is decadent, apathetic and indifferent. He is a placid, immovable man who goes about his job and his domestic life with equal resignation.

Meg Boles runs her house inefficiently and provides badly. She serves sour milk with her corn flakes, fails to make the tea on time and issues a "cooked" breakfast of simply fried bread. Petey, of course, never complains but Stanley does—as well as pointing out that the place is a pigsty which needs cleaning up and that his room is long overdue for redecoration. Nevertheless Meg believes her establishment to be well in order. As far as she is concerned it is as good as any other and, she prides herself, it is "On the list." In her usual underproviding way she has made Stanley a birthday present of a toy drum. "It's because you haven't got a piano," she explains Meg lavishes a strange, selfish sort of affection upon Stanley—forever trying to woo him into contentment. Stanley resents this but realizes the futility of trying to change his situation. There is nowhere else to go—a fact which he vainly attempts to convey to the body beautiful, but brain lacking Lulu.

The appearance of Goldberg and McCann is met with apprehension and resistance by Stanley because he alone recognises them for what they are . . . "Let me—just make this clear. You don't bother me. To me you're nothing but a dirty joke. But I have a responsibility towards the people in this house. They've been down here far too long. They've lost their sense of smell; I haven't. And nobody's going to take advantage of them while I'm here . . . " But Stanley's unaided resistance is soon broken down by the two hoods. Goldberg is a smiling, insincere and confidently charming smooth-talker, whilst McCann is a violent, threatening savage who is handpicked tool for Goldberg's use.

The complete picture is made apparent at Stanley's birthday party that night, where the situation comes to its inevitable head. Petey, true to form, isn't even there. Meg is ridiculously overdressed for the occasion and responds to Goldberg's flattery. She proposes an inadequate toast to Stanley and Goldberg steps in to take complete control of the party. He proposes another toast. The guillible and short sighted Lulu is totally taken in and becomes easy and willing prey for Goldberg. Stanley is vacant and hopeless. The party ends with a game of *Blind mans buff*. First Meg is blindfolded and stumbles on McCann. He in turn deliberately seeks out Stanley who is then blindfolded whilst McCann smashes Stanley's glasses. Stanley at last breaks down. He attacks Meg; the lights go out and chaos reigns while Stanley runs amock through the party. Goldberg finally recovers the situation.

The following morning brings complete victory for Goldberg. He has seduced Lulu, who now reproaches him for it, although she has no leg to stand on, since she entered into the relationship both willingly and without a second thought. Goldberg and McCann take Stanley away after feeble protest from Petey, who immediately returns to his routine existence. Meg, meanwhile, reminiscing about having been the "Belle of the ball" the night before, continues to delude herself.

The Drama Society staged this difficult play with admirable confidence and ability. The cast was well disciplined and all individual performances were of a high standard. However, the main difficulty arising from the production of this play, (as with any of Harold Pinter's plays), is that of interpretation. The audience is faced with characters which the producer has created out of blank lines and from them it must draw what symbolism there is to be drawn. The play is not intended to be immediately understood. Ideally one should leave the theatre with a firm impression of the gross sybolism inherent in each of the characters—this acting as a framework upon which one can later hang, after clarification by further thought, the more subtle and interesting symbolisms arising from the interaction of the characters. The important thing is that this basic framework must be got through to the audience. How much of the rest each individual appreciates depends largely upon himself. Therefore to say that the production was a complete success from this aspect would be untrue and an insult to the intelligence of producer and cast. One questioned the necessity of Lulu as a character and there were one or two scenes where one had the uneasy feeling that the concept was perhaps lacking. Happily, however, the audience were not totally confused and this to my mind is a measure of success.

As far as the technical side of the production went there was little fault to be found. The play moved at an exciting pace and interest was held throughout. The action tended to be crowded by the table in the centre of the stage and one was often faced by the actors back as a result. This could probably have been avoided had the large areas on either side of the table been more fully utilized.

Personally, I thought the set was unoriginal and gimmicky. Its only saving feature being that the actors' voices were resonated by the empty oil drums giving a weird echo effect which served to add an exciting and spine chilling quality to the dramatic moments of the play.

James Griffiths as Petey Boles gave a fine, carefully studied character performance. In particular his movement and facial expressions were convincing. His voice, however, occasionally betrayed his youth.

Meg Boles was played by Benita Wylie whose characterisation was approached with sensitivity and whose superb comedy timing scored repeatedly. This was a beautifully moderated performance in which one was totally convinced.

Marcus Setchell played the difficult part of Stanley Webber with confidence and ability. His understanding was good and his performance intelligent.

Sarah Rowntree, who although giving a sound performance as Lulu, suffered a little from the production point of view. She was too intelligent a character who gave the impression of being a sultry and experienced seductress instead of a painted, slightly tarty but innocent young scatterbrain. As a result she became symbolically purposeless and her reproach of Goldberg was inevitably unconvincing.

Nick Wagner played Goldberg with studied self assurance. His accent was convincing and he took good advantage of his comedy lines. However he did fail to instill into this character an endogenous humour with the result that it tended to lack charm and he made it difficult for himself to moderate the pace of his performance. Thus the disarming smooth talker became at times long winded and smarmy.

Iain Miller; McCann, gave a good and consistent perforance. His Irish accent was very well maintained throughout the play. His "juvenile lead" appearance was a little incongruous and he would have benefitted by being made slightly older and tougher.

Congratulations to the Drama Society for the selection of an interesting and challenging play the good performance of which was no mean achievement.

G. O. Dunn

A case of CIGARETTE ANGINA

by Geoffrey Bourne

A Cingalese patient aged 51 was re-examined recently. I had first seen him in 1961, when he gave a history of chest pains radiating to the neck and jaw, lasting a few minutes, and coming on at any time. Seven days later he had suffered a more acute pain, radiating also to the left arm. He collapsed, and became cold; the pulse was irregular and the blood pressure was 98/60. He was somewhat dyspnoeic. After recovery the blood pressure returned to 140/100, and the rhythm became regular. An electrocardiogram taken a week after the onset showed slight inversion of T in Lead 1, and sharp inversion of T from V1 to V4. A blood count showed a normal W.B.C., 7,800, but the E.S.R. (Talquist) was 35 mm. in 1 hour. A diagnosis of coronary ischaemia was made.

When seen again just over a year later, he had kept well, and was free from his previous considerable personal anxieties. The anginal pain had not returned. He was smoking about ten cigarettes a day. The heart was normal on clinical examination, and the rhythm regular. The blood pressure was rather low (96/64), the August weather being warm. The electrocardiogram was normal, the T waves being of full amplitude, except in aVL. Radiologically the heart was normal in size and shape.

He was seen again recently, after an interval of four years and three months, having kept well until five nights previous to the day of examination. The chest pain had then returned, and was severe enough to prevent his sleeping until he took sodium amytal gr.3 and a tranquilliser. It recurred on the next and subsequent two days, lasting about ten minutes, but being unrelated to exertion. It radiated at times to the left arm. On examination he looked fairly well. The heart rate was 60, the rhythm was regular; the blood pressure was 120/82. The electrocardiogram showed very small upright T waves in Lead 1 and lowered, but not inverted T waves in V5 and V6. Radiologically the heart was still normal in size and shape. The W.B.C. was 7,400 and the E.S.R. was 14 mm. in 1 hour. The transaminase (S.G.O.T.) was 44 units.

The interesting point was the patient's reaction to tobacco during the initial period when the pain was coming on in brief attacks. He volunteered, without any leading questions, that the pain, clearly of a coronary origin, was accentuated by cigarettes. He stated that he would light a cigarette, only to put it out because the discomfort increased to an unpleasant extent. He repeated the experiment at least ten times, and ultimately gave it up because pain always followed. A point worthy of note is that a mild cigar was tried instead, and on three occasions was smoked without pain resulting. A pipe was similarly innocuous.

The writer has been aware of a similar situation in three patients, but in none of them was a comparison attempted between the effects of a cigarette and mild cigars or pipes. In only one case, that now recorded, was an electrocardiogram taken while the patient was smoking a cigarette, and no change was detected in the tracing. The patients were all at that stage of coronary disease at which it seemed uncertain whether or not a full infarction would develop, and in at least two cases it did in fact do so within a matter of days. It would seem that the phenomenon would only be noticed if the coronary or the myocardial situation was so "balanced" that a slight increase of coronary spasm was sufficient to produce pain. Nature is rarely so kind as to produce for our observation exactly the correct experimental conditions in the "human animal".

An authoritive description of nicotine angina is to be found in a paper by Dr. Samuel Oram in the *Quarterly Journal of Medicine* (*Q.J.M.* Vol. XXXII, No. 126, *April* 1963, p. 115), in which he reports anginal pain immediately following cigarette smoking. Electrocardiographic changes suggesting ischaemia accompanied the pain in three cases only out of 20 fully investigated. His paper is an excellent study of the subject, and contains a full bibliography and detailed pharmacological experiments. He quotes a total of fourteen cases from the literature, in which electrocardiograms were taken with a positive result, making 17 in all. Twenty of his own patients out of 534 questioned thought that smoking induced coronary pain. He concluded that true "tobacco angina" was a rare but real condition.

The Ninth International Cancer Congress *via SIBERIA*

by Malcolm Donaldson

If anybody is thinking about travelling to Japan by this route, my advice is the same given by Mr. Punch to those about to marry, *"Don't"*.

My wife, however, dislikes flying, so we took a ticket for a "First Class de luxe sleeper", but unfortunately such a train does not exist. However, we had the carriage to ourselves as far as Moscow, passing through Poland. The last time I travelled through Poland, at that time part of Germany, was as a prisoner of war in a cattle truck on the way to Königsberg.

I have visited Moscow three times. Many of your readers will have been there so there is no need to describe it in detail. The streets are wide and very clean, one dare not drop a spent match on the pavement. We were handed over to the "Intourist" and taken to a very fine hotel, the "Leninski", with an entrance hall about 50 feet high. Going up in the lift a man said to my wife, in perfect English, "How old is he?" On being informed he said "Marvellous". I can only conclude that elderly people are rare in Russia and it was marvellous that I was alive, and even able to walk! The Intourist guide showed us round the usual places, Red Square, the Kremlin, etc. The last time we were in the Kremlin we had a stand up banquet in a wonderful, huge, white marble hall and danced afterwards. We stayed two days in Moscow and then started on our never to be forgotten journey across Siberia.

The second night, about 11.00 p.m., two peasants were put in our carriage in spite of protests. The woman had the usual vital statistics of Russian women, 50-60-50 *inches* not *centimetres*, and the man was quite the ugliest I have ever seen. They brought in many packages, including a large sack of onions. The ventilation was very poor, and no windows were allowed to be opened. An hour later, at midnight, we were told that we had filled in the form about jewellery incorrectly, leaving out watches, and supplying insufficient detail about rings. The food was edible if not enjoyable. One lady took a mouthful of meat, then removed it with her fingers, smelt it and popped it back again. The restaurant was used chiefly for drinking weak beer in very large quantities.

Looking out of the window, one saw thousands of acres of forest, mainly firs and birches, and enormous government farms. The soil is coal black, due to minerals; the roads are mud tracks; and the villages consist of black wooden huts in poor condition, and not a flower anywhere; many horses but no tractors.

Things improved greatly in Eastern Siberia where large towns, of chiefly large blocks of flats, are being built by the rivers. There is evidently a plentiful supply of electricity, even in the smallest village, and radio and sometimes television masts were seen. We stopped at Firkutsu for two days in a very good modern hotel with sitting room, bed and bathroom. Next day, the Intourist guide took us 40 kilometres along a road, not a very good one, but of which they were very proud, to Lake Baikal, the deepest and one of the largest lakes in the world. It contains fresh water seals and many curious and rare fish.

During our visit we saw a funeral procession. First came a monument about 10 feet high on a lorry, from which a man threw pieces of evergreen out on each side. Then a coffin on a motor lorry and a second coffin on the third. I was told that the first coffin contains the corpse exposed to view and that when the procession reaches the grave the body is transferred to the second coffin. Behind the coffins came a large number of paid "wailers" in bright clothes, who were certainly earning their money. We finished the day crossing the lake on a motor launch.

The next day when we got to the train, we found we had to travel with two other adults and one boy aged about six in a four berth carriage. I counted over 20 large packages as well. We slept, or tried to sleep, with our suit-

The Great Buddha of Kamakura

cases at our feet. The woman with the child in contrast to the other, a peasant, was very smart and might have been a film star. After two days and two nights, during which the lady turned us into the passage when she wanted to do her hair and make up, we arrived at Nakhobka. Then after staying one night at Karbodus, a suburb of Vladivostok, we embarked on a Russian ship, after being turned back three times from the gangway because our papers were not properly stamped. On this Russian ship they refused to take Russian money, only Japanese or American dollars, of which, fortunately, we had a few. After two days we reached Yokohama, and drove into Tokyo to a modern, very comfortable hotel called "The New Japan", very pleased that our eight days and seven nights in the train were over.

There are many large, modern hotels in Tokyo, built for the Olympic games. The Stadium is a splendid building. Outside our hotel were three lanes of traffic moving very fast. The accident rate is very high, but the taxis we took were driven well, the "survival of the fittest" perhaps operates here too.

The Congress, 23rd-29th October, 1966

These Congresses are held every four years under the auspices of the International Union Against Cancer (U.I.C.C.). The President is Alexander Haddow (U.K.), The President of the ninth congress was Dr. Tomizo Yoshida of Japan.

The opening ceremony took place in the presence of Their Imperial Highnesses Crown Prince Akihito and Crown Princess Michiko. Following the opening speeches, two classical Japanese plays were presented, which resembled slow motion films and were quite incomprehensible to foreigners.

During the congress, five congress lectures, 23 panel discussions were given, and 33 sectional meetings were held, comprising in all, 1,368 papers. Abstracts of these papers were published in one large volume.

I attended those lectures which dealt with cancer education or early diagnosis. I regretted finding that many other countries were far ahead of Great Britain in these subjects. As everybody knows, the mortality of different types of cancer varies in different countries. The mortality from gastric cancer in Japan is the highest in the world, cancer of the breast having the lowest rate. Of course, much research is being carried out to account for these geographical distributions of the various types. The Japanese are doing splendid work in the early diagnosis of gastric cancer. There are over 40 travelling X-ray vans with indirect vision equipment to protect the operator from excess radiation. Anyone can ask for such a viewing, and if there is the slightest sign of abnormality, the patient is taken into hospital for further investigation using a gastro-camera which enables coloured photographs to be taken of the gastric mucosa.

The Japanese are not yet very interested in cancer of the lung which since the American occupation has increased rapidly. It will be some time before they take any "anti cigarette" measures because the manufacture and sale of cigarettes is the Government monopoly, and they refuse to believe that there is any connection between cigarettes and lung cancer. An interesting panel discussion took place on the subject, papers being read by the Chairman, Wakefield (U.K.) and representatives from Canada and the U.S.A., and others.

It is of interest that all packets of cigarettes sold in the U.S.A. must have printed on them a notice that cigarettes are "dangerous to health". This is said to be having some effect, but the Japanese Government refused this suggestion for obvious reasons.

There are three main organizations in Japan dealing with Cancer. The first of these, the "Japanese Foundation for Cancer Research" was founded in 1908. In 1958, "The Japan Cancer Society" was formed. Both these are voluntary bodies, and have amongst their objects the cancer education of the public. In 1960, the National Cancer Centre was formed and is run by the Government. It is a large hospital with 400 beds, and a large outpatients department dealing with 500 patients each day, a large record department and also a research laboratory.

During the voyage home, I did a little Cancer Education propaganda by putting a set of pamphlets, leaflets, and my book "The Cancer Riddle" in the ship's library. I was pleased to see a number of passengers reading them. A notice was put up asking for votes of approval or otherwise. The result was interesting: 28 in favour, one against. I hope many more read the pamphlets without bothering to vote.

The weather in Japan and on the homeward journey was perfect, hardly a day of rain and little wind, in contrast to our arrival home just before Christmas, in the cold, wet weather of Britain.

"He went out to examine for the Fellowship...... They gave him an Honorary Degree...... and he hasn't been right since!"

Medicine in Literature

an extract from

MADEMOISELLE CLAUDE

by

Henry Miller

(printed by kind permission of New Directions Ltd.)

When I broach the subject to Claude she looks at me in astonishment. 'I know you have every confidence in me, Claude, but. . . .' Claude refuses to waste time on such a subject. A man who would consciously, deliberately give a woman a disease is a criminal. That's how Claude looks upon it. 'C'est vrai, n'est-ce pas?' she asks. It's vrai all right. However. . . . But the subject is closed. Any man who would do that is a criminal.

Every morning now, when I take my paraffin oil—I always take it with an orange—I get to thinking about these criminals who give women diseases. The paraffin oil makes the spoon very sticky. It is necessary to wash it well. I wash the knife and the spoon very carefully. I do everything carefully—it is my nature. After I have washed my face I look at the towel. The patron never gives out more than three towels a week; by Tuesday they are all soiled. I dry the knife and the spoon with a towel; for my face I use the bedspread. I don't rub my face—I pat it gently with the edges of the bedspread, near the feet.

The Rue Hippolyte Mandron looks vile to me. I detest all the dirty, narrow, crooked streets with romantic names hereabouts. Paris looks to me like a big, ugly chancre. The streets are gangrened. Everybody has it—if it isn't clap it's syphilis. All Europe is diseased, and it's France who's made it diseased. This is what comes of admiring Voltaire and Rabelais! I should have gone to Moscow, as I intended. Even if there are no Sundays in Russia, what difference does it make? Sunday is like any other day now, only the streets are more crowded, more victims walking about contaminating one another.

Mind you, it's not Claude I'm raving against. Claude is a jewel, un ange, and no presque about it. There's the bird-cage hanging outside the window, and flowers too—though it ain't Madrid or Seville, no fountains, no pigeons. No, it's the clinic every day. She goes in one door and I in the other. No more expensive restaurants. Go to the movies every night and try to stop squirming. Can't bear the sight of the Dôme or the Coupole any more. These bastards sitting around on the terrasse, looking so clean and healthy with their coats of tan, their starched shirts and their eau-de-cologne. It wasn't entirely Claude's fault. I tried to warn her about these suave looking bastards. She was so damned confident of herself—the injections and all that business. And then, any man who would. . . . Well, that's just how it happened. Living with a whore—even the best whore in the world—isn't a bed of roses. It isn't the numbers of men, though that too gets under your skin sometimes, it's the everlasting sanitation, the precautions, the irrigations, the examinations, the worry, the dread And then, in spite of it all. . . . I told Claude, I told her repeatedly —'Watch out for the swell guys!'

No, I blame myself for everything that's happened. Not content with being a saint I had to prove that I was a saint. Once a man realizes that he's a saint he should stop there. Trying to pull the saint on a little whore is like climbing into heaven by the back stairs. When she cuddles up to me—she loves me now more than ever—it seems to me that I'm just some damned microbe that's wormed its way into her soul. I feel that even if I am living with an angel I ought to try to make a man of myself. We ought to get out of this filthy hole and live somewhere in the sunshine, a room with a balcony overlooking a river, birds, flowers, life streaming by, just she and me and nothing else.

TUNA FISHING in NEWFOUNDLAND

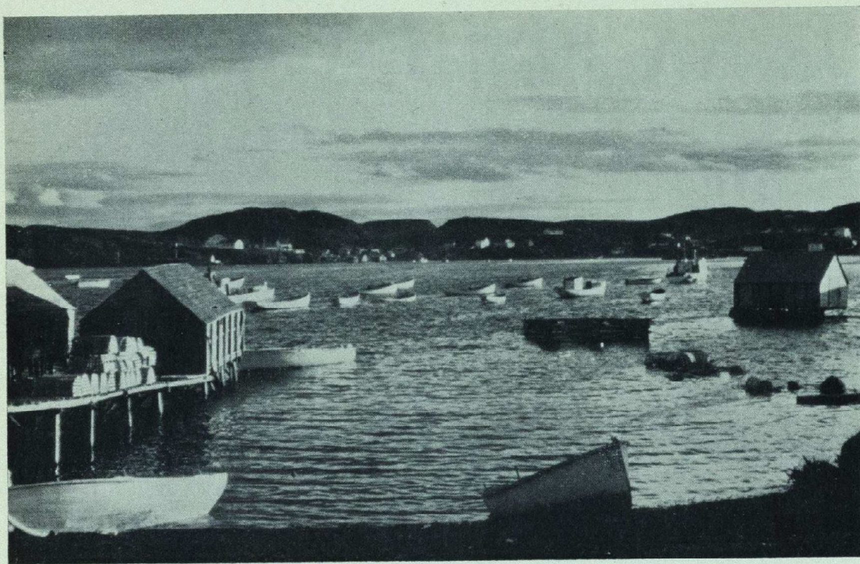
by Michael Keighley

It was 6.30 a.m., the skies were dark, big billowing black clouds made the sea look very oppressive and the wind was howling through the rigging on the tiny vessel that we were boarding. We chugged out of the shelter of the friendly harbour at Twillingate, amongst a fleet of fishing smacks, rounded the headland and then hit the Atlantic spray. More asleep than awake, for three of us had been up half the night with a midder case, we clung to the railings. The boat was small and the stormy weather made it difficult to keep a straight course—spray was flying everywhere which made the task of seeing where we were going no easier. We hugged the rocky coastline as close as we dare, but there was little shelter from the wind.

The tuna fish would soon be gone, for they were moving north every day now, and the season would be over. The stormy weather had come at just the wrong time and during the last week it had been impossible to leave the harbour, the seas had been so high. We had been out tuna fishing before and had returned disappointed, having lost our fish after a fight lasting three-quarters of an hour, and all we had to show for it was a broken rod pivot —but this time we were determined that fate should not repeat itself, The weather reports assured us that the storms were due to break today, but the sky showed no sign of change; however we all knew the speed at which the weather could alter in these shores and despite being wet and cold we were all hoping to see the fish that had filled our thoughts throughout the summer.

There were no other boats out that morning, the cod traps lay sadly unattended in the storm, but we battled on to the grounds where the locals had reported the "blue fin". Everyone seemed to be talking of them this year; and reports of them overturning fishing boats had filtered towards the hospital, indeed rumour had it that one lad of fourteen had been out squid-jigging by himself, when a tuna fish took his line and towed him for three hours before breaking loose. There was no sign of them that morning, there was no sign of anything but rocks and spray, the birds seemed to have vanished, even the whales were not to be seen. One minute we were covered in salt, the boat mounting the wave-crests and thudding to a valley of water behind, and the next all was quiet. Within fifteen minutes the sky had cleared, the sea was calm and soon the sun filtered through the last of the storm clouds; the weather reports had been correct!

By now we knew the routine, for as soon as the seas had abated we had strapped a chair to the deck-top and one person was scanning the horizon with the glasses for the tern diving on the wave tops. This was our guide to the "blue-fin" below, whose diet was the same as that of his feathered friend above. With two



One of the fishing Communities

of us on the look-out, the rest were busy in the well, preparing bait—squid, herring and mackerel were used and were threaded whole with a six-inch hook and weighted. The line of 110 lbs. breaking strain was checked and the fishing chair assembled with its thick rod and pivot on the floor.

The fishing ground that had been talked about so much was as unruffled as the rest of the sea. Two whales were blowing off Black Island so we went to see if the tuna were with them . . . but not a sign. By now the local fishing vessels were out busily pulling up the long neglected nets, and from each one we received the same reply, no fins had been seen since the storm began a week ago. Despite the clear sky and calm seas our spirits were low, nothing had been seen and we had scanned ten miles of coastline.

With nothing seen all morning, weather beaten and tired we went below for some coffee and lunch when suddenly the mugs were flying across the floor, the motors roared and we were all on deck. Doctor Olds was seated in the chair and suddenly there were "blue-fins" all around us. They seemed quite unaware of our boat, aimlessly breaking the water surface with their two dorsal fins in a rhythmic circular manner. There must have been about a hundred in the school . . . a majestic sight. The terns were diving above the school, folding back their wings and dropping like stones to the water, emerging from their effort triumphant with a beak full of herring sprat. The bait was out about 100 ft. behind the boat, and must have been in the thick of the school by now, but the tuna still nonchalantly surfaced unaware of our six inch hook. Uninterested in our first pass we came through the school again. Suddenly confusion replaced the ordered rhythm of the tunas' rolling gait, the bait had been seen, and they were swimming purposefully around it.

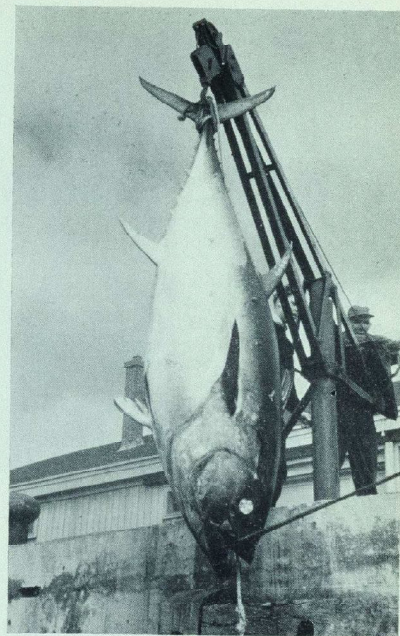
A splash, a whine from the line, Dr. Olds bent double over the rod and out of the sea rose a huge fish, which with a crack hit the water and broke the line! As soon as it had begun, it was all over, it was as if we hadn't been given a chance. Stunned, we looked around and realised that the whole school had disappeared. Not only had we lost the fish, but a lot of precious line had gone as well.

It was mid afternoon and we had replaced

some of the lost line. I was sitting in the chair and for the last hour we had been drifting on the water having seen nothing. The sun was hot, the afternoon a lazy one, and by now it was an effort to keep an active look-out on the horizon. Our spirits had again wilted in the heat and we were bitterly disappointed in having lost the second opportunity. Again, quite suddenly our spirits were allowed to wilt no longer, laziness had been replaced by a hive of activity—"terns on the horizon" was the cry that had aroused us all from our stupor. The motors roared and we were all on deck again, strapped to the harness. I looked over my shoulder to see the terns over the water and before I knew what was happening there were "blue-fins" all around us. The bait out, I anxiously sat in the chair, but none were interested in the first pass. We came through them again and I had my first strike, with a whine from the reel the line spun out—the fish must have taken 400 ft. before changing direction, and then it was a race to bring in line fast enough to keep it taut. It was a delicate job with such thin line, not to use too much strength and yet to keep the fish within the range of what line was available. By now, both line and metal fittings were far too hot to touch. It was a struggle to keep the fish at bay and the sun seemed to grow no cooler as the afternoon wore on. I would lever in line inch by inch and if lucky might reduce the gap between us and the fish by 100 ft., then all of a sudden ten minutes hard work would all be lost, the line would whistle out again while the fish dived deep or scudded across the surface.

An hour later, my back sore and arms weary, I was still pulling in line and losing it to the fish at the same rate, but he was still hooked and sooner or later he would surely tire. The skipper played the boat with cunning, making my task a little easier. It was just 90 minutes after the strike that I caught a glimpse of my fish for the first time; suddenly, as I was pulling hard the line went limp. Horrified I assumed the fish had broken loose, when out of the water leapt the huge beast, and landed on the surface with a crack. The boat shook with the impact, and then all was quiet as the fish disappeared below. How long could this struggle go on, the fish seemed so enormous, was this one going to get away as well?

The next time the fish was seen, it seemed as though the end would not be far away—he showed his side and we knew the fish must be tired by now. I hauled in line and brought him within gaffing distance when suddenly he was



The Catch!

off again, splashing, jumping, diving, pulling out line as he went. The gaff prepared, we were all given instructions for the hooking, which apparently was to be no easy business. Three times he was within gaffing distance, and three times he was off again, but each time with a little less energy than before. The final panic came with the fish alongside, "crack', the rod broke and pandemonium ensued. Two people tried vainly to hold the line, frantically throwing the gaff I thought of the disappointment of losing the fish, but our luck was in, the hook went deep, and soon the fish was lashed to the stern. It was just 140 minutes after the fight began that we chugged away triumphant, an eleven foot carcass secured behind us and a trail of fresh blood tarnishing the quiet sea. Soon amongst the fishing boats we had a mass of onlookers around us, we hailed help as it needed nine of us to haul our prize aboard. Great was our surprise when on our return to harbour the following morning the scales topped 605 lb.

The Boat Club Ball

The interior of College Hall is rather too austerely functional to be described with any accuracy as intimate, however, the organisers of the Boat Club Ball, with enthusiasm, many yards of paper streamer and coloured lights managed, at least partially, to effect a transformation. The three bands, each of them good, played a variety of music. A Jazz Band in the Assembly Room, playing a sophisticated rather than spontaneous Jazz, found time to exchange the traditional banter with their audience between tunes. The Beat Group in the Refectory, which was only moderately raucous, also maintained a dialogue with their audience. This Group seemed rather more hygienic than most of their brethren in other Groups, certainly they were less simian than most. Varying the standard repertoire of songs we have loved to listen to on Commercial Radio over the past triennium, were some Cockney tunes. Audience participation was invited, the response was enthusiastic rather than melodious. Steel Bands play often at Bart's Balls, they are invariably popular and the Boat Club Ball was no exception. The Bands played and couples danced, although any connection would seem to be fortuitous, as people happily performed anything from Victor Sylvester Olde Tyme, to something between Supplication to the Rain God and a Fertility Rite, all to the same music.

As a means of feeding the hungry with maximum efficiency, the Buffet would have been better had access to the food been by more than one door. The result of this oversight was a queue stretching from the Abernethian Room to the Foyer, reminiscent of a *W.V.S. Soup Kitchen* or a *Joe Lyons Tea Shop*. Sustinence procured, the massed gourmets still had to find somewhere to enjoy it. Apparently large numbers solved this problem by eating off the floor, leaving the Bar and Lounge strewn with used plates carrying choice gobbets of residual Potato Salad and Savory Rice.

After the Buffet came an amateur Cabaret, an excellent production by a group called "Four Square". Students, and veterans of the Smoking Concert, they performed with wit and versatility. The account of the saga of a Stud Stallion was particularly well received. Maidens and non-maidens alike, in the audience, seemed glad to be spared the "sophistication" of professional transvestism featured in the Rugby Club Ball Cabaret.

It is doubtful if even the most fanatical Puritan could have found the impeccable behaviour of the patrons of this Ball fitting subject for a diatribe in this Journal. When the Ball ended the exodus was as seemly as any congregation leaving Matins on a Sunday morning.

P. J. Dady

Epicurus

The bulk of that public who have accompanied me so far will have come to the conclusion that this is some form of column dedicated to Gastronomy. However the literati have pointed out to them that Epicurus (341-270 B.C.), although professing egoistic hedonism, was a sober ascetic who observed "I am pleased with bread and water" but added in a moment of weakness "yet send me a little cheese that when I want to be extravagant I may be". This latter clause was the green light for Imperial Rome, which had its throat tickled with a feather in between bouts of nightingales' tongues and stuffed mice. This is Epicureanism as *Hoi Polloi* and myself understand it—that glorious art, the only one to embrace recognition of and by all "five senses".

The Oxford Companion to Music connects the various schools of art and music, seeing similar trends in each at different times; thus drawing and melody, the addition of harmony (polyphony) and the laws of perspective. Let us continue this syncretism into gastronomy—let us discourse on the Gothic period of the Wiener Schnitzel, the Fauvism of Paella Valenciana and the daring Synthesism of Eclectic Artichauts, Futuristic Morilles and surrealistic Champignons in a Provençale Potage. Wines are easier—the Dada in a Schloss Bockelheimer Kupfergrube trockenbeeren auslese '49 is apparent to all.

Educated as we are to regard the ultimate aim of ingestion as the formation of high energy phosphate bonds, certain of us may be excused for honouring the Muse of Cuisine in greasy little bars full of meat marketeers and milliners. Perhaps a few ideas from the mists of nectar will not come amiss to the Neophytes of the Palate. Soho is the obvious place for good food. I chose the same meal at three differing Italian restaurants, The *Rugantino* (Romilly Street), trendy and expensive; *Ristorante Venezia* (Great Chapel Street), traditional and suave; *Trattoria Piemonte* (Frith Street), cheaper and peasant in the best sense of the word.

Fare:

Onion Soup
Caneloni (Minced meat, spices, vegetables in a cheesy pasta with a thick tomato sauce)
Steak
Fruit Basket or Cheese
Coffee

Wine:

Lacrima Christi (Similar to Gerwurtztraminer, not to be confused with the liqueur)
Et Al

At the Rugantino, I had Lacrima Christi. Tuscan White at the other two. (Purists note—white wine with steak!) The Rugantino was the best—waiters dressed in polo-neck sweaters and track suits served with that blend of reticence and excellence, lamented as departing in the present generation of club servants. The food was superb and the management provided two free liqueurs each to my dining companion (Honi Soit Qui Mal Y Pense) and myself. The habitués were all Italian, the classic test. A memorable meal—I paid accordingly.

On ordering the same dinner at the Trattoria, à la carte as usual, it was pointed out that the same meal could be had (excluding the steak) as a set meal. The three course meal (10s.) includes every item à la carte! I have returned twice to pay homage at the same shrine.

Although providing the best onion soup I have ever eaten, The Restorante Venezia was less interesting for the Classicist I would say. However, it had a gigantic Victorian Fruit Bowl and those slabs of cheese in the soup! . . .

It will be observed that I am somewhat enamoured of cheese and here is the greatest cheese dish of them all—CHEESE FONDUE. This Swiss dish is excellent for after the theatre or a party. It is basically a heated dish of molten cheese, into which one dips cubes of bread on a fork.

¾lb. Emmentaler } Finely sliced and
¾lb. Gruyère } dusted in flour.
½ to ¾ pint white wine, 1 bead of garlic finely chopped
Simmer gently till bubbling occurs
Add a little Kirsch and freshly ground nutmeg
Serve on a hot plate

Wine:

I suggest a heavier *Riesling*

In Neuchatel cubes of toast are preferred and Swiss shepherds have been known to dip the bread first in a bowl of Kirsch. Bibulous partakers normally imagine cheese on other forks to be more delectable.

Inspired by the current edition of "Wine and Food" and a copy of the German Tourist Bureau's "Deutschland bittet zu Tisch", I hope to visit the German Food Centre's Berlin Room for next month.

R.O.L.

Penguin Reviews

BARON CAPTURED

The Quest for Corvo, by A. J. A. Symons. Price 6s. *Biography*

Of A. J. A. Symons' literary accomplishments, it is his superb biography of the enigmatic Frederick Rolfe (Baron Corvo) that is remembered best. The quest began by accident, for while still fascinated by his initial reading of *Hadrian the Seventh,* Symons learned of a scathing attack on its author (The Baron) in the *Aberdeen Free Press.* Perplexed by the incongruity between his conception of the author of *Hadrian* (which is partly autobiographical) and the account of him in the Press. Symons became resolved to discover more about the bizarre Rolfe. Thus he embarked upon the researches which led him to publish his eminently successful "experiment in biography". It was not therefore by the conventional chronological sequence of biography that the subject was revealed; rather we gain insight into Rolfe's strange existence through the author's account of his own investigations. Thus Symons allows the reader to follow his construction of Rolfe's life in the succession of facts, correspondence and autobiography as they became available to him, and so mocking the conception of a purely objective biographer, he himself is mirrored in his work.

Frederick William Rolfe was born at 61, Cheapside in 1860, at school he placed enjoyment and drawing before his more academic studies, and then disappointed his family by deciding to leave at fourteen. Following a brief period of idleness, he became a schoolmaster but soon turned his attention to Catholicism and became a theological student at Oscott.

For Rolfe, a complete Mediaevalist, the Catholic Church loomed as a haven from the civilisation he disliked so intensely, for it championed learning and beauty. His eccentricities however soon made him an outsider at Oscott and he left "unlamented" by his contemporaries. Still determined to pursue the priesthood, he resumed his studies at Scots College, Rome, but by now his ability to incur debts was apparent and he was dismissed from the College. Although a brilliant and fascinating character Rolfe's peculiar behaviour, debts, unfounded anger and his view that others should maintain him financially, made him many enemies. His basic defect was the pathology of his inter-personal relationships and although he attracted many friends, he soon became suspicious and rejected them. He saw his publishers as defrauding him and his accusatory letters to them are clearly those of a paranoid personality.

In *Hadrian* Rolfe vents his spleen by winging arrows of bitter criticism at his successful Catholic contemporaries, whom he considers initiated a conspiracy to ruin his career.

From *Hadrian* and *Don Tarquinio,* his best known writings, he received no financial reward and after several years of poverty, he died in Venice during 1913, writing until the end his venomous letters of accusation.

As Rolfe's works are increasingly studied, interest in this baroque character is growing and A. J. A. Symons' biography provides the fullest explanation of this peculiar man.

Jeffrey Gawler

FANTASY

Malcolm, by James Purdy. Price 4s. 6d. *Fiction.*

The greatest impression that this story conveyed to me was of unreality. It is difficult to believe in any of the characters although their motives were real enough.

Malcolm is a fourteen year old boy of "great physical beauty" who is discovered sitting on a bench—waiting for his father. (The way in which his father has abandoned Malcolm is never satisfactorily explained.) The boy's rapid downfall, both physical and moral, is wrought by an astrologer, Mr. Cox, who chances by and who introduces Malcolm, via a list of addresses, to a series of extraordinary people; a wealthy Negro undertaker, the oversexed wife of a millionaire who wants to buy Malcolm, a handsome midget and a nymphomaniac artist whose homosexual husband presumably seduces Malcolm.

Add to this savoury crew Melba, a young and famous singer, who marries Malcolm and it is hardly surprising that the adolescent innocent is thoroughly deflowered by the end of the story.

Two scenes are worthy of note:— a painful session in a Tattoo Palace (a nice sadistic touch here) and the rather grim overnight stay in a Turkish bath-cum-brothel. For the rest I found the descriptions tedious and the conversations both trivial and puerile. The heavily implied sexual overtones were distasteful and blurred what I felt the author intended as symbolism and simplicity. (Surely lust isn't the only vice?)

The obscene jacket was singularly appropriate and sums up my attitude to this grotesque little fantasy.

P. R. Jordan

PROTEST MESSAGE

Wild Cat Falling, by Colin Johnson. Price 3s. 6d. *Novel.*

This short book is the first from its part-Aboriginal author. Although not autobiographical it shows the feelings and attitudes of those Aborigines who, though capable, fail to escape from a suppressed society which in status is not dissimilar to that of the coloured in the Southern States of America.

As an essay it won a university quarterly competition and last year, expanded into book form, was runner-up for the John Llewellyn Rhys Memorial prize. A foreword by Mary Durack shedding some light on the character of the author sets the scene for the story proper.

The story is about a half-coloured youth who is sheltered by his mother until his first spell of trouble, when he is taken away to a home. The story is built around his release, short freedom and his inevitable return to prison.

Placed in an environment where to be tough, or at least pseudo-tough, is needed for survival he quickly adopts the guise of his contemporaries who are embittered against society. In prison, recalling his past, he realises even now that the future holds no promise. Although smart he lacks a basis on which to build a stable future. He realises this and becomes a rebel against the society in which he could never play a normal part. When released he again slips into trouble which assures his return to prison.

This is a pathetic story which occasionally evokes sympathy. The futility of knowing that progress is barred by the barriers of society is too much for the intelligent half-Aborigine. Rather than passively accept the situation he reacts so violently against it as to destroy himself.

The story is another angle on the familiar protest message. The style is suitably abrupt yet at times vividly descriptive, this standing out in the harshness of the text.

Although recommended, this book will not make a wet Sunday afternoon seem any brighter.

I. D. Fraser

INFLAMMATORY QUESTION

Is Paris Burning? By Larry Collins and Dominique Lapierre. Price 7s. 6d.

One of the leading questions of the 1940-45 war was how Paris, which Hitler condemned to utter annihilation, escaped total demolition. Under the auspices of Ebernach many of the most beautiful monuments of Paris including the Place de la Concord, Palais de Luxenbourg, the 45 bridges crossing the Seine and the Eiffel Tower were to have been reduced to dust and debris. When the latter had been razed to the ground, the morale of the Parisiens and the French would have been crushed.

With enough T.N.T. "to shoot through two wars", according to one German, how was the burning of Paris averted? It was largely due to the work of the Resistance and Cholitz, the German in command of Paris, who had never, until August 25th, 1944, questioned an order however harsh it had been. Although aware of his intense loyalty to his country, he was, fortunately for the Parisiens of 1944 and posterity, stricken with indecision to carry out the Führer's order.

Larry Collins and Dominique Lapierre aptly describe in a fluid manner the events during the last week of the Nazis' occupation of Paris.

There is a keen tempo throughout the book, making it lively and interesting. The race between the de Gaulle supporters, the Communists of the Resistance and the Allies to reach and take control of Paris is well constructed. However the authors could have elaborated on the antagonism between the French Resistance and its Communist members. Unfortunately only one incidence is mentioned.

The sound of the Marseillaise and the sight of the Tricolour brighten up an ending which is pathetically flat and does not do justice to the rest of the book.

Barbara Appleby

AFFAIRE DE GUERRE

The Sun's Attendant by Charles Haldeman. Price 6s. *Novel.*

No ordinary book this; a kaleidoscope of memories and impressions, mainly of people, taken from a context of the Second World War and its aftermath. This is a segmented account of diary entries and short incidents with abrupt changes in the narrative and style.

Stefan Brüchman, the central figure, is an orphan with gypsy blood and a Jewish background. It is through the faculties of this waif that the sense of war is perceived: "I lived in death itself, not merely in its vicinity.... We developed an odd kind of patience, unthinkable to adults." A chequered childhood and adolescence through war and refugee camps is terminated by retreat to America and adoption by Moon, a game warden. Life is not smooth here and after some tumultuous clashes, Stefan returns to France and later, Germany where he mingles with artists and intellectuals, and develops his own talents as a poet and writer. To his editor, he expresses a wish "to shed his past" by writing.

The supporting characters who are sensitively portrayed, appear and disappear neither tightening nor loosening the threads of a disjointed plot. In fact, the substance of this plot may not be narrowed into one set of figures. It is widely relevant and the second half of the book reveals the effects of war on the lives of individuals.

After many encounters and emotional entanglements, Stefan marries a widow, Barbara Speel. The ghost of her suicide-poet husband haunts their marriage.

The book is full of human conflicts and relationships, both melancholy and poignant. Charles Haldeman leaves the reader with the questions, to sort out and answer for himself.

Patricia Kilshaw

ARCHAEOLOGY

The Penguin Book of Lost Worlds, by Leonard Cottrell. Vol. 1, price 10s. 6d., Vol. 2, price 8s. 6d.

These two volumes provide a brief but graphic description of seven ancient civilisations. The first volume describes the more distant and exotic civilisations of Egypt under the Pharaohs, the rise and fall of the Sumerian culture in Mesopotamia and the Indus Valley culture. The second volume describes the more European cultures of Crete and Mycenae, of the Anatolian uplands and lastly the people who had an indirect effect via the Romans on our own culture, the Etruscans.

Mr. Cottrell sets out to try to bridge the gap between the professional archaeologist and the informed lay reader and one feels that in general he has succeeded. The section on the Pharaohs is, however, a little confusing owing to the multiplicity of long and complicated names and the lay reader would probably have to be dedicated to digest it all. This section has a great emphasis on the royal line and comparatively little on the ordinary people but it must be realised that most is known about the Pharaohs owing to the solidarity of their monuments. The section on the Sumerians and the Indus Valley seem more balanced with descriptions of life on both sides of the tracks. These provide a good background for the general reader to two civilisations which are comparatively unknown and about which there is very little readable material.

In the second volume the two sections in Greece and Crete provide a good summing up of these two cultures which will be useful for the visitor and the armchair traveller. The section on Anatolia is very topical owing to the publicity concerning a lost treasure from one of the sites which appeared in a Sunday newspaper. Most of the work carried on in Italy today is on the Etruscans so that for an interested person the section on these people is an invaluable brief guide, but it does tend, as the reports of work do, to be a catalogue of finds from Etruscan tombs.

Generally these books will be valuable additions to the works on these cultures being so readable and with a large number of drawings and good photographs.

Ian McLellan

AMERICAN HUMOR

The Russians are Coming, by Nathaniel Benchley. Price 4s. 6d

All out War? All out Farce!

These two headlines tell you that you are in for a lighthearted ridiculous comedy based on the homely and wholesome type of American humour.

A Russian submarine cruising against orders in the waters of some off-shore islands off the North East coast of America gets stuck on a sandbank. The Captain fearing a fate worse than death sends a party of crew ashore to steal a boat to pull them off. The party on losing themselves obtain a guide at gun point who leads them to the nearest boat. During which time the general alarm is raised and every available male and firearm, able bodied or otherwise is gathered in the island's bar.

Frustrated in their attempts to obtain a boat the Russians cut all telephone wires, rape the telephonist and beat up their guide.

The submarine has freed itself from the bank and they return to it only to find they are missing a deserter. Another party is sent ashore to find him.

There is a confrontation battle at the island's refuse dump, ammunition being in the form of tin cans and broken bottles. Finding this too much the Russians abandon both battle and deserter and return to their submarine which glides safely away.

Quite a funny situation but it wasn't a very funny book.

The amusing highlights are numerous enough, but they tend to be very drawn out. You can see the potential of a funny situation but by the time the author has reached it, you find you have lost the point. With every other chapter a new set of characters is introduced and another funny situation starts to develop. However a lot of these people and situations were just left, and you never get to the punch line. The Russians are made to appear, by any exchange of conversation they have with their guide a stupid, clumsy, and feelingless lot. In their remarks they praise any unpleasantness and denigrate anything of aesthetic beauty which their guide points out to them as if to show how praise were an admittance of weakness. For example, in the guide's exclamation of how pretty the colours of the Autumn moor are, the retort is "Bourgeois capitalist taste. In the Soviet Union we know what real beauty is. The sweat under a woman's arm, that is beautiful"—which, however provoking, a remark, I would give no Russian credit for calling beautiful, and so instead of seeming farcical, they just seem unauthentic.

However, some of the incidents are very funny, especially the fight at the refuse dump, and the insistence of some wives for their husbands to put on their old battle dress, and go out to defend America.

Julie Gould

TALES OF HORROR

The Insanity of Jones and Other Tales, by Algernon Blackwood. *Short stories.* Price 6s.

Algernon Blackwood remarks in the preface of his 11 tales of horror and the supernatural "that to write a ghost story I must feel ghostly, a condition not to be artificially induced". I feel that this statement applies equally well to the reading of ghost stories, and is a major stumbling block to an appreciative review of this book. Blackwood is interested in the faculties which under exceptional stimulus register beyond the normal gamut of seeing, hearing, feeling. But surely the stimulus which evokes the involuntary shudder of the mind must come from the truly unnatural happening in our natural environment. The very translation of such happenings to the printed word lessens their impact and prematurely soothes the nerves, whether we believe in extrasensory perception or not.

Apart from this initial criticism, these tales are well written and for the most part manage to involve one in the fate of each protagonist. "The Willows" and "The Listener" are two that I would pick out as exceptional. In the former the loneliness of the scene, the vivid description of rising wind and water, the feeling of control slipping and mounting panic are too vivid not to feel some small measure of fear. It is a story of horror induced by the power of the elements—the nascent fluidity of wind and trees conjuring up ideas and images beyond the practical, the substance of realism.

"The Listener" is a rather nasty claustrophobic story. It concerns the persistent desire of a leprous ghost to take over the more wholesome body of a young writer occupying the rooms of the, now dead, leper. Perhaps nowadays the idea of leprosy has lost the bloodcurdling chill imagined by the author, but the story, in the form of a culminative diary of events produces considerable tension.

Jacqueline Hall

MEDICAL BOOKS

Anaesthetics

An Introduction to Anaesthetics, by John D. Laycock, C. A. Foster, 2nd edition. Published by Lloyd-Luke. Price 15s.

The second edition of this excellent book should suit the student's purse and pocket. It serves as an introduction to clinical anaesthetic training. Apparatus and drugs are described adequately and the volume should enable the student to gain more benefit from his time in theatre.

Despite the lack of a formal section on resuscitation the book covers the practical treatments of airway obstruction and cardiac arrest; some illustrations on the application of external cardiac massage would assist the text.

It can be recommended both to student and house surgeon as a straightforward introduction to anaesthesia and the pre- and post-operative care.

D. W. Bethune

Bibliography

Medical Books, Libraries and Collectors. A short Study of Bibliography and the Book Trade in relation to the Medical Sciences, by John L. Thornton. 2nd edition. Published by André Deutsch Price 84s.

Once again the Hospital's librarian, Mr. Thornton, has put all readers of medical literature deeply in his debt. Seventeen years ago he published an absorbing history of Medical Books, Libraries and Collectors, which he has now revised, adding to the scope of his survey and talking cognisance of what has been written in the historical and bibliographical journals during these years. In result the new edition is half as long again as the first.

Most bibliographies are unreadable: they serve the same utilitarian purpose as a time-table or a salesman's list, to answer particular questions. This book, as Sir Geoffrey Keynes points out in his Introduction is "semi-readable, capturing the best of both worlds" between the factual bibiliography and the readable treatise, and combining the usefulness of the one with the interest of the other.

Mr. Thornton's method is to take the principal medical writers of all periods and countries, more or less in chronological order though with some arrangement by subjects, and to discuss the value or interest of their work, while providing a concise record of their published writings with accurate references to previous appraisals or fuller studies of them. In this new edition he provides a greatly enlarged bibliography of such references, supported by a full index, which makes the book easy to consult in spite of its discursiveness and the wealth of detailed information which it comprises.

Each reader may regret that one or another of his heroes has not been included, but with such a vast literature to survey Mr Thornton has had to restrict his purview in order to keep within reasonable bounds; this he has achieved by sacrificing the greater part of foreign literature in the modern period. Similarly his account of the principal libraries, and of the famous physicians and surgeons who have gathered goodly private collections, is restricted in the main to the English-speaking countries.

For good measure he provides a valuable survey of the rise of medical societies, though he has omitted the somewhat indigestible list of them which appeared in the first edition. He also deals very informatively with the slow development and recent proliferation of periodicals, and provides an excellent short history of medical bibliographers and their compilations, but his chapter on medical publishing and bookselling is less complete.

Mr. Thornton has not been afraid to voice pertinent criticism of modern tendencies in the production and provision of medical literature, and offers some constructive suggestions for better service to medical readers on a national basis.

W. R. LeFanu

Cardiology

An Introduction to Electrocardiography, by L. Schamroth. 3rd edition. Published by Blackwell.

This book is an excellent summary of basic electrocardiography and reflects the experience of the author at the Baragwanath Hospital in Johannesburg, the largest hospital in the Southern Hemisphere. However, although the book is short, the emphasis is on relatively advanced aspects of electrocardiography of interest to the cardiologist in training, and it cannot be regarded as suitable for undergraduate study.

The considerable space devoted to a discussion of the "electrical position" of the heart gives the book an old-fashioned air, but the description of ventricular hypertrophy, bundle branch block and cardiac infarction are clear and concise. The author refers to vectorcardiographic principles from time to time, but in many aspects the discussion is based on the detection of local effects by exploring electrodes, an idea that is radically opposed to the fundamental theory of vectocardiography. The electrocardiographic changes in cardiac infarction are attributed to the infarct forming an electrical window into the interior of the heart, a concept which I find unhelpful and which lacks any experimental support.

The discussion of the minor ST and T wave changes which may occur in myocardial ischaemia is interesting, but creates the impression that these abnormalities are often of diagnostic value; in fact, so many other factors may be responsible that interpretation of slight ST and T wave disturbances is very difficult. It is good to see a clear description of peri-infarction block and of the importance of the QRS-T angle, but it is perhaps unfortunate that the theory of the different electrocardiographic effects of systolic and diastolic overload of the ventricles has been accepted uncritically.

Arrhythmias are dealt with in considerable detail. In particular, phasic aberrant conduction and atrioventricular dissociation are extensively treated. This emphasis is the result of the special interests of the author. Detailed knowledge of the complex arrhythmias is not necessary for the medical student or the general physician, but if guidance is needed in this field the presentation here is interesting and precise as might be expected from Dr. Schamroth's extensive experience as a teacher of electrocardiography.

J. Hamer

Computerisation

An Introduction to Medical Automation, by L. C. Payne. Pitman Medical Publishing Co. Ltd., London. Price 25s.

Computers are becoming an important factor in modern life. In the business world, banking and insurance companies are quickly realising how they can use this new tool to improve the efficiency of their organisations and, at the same time, make data rapidly available for policy decisions. It is, therefore, important for every doctor to understand how the computer can affect progress in the life sciences and improve hospital efficiency. Dr. Payne was one of the first workers involved in medical automation and his book contains in part some of the work he undertook as Director of the Medical Automation Unit at University College Hospital.

The book is divided into two parts. Part I deals with the scope and character of medical automation, while the second part is an introduction to computers. In the first chapter the author is careful to define the term "automation" as "instrumenting information for decision or adjustment purposes". He points out that the crux of automation is therefore information. The medical record is the first to be considered and it is pointed out how a reel of magnetic tape small enough to be carried in a brief case can readily store hundreds of items of information on tens of thousands of patients. The information stored can be selectively retrieved in minutes and the importance of this can be immediately realised by those who have searched the files of any large hospital for even limited data on patients. Medical statistics, duration of stay, marriage status, diagnostic categories, treatments, etc., can be selectively tabulated in a few hours. The clinician will immediately ask how the computer can deal with written opinions, E.E.G., E.C.G., etc. This is dealt with in a separate category as Class 2 data and Dr. Payne points out the way in which the modern computer can deal with it without the limitations that are inherent in the "eye cerebral" link in the human observer. Computer assisted diagnosis is considered in a separate chapter and the method of the attack outlined with particular reference to bacteriological identification. The idea of a disease library is presented where data on diseases is accumulated, edited and added to as new knowledge becomes available. This development must gladden the hearts of all doctors who try to keep up to date and, in so doing, are appalled by the breadth and pace of developments in their subject. Laboratory measurement is an obvious field for automation and is treated in detail in a separate chapter with reference to autoanalysers, amino-acid analysers, etc.

Patient monitoring systems are considered with a discussion of the difficulties of transducing the signals for the computer to handle. It is pointed out, however, that developments are progressing rapidly in this field and some applications have already been found in intensive care nursing. The computer can help in this situation because it can handle many interacting variables and present information rapidly for easy evaluation by the doctor.

The final chapter in Part I deals with the paramedical uses of computers. Radiation treatment planning, pharmaceutical dispensing and critical path programming are all considered.

The second part of the book is an introduction to the computer and the basic principles are made easy to understand with the aid of simple examples to be worked out by the reader. The organisation of the computer and its physical attributes are then described. The book ends with binary arithmetic explained in two pages and a useful glossary.

A book thin enough to be read in a few hours and, for those who can stick with it to the end the chance of acquiring a little less fear of automation and an awareness of its effect on modern medicine.

B. W. Watson

Medicine

The Principles and Practice of Medicine, edited by Sir Stanley Davidson. Eighth edition, published by E. & S. Livingstone Ltd. Price 40s.

Since its first appearance in 1952 Sir Stanley Davidson's "The Principles and Practice of Medicine" has appeared in no less than eight editions and seven large reprints, a notable achievement. The eighth edition follows the same general pattern as its predecessors laying the main emphasis on common disorders and including some rare disorders selected for their educational value. A comparison of this edition with the previous one shows that each section has been thoroughly revised and the article on diabetes mellitus has been re-written and greatly improved. A welcome addition is a new chapter on genetics in relation to medicine and there is also a new chapter on acute poisoning which is appropriate in view of the growing number of deaths from poisoning in Great Britain, which is now only a little less than the deaths from accidents on the road. The book has been made more attractive by some new colour plates of blood cells and bone marrow and of the optic fundus.

During the clinical period a student is well advised to familiarize himself with two textbooks of medicine, a smaller one to buy and read thoroughly and a larger one to consult in the library. By referring to a larger book such as "Price", when greater detail is required and for information about rarer diseases, the book will already have become a familiar friend when later one comes to buy it in an up to date edition for use in practice. Of the smaller books "Davidson" is good value for the money and it has deservedly retained its popularity. No doubt its success owes much to careful editing whereby at each revision irrelevant material has been eliminated with the result that the text is concise and to the point. The plain and logical style and general excellence of this book are well maintained in the new edition.

Kenneth Black

The Clinical Apprentice, by J. M. Naish and A. E. A. Read. Published by John Wright & Sons Ltd., 3rd edition. Price 21s.

Corrigan once said that the trouble with doctors was not that they did not know enough, but that they did not see enough. Learning how to see in clinical medicine is a problem now just as it was then, particularly for the medical student. The difficulty for the medical student in these days is that the pressure of a multitude of disciplines with their vast amount of information is increasing at a time when traditional methods of teaching based on the apprenticeship system, such as the clinical "firm", are becoming inadequate.

It is therefore a pleasure to read a book which aims at showing the "clinical apprentice" how to gather facts. There must be a need for such books as several new ones of various sizes and cost have appeared in recent years. In comparison with others, this book is of high quality for moderate cost.

The text covers the examination of the systems and has two useful chapters on the physiological background of respiratory diseases and salt and water metabolism. It is surprising that the examination of the skeletal system can be dealt with in two paragraphs, and there is not even an introduction to simple mental testing in the section on the central nervous system. These would not be out of place in an introduction to clinical medicine. The separate section on the examination of the acute medical emergency is a good idea. The authors describe, for example, how the examination of an unconscious patient can be approached.

The diagrams are good, and as far as possible with black and white illustration, the photographs help. A small error occurs in Figure 89 where, after the text specifies the left lateral position for a lumbar puncture, the patient is seen lying in the right lateral position. The next figure adds little information on the technique of lumbar puncture.

This book should prove of value to those starting clinical work, and is to be recommended.

J. S. Malpas

Nursing

The Mechanism of Respiration and Closed Drainage of the Pleural Cavity. *Modern Nursing Series.* Published by The English Universities Press Ltd. Price 12s. 6d.

This book contains a short series of questions and answers upon the mechanics of respiration and then devotes no less than 107 pages of questions and answers upon the arrangement of tubes and bottles necessary for the treatment of a pleural effusion by closed drainage.

The King Edward's Hospital Fund for London has undertaken sponsorship of various projects concerned with "Programmed Learning". This science, if such it be, is in a very early stage of development. The present volume shows what can be done in two reasonably simple contexts. How far the science will eventually be applied to the training of nurses among others remains to be seen. The reviewer has the impression that the simplicity of the questions will prove irksome to nurses who have already been educated to the standard of five "O" levels. However, there must be many others who are less well qualified academically and who may indeed have difficulty with the English Language. Perhaps this volume will afford for them an example of the methods of programmed learning.

N. C. Oswald

Obstetrics

The Faber Pocket Dictionary of Midwifery, by C. W. F. Burnett, M.D., F.R.C.S., published by Faber and Faber. Price 10s.

This dictionary has been designed for the busy midwife, the student and the general medical reader. All the words and terms encountered in practice and in the literature are included as are some of the procedures which are simply and concisely explained. The two hundred or more simplified line drawings and diagrams are generally good, imparting information which could be lost in an otherwise cumbersome explanation. The dictionary is set out well and includes a pronounciation guide "to help the student, particularly from abroad".

At the price, this book is a good buy for the aspiring midwife who has not yet acquired her companion to the text books and lecture notes.

I. D. Fraser

Ophthalmology

Ophthalmology by Kenneth Wybar. 1st Edition Published by Baillière, Tindall and Cassell. Price 25s.

"These books are of particular value in helping the student to gain a sense of appreciation towards a subject and a grasp of its fundamentals."

This statement is found on the cover of all the books of this series. It may well be true of the other subjects but it is certainly not so of this particular volume. Ophthalmology is a specialized and rather remote subject to the medical student, and the voluminous material presented in this book does little to differentiate fundamentals from frills. Thus one may question whether the student should ever read the terms phaco-anaphylactic, abnormal retinal correspondence, etc., etc.

There are few photographs and strangely one of these shows the author using an ophthalmoscope and loupe—a technique of limited use—whilst eversion of the upper lid is not illustrated at all, described in ten lines of print, one sentence being five lines long. The line drawings, explaining the visual field defects, are superbly done, but again are taken too far for the student (a detailed description of the arrangement of the fibres in the individual optic nerve).

This book contains a large amount of information in a relatively small compass. It could be recommended wholeheartedly to the D.O. post-graduate student or the Eye House Surgeon—but not the medical student.

M. A. Bedford

Theatre Technique

A Manual of Operating Room Technology by Ginsberg, Brunner and Cantlin. Published by Lippincott. Price 40s.

This book, written essentially for the American operating room technician, has much to commend it to any nurse or technician working in the operating theatres in this country, and most certainly should be read by any who anticipate working in American or Canadian theatres.

These three nurses have had much experience both in working with and training members of operating teams—and have a very real appreciation of the demands on a theatre team—they touch on every aspect of the work—describing not only what should be done but why. Because it is so comprehensive, it is of necessity a little brief in places—illustration and diagrams make it both attractive and easy to learn from.

Since many of the methods described vary from those used in this country, it is more suitable for those who are already working in the theatre, rather than as an introduction.

This would be a most useful reference book in any library, and it is to be hoped that the paper cover and binding would be durable under the handling it would receive.

K. Bartlett

SPORTS NEWS

SPORTS EDITORIAL

Most of the winter sports fixtures have now been played, so a review of the season's successes as a whole can be made. Perhaps the most successful of the three major clubs has been the Hockey Club. Although they were eliminated from the Inter-Hospitals cup quite early in the season they have reached the final of the University of London cup competition. The Soccer Club are also out of the Inter-Hospitals cup, but they are doing very well in the U.L. and U.H. leagues. Despite the unfortunate elimination of the 1st XV in the second round of the cup by the Westminster, the 'A' XV have won their way into the semi-final of the Junior cup. which they won last year. We hope that they will win it again as it would be disappointing for the club to finish its Centenary season without any trophies. It does not look as though the Centenary Ties will make it in time. (Rumour has it that they are having 1866-67 inscribed on them!)

To those of us who play regularly at Chislehurst it is a constant delight to use the pitches that Laurie looks after so well. After such a wet winter he deserves great credit for all he has done.

HOCKEY CLUB

STOP PRESS

In the final of the U.L.U. Cup Competition the Hockey Club defeated *Imperial College* by **1-0** (after extra time). A full erport will be published in the May *Journal*.

THE
MEDICAL PROTECTION SOCIETY
FOUNDED 1892

MEMBERSHIP EXCEEDS 45000

Membership secures protection of professional interests by a personal advisory service and the provision of unlimited indemnity against legal costs and damages.

Senior Medical Secretary Herbert Constable MRCS, LRCP

THE MEDICAL PROTECTION SOCIETY
50 HALLAM STREET · LONDON · W.1
Telephone LANGHAM 9241

Dental Secretary Frank Allott, LDS

BOAT CLUB

U.L. Head of the River: *1st March*
Putney to Mortlake

A greatly increased stream all but stemmed the incoming tide, a strong south-westerly ensured a headwind for half the course and rough water at the start thoroughly doused the crew and put several gallons of water into the boat. The VIII had been unsettled during the preceding three weeks—due partly to an ill-timed skiing holiday—and consequently no progress had been made in training except perhaps in fitness.

After an indifferent row to Hammersmith the water became calmer, and we settled into a better rhythm and were greatly helped by the presence of Q.M.C. whom we gradually overtook, to be two lengths up at the finish. John Brooker in his first race for the 1st VIII steered an excellent course.

The Imperial College winning time of 23.17 shows how slow the conditions were:

Results—1 I.C.I. 23.17; 2 U.C.I. 23.25; 3 Guys 23.43; 4 I.C. III 23.49; 5 Bart's 23.58.

Crew: Bow, N. J. C. Snell, T. F. Coyle, B. Moore, P. A. B. Cheetham, P. I. Featherstone, J. D. C. Martin, B. D. Cutler, M. C Stallard; J. Brooker.

Jamie Martin

GOLF CLUB

Bart's v. C.E.M. Wednesday 22nd February, at New Malden. Won 2½—1½

Conditions were very wet underfoot, but the drizzle was occasionally interrupted by spells of sunshine. Stewart Davidson hit an unusually bad patch and went down 6 and 5. Mike Bowen, however, levelled the scores with a fine 5 and 4 win. Chris Booth, three down at the ninth, came back magnificently to win by 2 and 1. Angus Hoppe and Howard Rutherford both halved their matches.

A. Hoppe

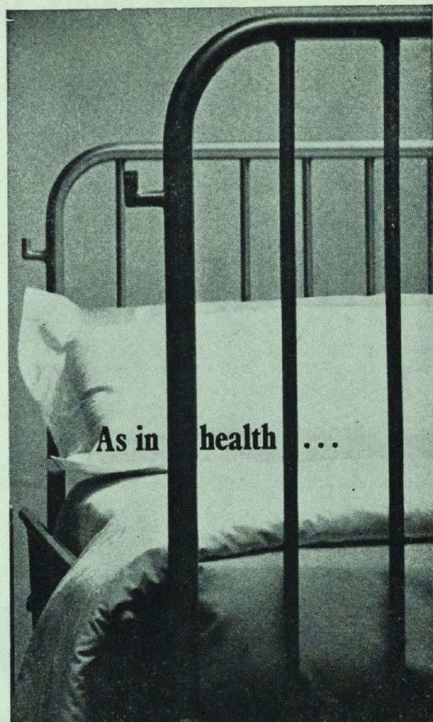
SOCCER CLUB REPORT

Since the last report the club has had mixed success, losing in the second round of the Cup to the London, but improving its position in both the University of London and United Hospitals Leagues.

3rd December v. Royal Dental Hospital (U.H.L.) at Chislehurst. Lost 0-1.

8th January v. United Hospitals' President's XI. Drawn 3—3.

Played on a hard, icy pitch at St. George's ground this was a close match, resulting in a 3-3 draw. The Bart's scorers were Turner, Dorrett, and an own goal by the opposing centre-half.



Trufood spans the dietary needs of children both in sickness and in health. Its range, in this important respect, is extensive and is the result of 40 years of specialised experience. We are glad to make special efforts—and special products—to provide wherever possible the right food for every baby however exacting his needs may be.

Minafen · Galactomin · Locasol · Edosol

TRUFOOD LTD

THE MEDICAL DEPARTMENT, THE TRUFOOD CREAMERIES. WRENBURY, NANTWICH, CHESHIRE.

TFD 113/1-6024-100

The Business Houses' Discount Buying Service

49 BOW LANE, CHEAPSIDE, LONDON, E.C.4.
Telephone: CENtral 7225

Authorised Suppliers of BRANDED MERCHANDISE to Staff Associations and members of Approved Organised Groups.

DISCOUNTS AVAILABLE LISTED ALPHABETICALLY

Item		Discount
Batteries (car)	UP TO	17½%
Bicycles	,, ,,	17½%
Branded Shirts	,, ,,	20%
Beds	,, ,,	17½%
Bedding (sheets, blankets, b/spreads)		17½%
Bathroom fittings	,, ,,	17½%
Blankets (electric)	,, ,,	17½%
BRANDED CARPETS	,, ,,	30%
Cars	,, ,,	10%
Car radios	,, ,,	17½%
Camping equipment	,, ,,	17½%
Car accessories	,, ,,	17½%
Clocks	,, ,,	17½%
Cookers (large)	,, ,,	10%
Cookers (small)	,, ,,	15%
Curtain fittings	,, ,,	17½%
Cutlery	,, ,,	33⅓%
Dressing table sets	,, ,,	30%
Electrical appliances	,, ,,	17½%
Furniture		
Bedroom	,, ,,	17½%
Kitchen	,, ,,	17½%
Lounge	,, ,,	17½%
Office (re-conditioned)	,, ,,	HALF-PRICE
Fridges	,, ,,	12½%
Gardening and General tools	,, ,,	17½%
Glassware	,, ,,	20%
Hi-Fi equipment	,, ,,	20%
Kitchen equipment and gadgets	,, ,,	17½%
Lawn mowers (hand)	,, ,,	17½%
Lawn mowers (power)	,, ,,	12½%
Leather goods	,, ,,	20%
Light fittings	,, ,,	17½%
Nylons (assorted)	,, ,,	30%
PHOTOGRAPHIC EQUIPMENT INCLUDING FILMS	,, ,,	17½%
Pen sets	,, ,,	10%
Perfume (French)	,, ,,	20%
Radios	,, ,,	17½%
Radiograms	,, ,,	20%
Record players	,, ,,	20%
Suitcases	,, ,,	17½%
Tape recorders	,, ,,	20%
Television sets	,, ,,	20%
Table lamps	,, ,,	17½%
Tyres (FITTED FREE)	,, ,,	17½%
Tools (POWER) and accessories	,, ,,	17½%
Typewriters	,, ,,	12½%
Towels	,, ,,	17½%
Venetian blinds	,, ,,	20%
Watches	,, ,,	17½%

This list is intended only as a guide to the range of merchandise we are able to offer. In addition to items listed, there are many others available at comparable discounts. The company reserves the right to amend prices and discounts without notification.

A DIVISION OF
THE RYAMS ORGANISATION (Southern) LTD

• • New & Recent CHURCHILL Publications • •

MEDICINE
Essentials for Practitioners and Students
New (Ninth) Edition. By G. E. BEAUMONT, D.M., F.R.C.P., D.P.H.
70 Illustrations. *Ready shortly* About 55s.

THE PATHOLOGY OF MENTAL RETARDATION
A New Book. By L. C. CROME, M.C., M.R.C.P. (Ed.), M.C.Path., and J. STERN, Ph.D.
129 Illustrations. *Just Ready* 84s.

A SHORT TEXTBOOK OF MIDWIFERY
New (Eighth) Edition. By G. F. GIBBERD, C.B.E., M.S., F.R.C.S., F.R.C.O.G.
190 Illustrations. 45s.

ANAESTHETICS FOR MEDICAL STUDENTS
New (sixth) Edition. By G. S. OSTLERE, M.A., M.B., F.F.A.R.C.S. and ROGER BRYCE-SMITH, M.A., D.M.,F.F.A.R.C.S.
(Paperback) 14s.

COMMON DISEASES OF THE EAR, NOSE AND THROAT
New (Fourth) Edition. By PHILIP READING, M.S., F.R.C.S.
2 Col. Plates and 45 Text-figures. 36s.

PATHOLOGY OF THE KIDNEY
A New Book. By ROBERT H. HEPTINSTALL, M.D.
Abundantly Illustrated. £10

MANUAL OF MEDICAL THERAPEUTICS
New (Eighteenth) Edition. By the Department of Medicine, Washington University School of Medicine.
(Paper Covers) 35s.

'Recent Advances' Series — Latest Volumes

PATHOLOGY
New (Eighth) Edition. Edited by C. V. HARRISON, M.D.
114 Illustrations. 70s.

OBSTETRICS AND GYNAECOLOGY
New (Eleventh) Edition. By J. A. STALLWORTHY, M.A., F.R.C.S., F.R.C.O.G., and G. L. BOURNE, F.R.C.S., F.R.C.O.G.
75 Illustrations. 60s.

MEDICAL MICROBIOLOGY
A New Book. Edited by A. P. WATERSON, M.D., M.R.C.P.
32 Illustrations. 65s

J. & A. CHURCHILL, LTD., 104 GLOUCESTER PLACE, LONDON, W.1.

25% DISCOUNT
on
Engagement Rings
from craftsman to wearer
and
Swiss Watches
large range of Ladies' & Gentlemens' styles available
"FINEJEWELS"
88-90 HATTON GARDEN, E.C.1.
Telephone: HOLborn 8058
Weekdays 9.30-5.30, Sat. 9.30-1

MEDICAL CORRESPONDENCE COLLEGE

Are you preparing for a
MEDICAL OR SURGICAL EXAMINATION?
Do you wish to coach in any Branch of Medicine or Surgery?

* The activities of the Medical Correspondence College cover many departments of Medical, Surgical and Dental tuition.
* Desultory reading is wasteful for examination purposes.
* The secret of success at examinations is to concentrate on essentials.
* First attempt success at examinations is the sole aim of our courses.
* Concentration on the exact requirements is assured by our courses.
* Our courses are up to date and frequently revised.

Write to The Secretary (B.H.) 19, Welbeck Street, London, W.1, to see if we have a course for your examination.

14th January v. London Hospital. (2nd Round U.H. Cup) at Chislehurst. Lost 0-3.
This was a deserved victory for a better side than we had expected. Bart's were forced into defence for the first 20 mins. of the match and the London pressure eventually resulted in their scoring. After this Bart's never looked like scoring and the London added further goals in the second half.

18th January v. Middlesex Hospital. (U.H.L.) at Chislehurst. Won 3-0.

An early goal from Mumford set the pattern for the match, additional goals from Weir and Farrow giving Bart's a sound win.

25th January v. London Hospital. (U.H.L.) at Chislehurst. Lost 0-2.
This match was a far closer game than the Cup match against the same opponents and it was only defensive errors that led to the two goals which cost us the match, despite excellent goalkeeping by Ellis.

1st February v. Guy's Hospital. (U.H.L.) at Honor Oak. Lost 1—6.
Bart's, despite playing with only ten men, managed to hold the Guy's side to 1-1 until half time, with a good goal scored by Leech. In the second half however the side cracked and Guy's were quick to capitalize on this, scoring five more goals.

4th February v. U.C.H. (U.H.L.) at Chislehurst. Won 3-1.
8th February v. City of London College. (Friendly) Away. Won 3-1.

11th February v. Trinity Hall, Cambridge at Chislehurst. Lost 1-5.
With a somewhat weakened side Bart's were in trouble right from the start and despite a fine goal from Farrow never looked like winning. Most of the Trinity Hall goals came from their fast and capable left wing.

15th February v. St. George's. (U.H.L.) Away. Won 1-2.
This was a well deserved win by a Bart's side which included two members better known for their prowess with the oval ball. Both goals were scored by Sutton.

WHAT DOES

STAND FOR?

IT STANDS FOR **security and peace of mind from the day you qualify—until the day you retire—and after.**

IT STANDS FOR **the provision of advice on all your professional problems . . . . for legal assistance in any difficulty or proceedings of a professional nature . . . . for unlimited indemnity in respect of damages and costs in the event of an adverse verdict or a settlement out of Court.**

IT STANDS FOR THE MEDICAL DEFENCE UNION **the oldest and largest organisation of its kind in the world. Further particulars can be obtained from**
THE MEDICAL DEFENCE UNION
Tavistock House South Tavistock Square London WC1

Secretary: Dr. Philip H. Addison
Dental Secretary: A. H. R. Rowe, M.D.S., F.D.S.

18th February v. Trinity College of Music (U.L.) at Chislehurst. Won 1-0.

A most unsatisfactory game in which, despite almost total possession of the ball, Bart's were unable to find the net until late in the second half through Dorrett.

22nd February v. Chelsea College (U.L.). Drawn 1-1.

This was a close game against the League leaders. An early goal by Raine gave Bart's the lead which was held until late in the second half when Chelsea equalised following sustained pressure on the Bart's defence.

27th February v. Free University of West Berlin at Chislehurst. Lost 0—4.

Our hosts on our last season's tour to Berlin proved themselves very adaptable to the British weather in this match. Torrential rain and gale-force winds persisted throughout the game. Despite these difficulties good football was played by both sides, Bart's eventually wilting in the second half and allowing the strong Berlin forward line to score four times.

The following players have represented the club since the last report: Ellis, Turner, McGechie, Raine, Thew, Mumford, Dorrett, Leech, Sutton, Farrow, Woodrow, Weir, Rawlinson, Hall, Offen, Wall, Hill, Bowen-Roberts, Pemberton, Johnson, Hopkins.

S. Dorrett

CROSS COUNTRY CLUB

On Wednesday, 1st February, we attended the final University League match which was run over the King's College course at Mitcham. We performed quite creditably with a somewhat weakened team, but only managed to pull up one place, to 13th, from the bottom of the 1st Division and so must be relegated for the first time for many years. Out of the five matches this year, we have missed two; on one occasion we left Bart's late and lost our way to the start: on the other, the League failed to notify us of a race. We should regain our 1st Division status next year with some hard work.

On the following Wednesday, we were third in the St. Mary's Hospital Hyde Park Race, and so lost the Porritt Cup to a combined side from St. George's and R.D.H. We were weakened by injury, but nevertheless would still have lost the cup to an extremely strong side. This combination of Hospitals, which also collected the United Hospitals trophy and the Middlesex Hospital Relay Cup, has come in for a certain amount of criticism within the United Hospitals Club, and although it is admirable that members of lesser Hospitals should be able to run for a team, it is questionable whether this concoction should have been allowed to lift the 75 year-old U.H. trophy from the London Hospital. As Bart's received no invitation to the Committee meeting which was hastily convened by telephone on the Tuesday before the race, the matter may have repercussions later on.

On Saturday, 18th February, although we tried hard, we only managed third place in the U.H. championship. John Brooks had a good run, and will take the Edward Graham Memorial Trophy. It was pleasant to see Terry Foxton and Roger Sanders at the race. Terry showed himself to be fitter than ever, and could have won the race had he not held back. If we could have scored all our past members, we would have won the championship: it is disappointing that our standard has dropped this year: we can only hope for more training from certain members and good luck with Freshmen next year. I feel sure that the talent is present and will become manifest if only the members can be persuaded to work hard.

A report of the tour to Norwich, where we drew the University of East Anglia, will appear in the next *Journal*.

Results:—

Porritt Cup

1. Dunbar (St. Georges)	27.44	31. Field	34.40
3. Brooks	28.20	32. Kitchener	34.45
5. Tunstall-Pedoe	29.16	33. Davies	34.55
19. { Wood / Markham }	32.03	35. Pagan	35.40
		1. R.D.H./Georges	
		2. The London	
30. Coltart	34.32	3. Bart's	

U.H. Championship

1. { Foxton / Hesselden (R.D.H. }	36.47	26. Markham	43.40
		29. Wood	43.52
	36.47	38. Davies	45.09
		40. Coltart	45.25
5. Brooks	38.31	43. Field	46.37
6. { Thompson / Steiglitz (Mary's) }	38.59	46. Pagan	47.41
		55 finished	
		1. R.D.H./Georges	53
11. Tunstall-Pedoe	40.38	2. The London	80
23. Sanders	43.12	3. Bart's	144½

R. S. Thompson

The **PARKE-DAVIS** range of anticonvulsants provides comprehensive control in the epilepsies

ZARONTIN* *(ethosuximide, Parke-Davis)*
Extremely effective in the treatment of *petit mal.*[1] Represents a real advance in the development of anticonvulsant drugs.[1]

In *petit mal*
MILONTIN* *(phensuximide, Parke-Davis)*
The first of the succinimides found to be effective in the treatment of *petit mal.*[1]

In *grand mal* and psychomotor seizures
EPANUTIN* *(phenytoin sodium B.P., Parke-Davis)*
The first of the hydantoins and still the best.[1]

EPANUTIN and PHENOBARBITONE
(phenytoin sodium B.P., Parke-Davis and phenobarbitone B.P.)
Clinical evidence confirms that when the two drugs are used together their effects are additive.[1]

1 TODAY'S DRUGS. ANTICONVULSANTS. BRIT. MED. J. 2:919. 1963
*Trade mark

O-1230

PARKE-DAVIS HOUNSLOW · LONDON · TELEPHONE HOUNSLOW 2361

A cricket player has his bat
A boxer has his gloves
A wet bob has a wooden oar
A tennis type his loves
A rugger man can have a try
A golfer has his clubs
A runner has some spiky shoes
A drinker has his pubs
But whether you are qualified
Or still a hard worked student
There's one thing that you ought to have
if you are wise and prudent

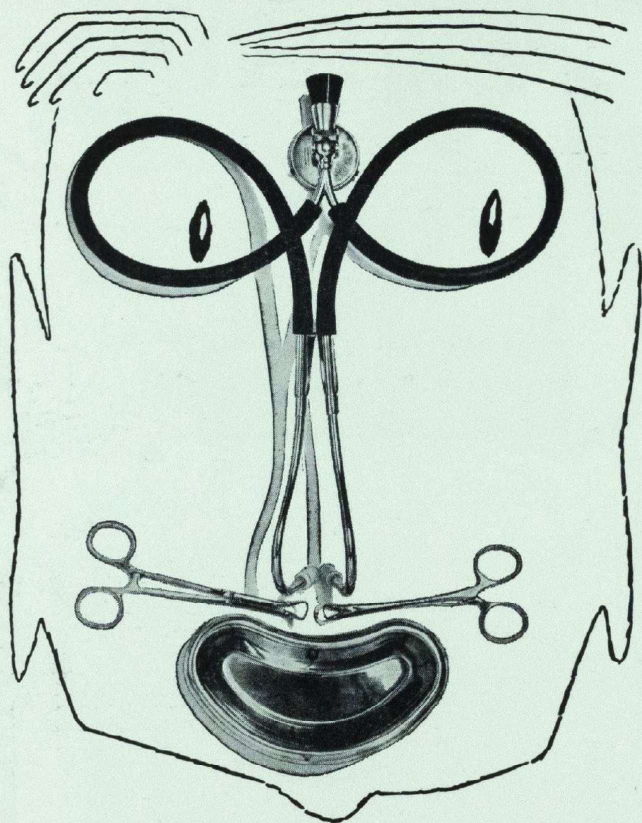
. . . and that's a policy with
The Medical Sickness Annuity and Life Assurance Society Limited
P.O. Box 449, 7-10, Chandos Street, Cavendish Square, London W.1.
Telephone: Museum 1686

Printed by Dramrite Printers Ltd., 91, Long Lane, London, SE1. j1559

View Day Colour Supplement

SAINT · BARTHOLOMEW'S · HOSPITAL · JOURNAL

VOL. LXXI No.5 MAY 10th, 1967



the bank for friendly service

The St. Bartholomew's Hospital Office, which is opened for your especial use, is under the management of Mr. R. B. Harrison, West Smithfield Branch, 59 West Smithfield, E.C.1 and enquiries will be welcomed.

To many friends, including some from Bart's . . .
Familiarly known as "The Gamage Arms"

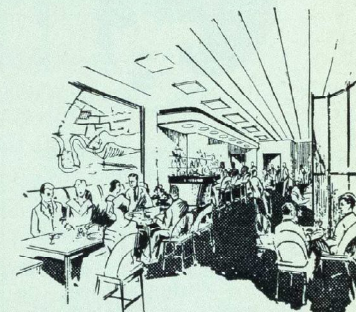
GAMAGES

SANDWICH BAR AND COCKTAIL LOUNGE

Rendezvous Here . . .

. . still the City's most luxuriously appointed Lounge. Smart and sophisticated, it is a place for gay conversation, earnest discussion or quiet reflection. Here you will find all the best drinks and more than 200 different kinds of sandwiches. **Why not try it . . . NOW?**

Adjoining Gamages 'CRYSTAL' DOME Self-Service, table-licenced Restaurant. Direct lifts to 3rd floor



GAMAGES, HOLBORN, E.C.1. HOL 8484 OPEN THURSDAYS until 7p.m. (Sats 1p.m.)

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL BARTS STAFF
ON OUR OWN MANUFACTURED GOODS

DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings,
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. -Teasets & Plate.

10%-20% DISCOUNT TO ALL BARTS STAFF
on all Branded Goods — ALL SWISS WATCHES, Clocks, Cutlery, Pens, and Lighters and on Second-hand Jewellery.

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTON GARDEN, E.C.1
405 0700 or 6431

OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00

Special attention to order by post or phone

FIRST FOR CARPETS

UP TO 30% DISCOUNT ON BRANDED CARPETS

Wiltons • Axminsters • Orientals • Tufted

£200,000 Carpets on display
in our extensive London and Northern Showrooms

- All makes available with full Manufacturers Guarantees.
- Free Delivery U.K.
- NO IMPERFECT GOODS SOLD
- Expert fitting service available most areas

Write stating requirements or for introduction to showrooms in most main cities

Open 9.30 to 5.30 Mon. to Fri. 9.00 to 12 noon Sats.

DODSON-BULL CARPET CO LTD

2, 4 & 5, Little Britain London EC1 (1 min St Paul's)
Tel: MON 7171 (10 Lines)

ELEGANT HAIR STYLES at

JOSEPHINE

of REGENT STREET

CITY BRANCH

ST. BARTHOLOMEW'S HOSPITAL
VOUCHER FOR

20% DISCOUNT AT

JOSEPHINE

TEL: CLE 0464-3
MONDAY—THURSDAY incl.
30 GOSWELL ROAD, E.C.1.
Valid for May 1967

UNIVERSITY EXAMINATION POSTAL INSTITUTION

G. E. OATES, M.D., M.R.C.P., London

POSTAL COACHING FOR ALL MEDICAL EXAMINATIONS

Carefully designed courses under the supervision of specialist tutors. Advice on reading, guidance notes to each lesson and solutions to all test papers are provided.

PROSPECTUS AND LIST OF TUTORS
on application to

Dr. G. E. OATES,
17 Red Lion Square, London, W.C.1
Telephone: HOLborn 6313

EVANS & WITT

Established 1866

58 LONG LANE, SMITHFIELD
E.C.1.

THE SMALL SHOP
with
THE LARGE STOCK
of
STUDENTS' STATIONERY
REQUIREMENTS

Ring Book Covers & Refills
Exercise Books, Folders & Files, etc.
At Reasonable Prices

Engagement Rings

25% DISCOUNT

All types and styles of Rings always in stock
Also Watches, Clocks & Wedding Rings, etc., at 10% – 20% Discount
Write for Ring Catalogue to the actual manufacturers

J&A JEWELLERS.

96 HATTON GARDEN, LONDON, E.C.1
Telephone: CHAncery 6025 & 4020
Business Hours: Weekdays 9.0–5.30
Saturdays 9.0–12.30 Evenings by appointment

The Business Houses' Discount Buying Service

49 BOW LANE, CHEAPSIDE, LONDON, E.C.4
Telephone: 01-236 7225
and at 8 PHILPOT LANE, FENCHURCH STREET, LONDON, E.C.3. Telephone: 01-626 2901

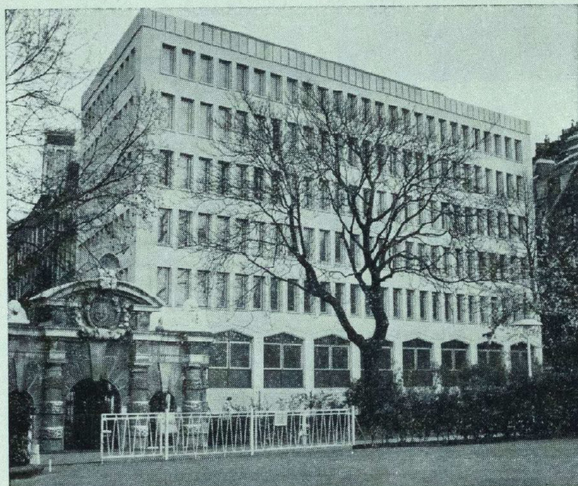
Authorised Suppliers of BRANDED MERCHANDISE to Staff Associations and members of Approved Organised Groups.

DISCOUNTS AVAILABLE LISTED ALPHABETICALLY

Item		Discount
Batteries (car)	UP TO	17½%
Bicycles	,, ,,	17½%
Branded Shirts	,, ,,	20%
Beds	,, ,,	17½%
Bedding (sheets, blankets, b/spreads)	,, ,,	17½%
Bathroom fittings	,, ,,	17½%
Blankets (electric)	,, ,,	17½%
BRANDED CARPETS	,, ,,	30%
Car radios	,, ,,	17½%
Camping equipment	,, ,,	17½%
Car accessories	,, ,,	17½%
Clocks	,, ,,	17½%
Cookers (large)	,, ,,	10%
Cookers (small)	,, ,,	15%
Curtain fittings	,, ,,	17½%
Cutlery	,, ,,	33⅓%
Dressing table sets	,, ,,	30%
Electrical appliances	,, ,,	17½%
Furniture		
Bedroom	,, ,,	17½%
Kitchen	,, ,,	17½%
Lounge	,, ,,	17½%
Office (re-conditioned)	,, ,,	HALF-PRICE
Fridges	,, ,,	12½%
Gardening and General tools	,, ,,	17½%
Glassware	,, ,,	20%
Hi-Fi equipment	,, ,,	20%
Kitchen equipment and gadgets	,, ,,	17½%
Lawn mowers (hand)	,, ,,	17½%
Lawn mowers (power)	,, ,,	12½%
Leather goods	,, ,,	20%
Light fittings	,, ,,	17½%
Nylons (assorted)	,, ,,	30%
PHOTOGRAPHIC EQUIPMENT INCLUDING FILMS	,, ,,	17½%
Pen sets	,, ,,	10%
Perfume (French)	,, ,,	20%
Radios	,, ,,	17½%
Radiograms	,, ,,	20%
Record players	,, ,,	20%
Suitcases	,, ,,	17½%
Tape recorders	,, ,,	20%
Television sets	,, ,,	20%
Table lamps	,, ,,	17½%
Tyres (FITTED FREE)	,, ,,	17½%
Tools (POWER) and accessories	,, ,,	17½%
Typewriters	,, ,,	12½%
Towels	,, ,,	17½%
Venetian blinds	,, ,,	20%
Watches	,, ,,	20%

This list is intended only as a guide to the range of merchandise we are able to offer. In addition to items listed, there are many others available at comparable discounts. The company reserves the right to amend prices and discounts without notification.

A DIVISION OF
THE RYAMS ORGANISATION (Southern) LTD



A modern building—a new look—
but the tradition of service remains

This service the RNPFN extends to all those engaged in caring for the sick, be they:—
civilians or members of the services, in the U.K. or overseas, salaried or self-employed or working on a voluntary basis.

For advice on a suitable pension scheme, life assurance or general investment and savings, please return the coupon.

THE ROYAL NATIONAL PENSION FUND FOR NURSES
FOUNDED 1887
ASSETS EXCEED £30,000,000

BURDETT HOUSE 15 BUCKINGHAM STREET, LONDON, W.C.2
WITHOUT OBLIGATION
NAME ....
.... (MR. MRS. MISS.)
ADDRESS ....
....
....
DATE OF BIRTH...
OCCUPATION OR QUALIFICATION.............................. 48

R. E. F.
PHOTO SERVICE

Wedding Specialists

Covering England

10% DISCOUNT

TO ALL HOSPITAL STAFF

Enquiries, full details;
13 HORNSEY RISE GARDENS
N.19.

SAVE up to 7/6 in the £

off the basic price on all your purchases

Almost anything can be supplied at most favourable discounts and delivery can be arranged anywhere in the country.

Furniture, Carpets, Watches 25%. Cutlery, Venetian Blinds 20½%. Tape Recorders, Projectors 20%. Record Players, Binoculars 20%. Radio, TV, Sewing Machines 20%. Screens, Lenses, Enlargers, etc. 20% Electrical Goods, Oil Heaters, Washing Machines, Spin Driers, Razors, Heaters, Food Mixers, etc. 17½% to 15%. Refrigerators, Mowers, Power Tools 12½% to 15%. Gas Appliances 12½%. Cars 10%.

All goods supplied are brand new and fully guaranteed

Reading Warehouses Ltd.
(Dept. BM)
TADLEY, HANTS.
Phone: TADLEY 3704

WE ARE YOU

LEPERS ARE HEALED
(15/- provides sandals, and off then to work)

REFUGEES ARE HOUSED
(£75 provides a Prefab Home)

SCHOOLS ARE BEING BUILT
(£300 provides an African School)

WELLS ARE BEING DUG
(£100 provides fresh water to thirsty village)

ORPHANS ARE BEING SHELTERED
(£25 provides a year's keep to Algerian Refugee)

CHILDREN ARE BEING TAUGHT
(£1 provides a year's primary education in Congo)

Your gift will help build a better world.

We forward without deduction. Save a life by using your pen

Received in gratitude by Hon. Treasurer

Rt. Hon. JAMES GRIFFITHS,
P.C., C.H., M.P.

WAR ON WANT

9 MADELEY ROAD
LONDON, W.5

Trading stamps provide an x-ray unit.

If you pay tax at standard rate, a covenant would add 14/- to every £1 at no extra cost to you.

CLOTHES DESPERATELY REQUIRED
WAR ON WANT DEPOT
CAXTON STREET SOUTH,
LONDON, E.16

INFECTIOUS DISEASES
by **A. M. Ramsay, M.A., M.B.,** and **R. T. D. Emond, M.B., Ch.B., M.R.C.P., D.T.M.&H.**
320 pages 100 illustrations **63s. net**

SCIENTIFIC FOUNDATIONS OF SURGERY
Edited by **Professor Charles Wells, C.B.E., M.B., F.R.C.S.,** and **James Kyle, M.Ch., M.B., F.R.C.S., F.R.C.S.I.**
654 pages 185 illus. 16 plates **126s. net**

CERVICAL SPONDYLOSIS
Edited by **Lord Brain, D.M. (Oxon), F.R.C.P., F.F.R.** and **Marcia Wilkinson, D.M. (Oxon), F.R.C.P.**
256 pages 150 illustrations **55s. net**

TEXTBOOK OF BACTERIOLOGY 9th Ed.
by **R. W. Fairbrother, M.D., B.Sc., F.R.C.P.,** and **G. Taylor, M.D., D.Path.**
512 pages Illustrated **35s. net**

HEWERS TEXTBOOK OF HISTOLOGY 8th Ed.
Edited by **C. L. Foster, Ph.D., M.Sc.**
496 pages 430 illustrations **42s. net**

THE NAILS IN DISEASE
by **P. D. Samman, M.D., F.R.C.P.**
140 pages 132 illus. 4 col. plates **40s. net**

AN OUTLINE OF UROLOGY
by **R. W. Barnes, B.A., M.S., D.Sc., F.A.C.S., F.I.C.S.** and **R. T. Bergman, B.S., M.D., D.N.B., F.A.C.S., F.I.C.S.** and **H. L. Hadley, B.A., M.D., D.N.B., F.A.C.S.**
580 pages **55s. net**

AN OUTLINE OF PSYCHIATRY
by **M. T. Eaton, jnr., M.D., F.A.R.P.,** and **M. Peterson, M.D.**
800 pages **42s net**

PRINCIPLES OF OPHTHALMOLOGY
by **H. E. Hobbs, M.B. (Lond.), F.R.C.S., D.O. (Oxon).**
260 pages 89 illus. 9 col. plates. **55s. net**

MEDICAL TERMS, THEIR ORIGIN AND CONSTRUCTION 4th Ed.
104 pages **8s.6d. net**

INTRODUCTION TO NEUROSURGERY
by **W. Bryan Jennett, M.D., F.R.C.S.**
326 pages 100 illustrations **45s. net**

ESSENTIALS OF PAEDIATRIC SURGERY 2nd Ed.
by **H. H. Nixon, M.A., F.R.C.S.,** and **B. O'Donnell, M.Ch., F.R.C.S., F.R.C.S.I.**
352 pages 75 illustrations **50s. net**
Distributors of the Journal of Developmental and Child Neurology and Clinics in Developmental Medicine (Spastics Society).

WILLIAM HEINEMANN MEDICAL BOOKS LTD.
23, BEDFORD SQUARE, LONDON, W.C.1

ANNUAL SPORTS DAY

will be held

on the afternoon of

Wednesday, **May 24th**

at Bart's Sports Ground

CHISLEHURST

REFRESHMENTS
FREE BEER!
CONSULTANTS' 100yds. Etc.

THE CHARTER PRESS

5 CARTHUSIAN STREET, E.C.1
CLErkenwell 4551
(JUST AROUND THE CORNER)

WE CAN SUPPLY ALL KINDS OF FILES, FILE PAPER, NOTE BOOKS, WRITING PAPER, BRIEF CASES, Etc . . . .
ALSO
GREETING CARDS AND GENERAL STATIONARY

PRINTING WORK
OF ALL KINDS CARRIED OUT QUICKLY AT REASONABLE PRICES

Visit the world's most important exhibition of modern hospital equipment and medical services.

6th International Hospital Equipment and Medical Services Exhibition Olympia London

5th-9th JUNE 10a.m.-6-30p.m. (Friday 5-30p.m.)
last admission half an hour before closing each day

Sponsored by
The Institute of Hospital Administrators and 'The Hospital'

Organised by
CONTEMPORARY EXHIBITIONS LIMITED
14 New Burlington St., London, W.1
Telephone: Regent 0855
Cables: Conib London W1

"I always prescribe Felsol—its action is so sure and swift."

Prescribed for

ASTHMA

by doctors all over the world

Felsol's widespread use and reputation rests securely on its immediate, safe and prolonged relief of bronchospasm—the chief factor in asthma, whatever the cause. Narcotic-free and easily administered, its complete effectiveness breaks the vicious circle of anxiety and apprehension, and strengthens resistance against recurring attacks. Doctors favour Felsol because it inspires the self confidence so essential to improvement in this difficult and distressing condition.

Clinical samples and literature on request.

BRITISH FELSOL COMPANY LTD.,
206/212 ST JOHN STREET, LONDON E.C.1

INFECTIOUS DISEASES
by **A. M. Ramsay, M.A., M.B.,** and **R. T. D. Emond, M.B., Ch.B., M.R.C.P., D.T.M.&H.**
320 pages 100 illustrations **63s. net**

SCIENTIFIC FOUNDATIONS OF SURGERY
Edited by **Professor Charles Wells, C.B.E., M.B., F.R.C.S.,** and **James Kyle, M.Ch., M.B., F.R.C.S., F.R.C.S.I.**
654 pages 185 illus. 16 plates **126s. net**

CERVICAL SPONDYLOSIS
Edited by **Lord Brain, D.M. (Oxon), F.R.C.P., F.F.R.** and **Marcia Wilkinson, D.M. (Oxon), F.R.C.P.**
256 pages 150 illustrations **55s. net**

TEXTBOOK OF BACTERIOLOGY 9th Ed.
by **R. W. Fairbrother, M.D., B.Sc., F.R.C.P.,** and **G. Taylor, M.D., D.Path.**
512 pages Illustrated **35s. net**

HEWERS TEXTBOOK OF HISTOLOGY 8th Ed.
Edited by **C. L. Foster, Ph.D., M.Sc.**
496 pages 430 illustrations **42s. net**

THE NAILS IN DISEASE
by **P. D. Samman, M.D., F.R.C.P.**
140 pages 132 illus. 4 col. plates **40s. net**

AN OUTLINE OF UROLOGY
by **R. W. Barnes, B.A., M.S., D.Sc., F.A.C.S., F.I.C.S.** and **R. T. Bergman, B.S., M.D., D.N.B., F.A.C.S., F.I.C.S.** and **H. L. Hadley, B.A., M.D., D.N.B., F.A.C.S.**
580 pages **55s. net**

AN OUTLINE OF PSYCHIATRY
by **M. T. Eaton, jnr., M.D., F.A.R.P.,** and **M. Peterson, M.D.**
800 pages **42s net**

PRINCIPLES OF OPHTHALMOLOGY
by **H. E. Hobbs, M.B. (Lond.), F.R.C.S., D.O. (Oxon).**
260 pages 89 illus. 9 col. plates. **55s. net**

MEDICAL TERMS, THEIR ORIGIN AND CONSTRUCTION 4th Ed.
104 pages **8s.6d. net**

INTRODUCTION TO NEUROSURGERY
by **W. Bryan Jennett, M.D., F.R.C.S.**
326 pages 100 illustrations **45s. net**

ESSENTIALS OF PAEDIATRIC SURGERY 2nd Ed.
by **H. H. Nixon, M.A., F.R.C.S.,** and **B. O'Donnell, M.Ch., F.R.C.S., F.R.C.S.I.**
352 pages 75 illustrations **50s. net**
Distributors of the Journal of Developmental and Child Neurology and Clinics in Developmental Medicine (Spastics Society).

WILLIAM HEINEMANN MEDICAL BOOKS LTD.
23, BEDFORD SQUARE, LONDON, W.C.1

ANNUAL SPORTS DAY

will be held

on the afternoon of

Wednesday, **May 24th**

at Bart's Sports Ground

CHISLEHURST

REFRESHMENTS
FREE BEER!
CONSULTANTS' 100yds. Etc.

THE CHARTER PRESS

5 CARTHUSIAN STREET, E.C.1
CLErkenwell 4551
(JUST AROUND THE CORNER)

WE CAN SUPPLY ALL KINDS OF FILES, FILE PAPER, NOTE BOOKS, WRITING PAPER, BRIEF CASES, Etc . . . .
ALSO
GREETING CARDS AND GENERAL STATIONARY

PRINTING WORK
OF ALL KINDS CARRIED OUT QUICKLY AT REASONABLE PRICES

Visit the world's most important exhibition of modern hospital equipment and medical services.

6th International Hospital Equipment and Medical Services Exhibition Olympia London

5th-9th JUNE 10a.m.-6-30p.m. (Friday 5-30p.m.)
last admission half an hour before closing each day

Sponsored by
The Institute of Hospital Administrators and 'The Hospital'

Organised by
CONTEMPORARY EXHIBITIONS LIMITED
14 New Burlington St., London, W.1
Telephone: Regent 0855
Cables: Conib London W1

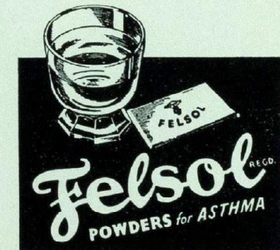
Prescribed for

ASTHMA

by doctors all over the world

"I always prescribe Felsol— its action is so sure and swift."

Felsol's widespread use and reputation rests securely on its immediate, safe and prolonged relief of bronchospasm—the chief factor in asthma, whatever the cause. Narcotic-free and easily administered, its complete effectiveness breaks the vicious circle of anxiety and apprehension, and strengthens resistance against recurring attacks. Doctors favour Felsol because it inspires the self confidence so essential to improvement in this difficult and distressing condition.



Clinical samples and literature on request.

BRITISH FELSOL COMPANY LTD.,
206/212 ST JOHN STREET, LONDON E.C.1

50
60
70
80

If the trouble is pollen-count on 'Actifed' to relieve it

The potentiated combination of antihistamine (triprolidine) and decongestant (pseudoephedrine) in 'Actifed' relieves the respiratory congestion of hay fever more effectively than either constituent used alone. Relief is obtained within 10-30 minutes.

'Actifed' BRAND tablets and syrup

Also available, 'Actifed' brand Compound Linctus containing pseudoephedrine and triprolidine together with codeine, for congestion with cough.

Burroughs Wellcome & Co. London
(The Wellcome Foundation Ltd.)

Saint Bartholomew's Hospital JOURNAL

Vol. LXXI No. 5

CONTENTS

10th May, 1967

A Problem of Society ... 164
View Day Supplement ... 164
Letters to the Editor ... 165
News ... 165
Scholarships and Prizes ... 166
Abernethian Society ... 167
Obituary; Frederick George Bailey ... 168
On Psychopharmacology. . . ., by Hannah Steinberg and Michael Besser ... 169
Addiction to Narcotics; The Addicts' Life ... 174
Comment, by M. M. Glatt ... 177
Cartoon, by Cull ... 179
Addiction to Narcotics; The Addict's Life ... 174
Prospect ... 186
The British Library of Tape Recordings ... 187
British Medical Students' Association ... 188
Reviews; Penguin ... 189
Medical Books ... 191
Sports News; 100 years of Bart's Rugby by P. A. Ashby ... 193
Rugby Club ... 195
Hockey Club ... 195
Boat Club ... 196
Cross Country Club ... 197
Athletics Club ... 198
Soccer Club ... 199
Rifle Club ... 200
Golf Club ... 200

THE JOURNAL STAFF

Editor: **J. A. Sills**
News Sub-Editor: **Miss E. A. Macdonald**
Reviews Sub-Editor: **I. D. Fraser**
Social Sub-Editor: **R. C. D. Staughton**
Sports Sub-Editor: **R. H. Soper**
Photographic Sub-Editor: **C. J. Hubbard**

Manager: **J. P. D. Reckless**
Assistant Managers: **C. S. B. Roch-Berry**, **N. T. Goodchild**, **M. Castleden**
Nurses' Representatives: **Miss E. Ferreira**, **Miss P. M. Kilshaw**
Charterhouse Representative: **Miss J. Hall**, **R. Littlewood**