

## The Bahere Lodge, No. 2546.

**A**n ordinary meeting of the Bahere Lodge, No. 2546, was held at Frascatti's Restaurant, W., on Tuesday, February 11th, 1902; W. Bro. Phin. S. Abraham, M.D., W.M., in the chair. Bro. Walton K. Kead was raised to the Third Degree, and Bros. Harke, Yetts, and Dunn were passed to the Second Degree. A subscription of two guineas was voted to the Soldiers' and Sailors' Families Association. The W.M.'s of the other medical lodges in London attended the meeting as honorary members of the Bahere Lodge. There was a large attendance at the subsequent banquet.

## Calendar.

Apr. 29.—On duty. Dr. Hensley and Mr. Walsham.  
 May 1.—Summer Session begins.  
 " 2.—On duty. Sir Lauder Brunton and Mr. Cripps.  
 " Examination for Medical Brackenbury begins.  
 " 6.—On duty. Sir Wm. Church and Mr. Langton.  
 " 9.—On duty. Dr. Gee and Mr. Marsh.  
 " 13.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 " 14.—View Day.  
 " 16.—On duty. Dr. Hensley and Mr. Walsham.  
 " 17.—Examination for Lawrence Schol. begins.  
 " 20.—On duty. Sir Lauder Brunton and Mr. Cripps.  
 " 23.—On duty. Sir Wm. Church and Mr. Langton.  
 " 27.—On duty. Dr. Gee and Mr. Marsh.

## St. Bartholomew's Hospital Students' Christian Association.

SUMMER SESSION, 1902.

MAY—JULY.

Meetings are held in the Inquest Room on Thursdays, at 4 p.m.  
 May 8.—Members' Meeting.  
 " 15.—Dr. Maxwell.  
 " 22.—Rev. Prebendary Webb-Peploe.  
 " 29.—Annual Meeting.  
 June 5.—Col. Wroughton.  
 " 12.—Missionary Meeting.  
 " 19.—Dr. Soltau.  
 July 3.—Rev. Geo. Tonge.

## Examinations.

CONJOINT BOARD.  
Second Examination.

*Anatomy and Physiology*.—W. G. Ball, R. H. Bott, R. A. Bowling, J. R. Briscoe, C. B. D. Butcher, W. R. Collingridge, C. H. Cross, P. A. Dingle, C. Elliott, L. Gray, J. P. Griffin, J. R. Kemp, J. E. R. McDonagh, M. Reichwald, C. F. O. White.

The following completed the examinations for the M.R.C.S., L.R.C.P., at the January examination.—G. H. L. Whale, A. S. Woodwark, H. M. H. Melhuish, J. McBryde, G. W. Miller, J. A. West, G. W. Stone, A. C. Young, H. N. Murratt, R. D. Stacey, W. R. Read, J. B. Cook, H. G. McKinney, V. G. Ward, S. G. Mostyn, G. F. Gill, C. S. Woodwark, S. B. Atkinson, R. J. Waugh, J. W. Llewellyn, N. Leonard, P. G. Harvey, F. W. Jackson, L. E. Hughes.

## Appointments.

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

COPE, R., M.R.C.S., L.R.C.P., appointed House Surgeon to the Dorset County Hospital, Dorchester.

DANKS, W. S., M.B.(Lond.), appointed Civil Medical Officer to the South African Field Force.

JACKSON, F. W., M.R.C.S., L.R.C.P., appointed Surgeon-Captain to the Highland Horse.

LLOYD, W. F., M.B., B.C.(Cantab.), appointed Assistant Surgeon to the Windsor Royal Infirmary.

NIXON, J. A., M.B., B.C.(Cantab.), appointed Surgeon to the s.s. "Johannesburg."

NOKE, F., M.B.(Lond.), appointed Assistant House Surgeon to the Metropolitan Hospital.

SHRUBSALL, F. C., M.B., B.C.(Cantab.), M.R.C.P., appointed House Physician to the Brompton Hospital for Diseases of the Chest.

TA'BOIS, A. C., M.D.(Lond.), appointed Deputy Medical Superintendent to the Gore Farm Hospital.

WILLIAMS, E. C., M.R.C.S., L.R.C.P., appointed Surgeon to the P. and O. s.s. "Peninsular."

WOOD, M. D., M.D.(Durham), appointed Second Assistant Medical Officer to the Hayward's Heath Asylum.

YOUNG, A. C., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Royal Sea-Bathing Hospital, Margate.

## New Addresses.

ADDISON, CHRISTOPHER, Urcar Croft, Northwood R.S.O., Middlesex.

BOX, S., 47, Gordon Road, Ealing, W.

CHOLMELEY, W. F., 3, Waterloo Road South, Wolverhampton.

COLEMAN, F., 6, Mount Park Crescent, Ealing, W.

GUTCH, J., 28, Fonnereau Road, Ipswich.

KENNEDY, W., 6, Alexander Square, South Kensington.

MALTBY, E., Avondale, Feltham, Middlesex.

NEVILLE, T. C., 238, Upper Richmond Road, Putney, S.W.

NIXON, J. A., 55, Venner Road, Sydenham, S.E.

SCORER, FRANK, St. Cuthbert's, Christchurch Road, Bourne-mouth.

SHUTER, G. P., Cleveland House, Chiswick Lane, W.

STEPHENS, J. W. W., 7, Quay Street, Carmarthen, South Wales.

STORRS, W. TOWNSEND, 39, Mount Ephraim, Tunbridge Wells.

TAPLIN, B. DUTTON, Thames Villa, St. John's Avenue, Bridlington, Yorkshire.

## Births.

ANDREWS.—On April 15th, at "Martindale," Tonbridge, Kent, the wife of H. Arthur Andrews, M.R.C.S., L.R.C.P., of a son.

HARRISON.—On April 5th, at 320, Humberstone Road, Leicester, the wife of L. K. Harrison, M.B.Cantab., of a son.

PEARSON.—On March 18th, at Alicedale, South Africa, the wife of Maurice Grey Pearson, M.B., B.Sc., F.R.C.S., of a son.


## Marriage.

HARRIS—SCALES.—At St. Mark's, Hamilton Terrace, N.W., on the 23rd inst., Herbert George Harris, M.D., B.S.(Durh.), M.R.C.S., L.R.C.P., son of the late W. T. Harris, Esq., of Worthing, to Hilda Mary, eldest daughter of G. E. Scales, Esq., of Ichleton, Cambs.

## Death.

PEARSON.—On March 23rd, at Alicedale, South Africa, the infant son of Maurice Grey Pearson, M.B., B.Sc., F.R.C.S.

# St. Bartholomew's Hospital



## JOURNAL.

VOL. IX.—No. 7.]

APRIL, 1902.

[PRICE SIXPENCE.]

## NOTICE.

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

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

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

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

## St. Bartholomew's Hospital Journal,

APRIL, 1902.

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

## The Pathological Department.

**W**E understand that very considerable changes will shortly take place in the Pathological Department, and that the teaching of pathology is to be more elaborate and more completely organised than hitherto. During the past few years the rapidly increasing importance of pathology both to the practitioner and to the student has necessitated a corresponding development on the teaching side; and the present scheme simply

represents a further stage in the evolution of pathological teaching in this Hospital. We believe that we were the first hospital to provide for the systematic examination of clinical material from the wards by the pathological department of the School; and for this we are indebted to the late Prof. Kanthack, who was then pathologist to the Hospital. As time went on the wards and the pathological department came more and more closely into touch, and the work of the latter constantly increased. Gradually more of these investigations passed beyond the experimental stage into one of undoubted usefulness; and with that transition there arose a growing tendency for them to be carried out by house physicians and research clerks in the wards. This has now led to a further change, and the Medical School Committee has decided that every student shall be taught clinical pathology as part of his routine work. In the first place, every ward clerk will be instructed by the junior house physicians how to carry out certain investigations on clinical material, and the wards have already been provided with the requisite apparatus. There is also to be a special preliminary course for men who are coming on as house physicians, at which they will practise those methods which they are to teach. In the second place, a class will be held in the pathological department intended mainly for men who propose to take the higher examinations, though not necessarily limited to them. By these means the pathological laboratory will be relieved from the burden of such investigations as may reasonably be expected of anyone in practice, while still being available for those that are more difficult; and at the same time the teaching of clinical pathology will become more systematic and complete. We believe that this scheme—which comes into full effect almost at once—will be one of the most important changes made in the School for some time. We hope that it is only the beginning of still further advance in this direction; and we are convinced that not only will it be fully appreciated by those for whom it is intended, but will do much to maintain our supremacy as a teaching hospital and school.

**Chlorosis.**

*A Paper read to the Abernethian Society in the Spring of 1902.*

By LIONEL JAMES PICTON.

(Concluded from p. 89.)



ENTLEMEN, I fear that I have been guilty of an eccentricity in postponing so long an account of the examination of the blood. The writer of an article on a medical subject nowadays must be well armed with the technical terms of blood pathology. He must have his quiver full of them, and must open his disquisitions with a shower of erythrocytes, microcytes, and the rest, keeping two or three of them in the air at once, as the archers of old maintained their arrowy hail. He comes to such commonplace things as the patient and her symptoms as an afterthought. In short, if you will forgive an old-fashioned metaphor, he cannot see the wood for the trees.

I fully agree in the deep interest of blood pathology. That of chlorosis still offers a vast scope, enigmas past finding out. Still, with an hour's work we can find out a good deal about the blood of a given patient. We take a Haegdon needle, straight, flat, broad, sharp, and turning the lobe of the patient's ear up, holding it lightly so as to avoid squeezing the part, an action which would alter the consistency of the blood in it and vitiate our results, we make a sharp stroke and puncture the ear. The stroke must be delivered by a movement of the wrist—sudden, arrested early, and rebounding, as it were, like the stroke of a piano hammer on the wires. A tiny deep linear wound is made. After a moment blood oozes from the cut. Do not squeeze any out; lightly wipe off the first few drops with a dry swab transversely to the cut, so as to open the lips thereof. Soon enough blood will flow. The flow in chlorosis is indeed surprisingly copious, more than in health even, and infinitely more than in a person who has had a severe hemorrhage. Dropped on to linen, chlorotic blood spreads more in red ink would than normal blood. It is thin, watery, slow to coagulate. The rouleaux are seen under the microscope, but are slow to form. The individual globules are smaller than normal, often only 3 or 4 μ in size. They are pale, and instead of being round and shapely they are ill-formed little blobs; on the other hand, they have seldom the bizarre polkyocyte forms seen in pernicious anemia. In number they are not reduced, or only slightly so; generally they are over 4,000,000. I fully admit that certain cases of chlorosis have a red count under 2,000,000, or even lower, but in such cases some complication is invariably present. There is little, if any, reduction in the numbers of red globules in blood from a patient with uncomplicated chlorosis.

The colouring matter is estimated best by Von Fleischl's apparatus. The operation takes about ten minutes. The results are accurate within about 3 per cent. after a little practice. I will not describe the method, but will mention a hint I had from Dr. Andrews. The centre of the scale gives the most accurate readings; that is, readings somewhere near 50 per cent. or 60 per cent. are more accurate than those of 20 per cent. Therefore it is wise when you guess that the count will be 30 per cent. or under to take twice the ordinary amount of blood; that is, take a second pipette-full and then halve the reading you obtain. That by the way.

The estimation of the hemoglobin by this instrument shows an immense fall in cases of chlorosis. Instead of being in the 70 per cents. or 80 per cents., as the red count would lead us to expect, we find the record is more often between 20 and 40 per cent. of hemoglobin.

The relation between the percentage of corpuscles, regarding 5,000,000 per c.m.m. as equivalent to 100 per cent., and the percentage of hemoglobin, which in healthy blood with a count of 5,000,000 reds is taken to be 100 per cent., it is customary to represent by a fraction, the numerator being the percentage of colouring matter, the denominator being the percentage of red globules; this fraction is called the colour index.

Now a typical chlorotic count would be, say, 4,000,000 red globules, or 80 per cent., with only 40 per cent. of hemoglobin. In such a case the colour index would be  $\frac{40}{80}$  or  $\frac{1}{2}$ . Such a colour index is pathognomonic of chlorosis. That you may hear the same statement in more interesting language, may I read a sentence from Dr. Hunter? (*Pernicious Anæmia*, p. 60):—"There is no feature of chlorosis more

remarkable than the extraordinary disparity between the actual diminution in the number of corpuscles and the profound degree of pallor. The colour index, then, of chlorosis is characteristically  $\frac{1}{2}$ , and we may set in contrast that of the other idiopathic anæmia, the pernicious type, for the latter has an index which is always over 1, say 1.2 or 1.3. There is something very striking in the constancy of these respective opposite phenomena in these two diseases."

It is here right to mention a matter extraneous to the blood examination of a chlorotic. I am informed by Mr. Etherington Smith that in the investigations on the blood of the Cambridge crew in training, in which he assisted Mr. Stangeways Pigg, the colour index was sometimes found to rise considerably above the figure 1. For instance, one week the count would be 6,000,000 and the hemoglobin 110 per cent., which gives a colour index of '91. Next week the corpuscles might have come down to 4,500,000, whilst the hemoglobin had risen to 120 per cent., a count which gives a colour index of 1.3. I do not pin Mr. Etherington Smith to these figures, for I only had the facts from him in conversation, and the instance I have used is probably more emphasised than the truth. But the fact, which he kindly allowed me to mention, he vouches, and it is of extreme interest. Here is a blood phenomenon exhibited alike by a state of the best health and by a fatal disease.

To return to chlorosis, the ordinary clinical examination of the blood extends no further than the methods I have already mentioned. But the specific gravity of the blood is of interest; and may be learned by placing a drop of blood in a bottle containing benzol and chloroform, and adding either liquid until the blood-drop hangs in the line of division between the two. The specific gravity of the mixture of liquids is then taken in the ordinary way; and it is of course identical with that of the blood examined, which is thus learned.

I suppose that every one would suspect that the specific gravity of chlorotic blood would be lower than that of healthy blood. And that is the case. There is, however, a remarkable qualifying statement to be made. The specific gravity of the plasma from which the corpuscles have been removed by the centrifuge is said to be the same as in health, or even higher. This suggests that the corpuscles are alone at fault.

At this point we reach an important stage in our investigation; for, coming to ask whether a lowered specific gravity of the blood is characteristic of chlorosis, we are met by the remarkable fact that the specific gravity of the blood in all young women of the ages at which chlorosis is common is markedly lower than in men at the same age, and in women and little girls after and before that period of life. Healthy young women, then, from fifteen to twenty-five are found to have blood of a markedly lower specific gravity than the rest of mankind.

Gentlemen, may I recall that in an earlier part of my paper I suggested to you a theory which I asked you to bear in mind? It was based upon the obvious considerations of the youth, sex, and commonness, and was to be summed up in the statement that chlorosis is only an exaggeration of a certain condition of the blood which in young women is normal and natural. In the investigations on the specific gravity of the blood in subjects of the disease, and in young women generally, investigations elaborately carried out by Dr. Lloyd Jones, and the results of which I have just mentioned to you, I think you will agree in finding a striking confirmation of the truth of that theory.

I have not, I am afraid, yet done with the physical examination of the blood. The reaction I may dismiss in a word, by saying that the alkalinity is not diminished, but generally a little increased. The volume of the blood and the total oxygen capacity it would seem impossible to arrive at; but Dr. Haldane, of Oxford, and Dr. Lorrain Smith have overcome, by a most elaborate and ingenious method which they have devised, the apparently unsurmountable difficulties in the way. How can you estimate how much blood a person has in his body, and gauge its total capacity for oxygen? This is their method:—They first determine the percentage oxygen capacity of 100 c.c. of ox blood by their ferricyanide method. A small quantity of the human blood to be investigated is then compared, with regard to colour, with the ox blood, and by colorimetric methods the relative strength of the hemoglobin is ascertained. Hence, since oxygen capacity varies directly as colour, the percentage oxygen capacity of the human blood can be easily calculated.

Their next step is to ascertain the volume of the blood of the human subject. This is a more difficult business. The principle of it depends on the inhalation by the patient of a known amount of carbon monoxide, which is administered in a bag mixed with oxygen. The patient's blood, a specimen of which is examined after a few

minutes, of course contains carbon monoxide, and the amount in a given specimen of blood is measured. Now, since the total amount of the gas taken up is known, and the amount present in a measured quantity of blood is also known, it is evident that all the factors required for an estimation of the total volume of blood in the body are present. The volume being thus learned, and the percentage oxygen capacity being known, the total oxygen capacity is, of course, easily calculated. If the specific gravity of the blood be taken, the mass of the blood in the body is also arrived at.

The details of these ingenious processes belong to the sacred domain of the experimental physiologist, and are out of reach of the ordinary clinician; but in the *Proceedings of the Physiological Society* for 1900, Dr. Lorrain Smith gives the results of applying the method in chlorosis and in pernicious anæmia. Here are some of his statements with regard to chlorosis:

1. The total oxygen capacity is maintained at approximately the normal amount.
2. The percentage oxygen capacity is markedly diminished, e.g. below 50 per cent.
3. The volume of the blood is markedly increased.

An illustrative case may bring the matter more clearly before our eyes. In health, a man of eleven stone, that is about 70 kilogrammes, is found to have about 3½ litres of blood in his body. A chlorotic girl, however, weighing only 4½ kilogrammes, that is between six and seven stone, is discovered to possess 6½ litres of blood, nearly twice as much as that of the healthy man.\*

Gentlemen, I think that you will agree that such a conclusion is a very astounding one; yet it is not so astounding as might at first sight appear. There have been many observations made, before such a definite and scientific research was ever undertaken, which point to an increase in the amount of blood in chlorosis; and indeed, even supposing the remarkable investigations which I have quoted to be vitiated by some error in the technique, which there is certainly no reason to imagine, the case for an increased volume of blood would still remain very strong.

\* CLINICALLY TYPICAL CASES (LORRAIN SMITH).

|                                     | Ratio of weight of blood to weight of body. | Red globules.   | Total volume of blood in c.c.              | Percentage oxygen capacity of the blood. | Total capacity for oxygen. | Saturation of blood by CO <sub>2</sub> . | Body-weight in kilbs. | Vol. of CO <sub>2</sub> absorbed in c.c. |
|-------------------------------------|---|-----------------|--|--|----------------------------|--|-----------------------|--|
| Case of chlorosis (et. 18).         | $\frac{1}{72}$                              | 2,110,000       | 6181                                       | 6.6                                      | 4.8                        | —  | 44.5                  | 33.4                                     |
| Case of pernicious anæmia (et. 41). | $\frac{1}{89}$                              | 600,000         | 6500                                       | 3  | 1.95                       | —  | 53                    | 37                                       |
| In health.                          | About $\frac{1}{20}$                        | About 5,000,000 | About 3200 (3.2 litres in a man of 11 st.) | About 18.5                               | 5.99                       | —  | 70                    | —  |

Such an increase explains the fact to which I drew your special attention earlier, that chlorotic patients do not waste, but are rather inclined to become fatter, in the face, and to have a layer of flabby fat upon the muscles. It explains the full feel of the artery when the pulse is examined, and the maintenance of a fair or even raised arterial tension when the heart and vessel walls are flabby from want of oxygen.

It seems to me likely, also, that it has a great deal to do with the distension of the flabby heart. I can imagine, though I cannot define a causal connection between this replete state of the circulatory system, and the characteristic venous hum in the neck. I see in the full state of the veins, which has been so often noted in chlorotics, another exhibition of the same state of hydremia. We are told nowadays that the circulation is never over-full, and that true plethora does not exist. A regulating mechanism has denied its possibility. What has happened to the regulating mechanism in chlorosis I do not know; but the state of repletion the blood-vessels must be in, if Dr. Lorrain Smith's facts are to be accepted, strongly recalls a state of affairs which is closely analogous to the old-fashioned conception of plethora.

It is important to note that in spite of all the extra blood, the oxygen capacity is only normal. That is almost the same thing as saying that the chlorotic has her due amount of hemoglobin, but that she has so much blood in which to distribute it that any given drop contains only half the amount of colouring matter that would be present in normal blood. Further considerations follow.

That the red globules are but little diminished in a given drop we have already said. We are therefore obliged to suppose that there is an enormous increase of red globules in the whole body, in order that each drop of the increased amount of blood may have its due proportion. So far, then, from chlorosis showing a diminution of erythrocytes, their absolute number must often be well-nigh doubled. In face of such a conclusion, the poor quality of the individual red corpuscles is not surprising. It has seldom been claimed that there is increased destruction of corpuscles in chlorosis, although there is abundant evidence of excessive hemolysis in pernicious anæmia, as is shown by the pigment found in many organs, and in the urine, in cases of the latter disease. On the other hand, there is evidence in chlorosis of diminished hæmolytic action. The estimation of iron in the urine affords light on this point. Dr. Hunter\* says that "although the observations in chlorosis are not sufficiently numerous to enable one to speak with certainty as to the excretion of iron in this condition, they show a diminished excretion . . . considerably lower than the average obtained by Gottlieb in health, and still lower than the average obtained by himself." For example, he found that in health the excretion of iron in one day was over five milligrammes, whilst in chlorosis it was only between one and two. In pernicious anæmia, on the other hand, it rose to as much as thirty-two milligrammes of iron excreted in one day.†

Accepting, then, the view that there is diminished destruction of corpuscles in chlorosis, we are forced to conclude that the increased

\* *Pernicious Anæmia*, "Excretion of Iron in Urine in Chlorosis," p. 277.

| Condition.  | Quantity of urine in c.c. | Sp. gr. | Excretion of iron in milligrammes. |
|---|---------------------------|---------|------------------------------------|
| HEALTH  | 1500                      | 1018    | 5.65                               |
| CHLOROSIS   | 900                       | 1018    | 1.71                               |
| Reduced iron, gr. vj per diem for 3 weeks; greatly improved       |                           |         |                                    |
| CHLOROSIS   | 1175                      | 1014    | 1.96                               |
| Tr. Ferri Perchlor., ℥xxx per diem, for 3 weeks; good improvement |                           |         |                                    |
| CHLOROSIS   | 1365                      | 1015    | 1.65                               |
| Treatment not begun   |                           |         |                                    |
| PERNICIOUS ANÆMIA   | 1100                      | 1014    | 32.26                              |
| May 2nd. — Death. May 22nd. — High-coloured urine with urobilin + |                           |         |                                    |

numbers of corpuscles required in that disease are maintained by a re-engagement of the veterans for a further period of service, a view which throws light on the somewhat shabby and decrepit appearance of many of the red globules.

Let us now leave the subject of the physical condition of the blood, and consider one or two symptoms of chlorosis which are probably dependent on the condition I have been attempting to describe.

First of all, it is easy to imagine that the puffiness of the eyes and ankles, and soft oedema of the dorsa of the feet, symptoms common in marked cases of the green-sickness, have a close connection with the hæmæmia. I think also that we shall not be far wrong in imagining that this plethoric condition of the blood—if I may be allowed the term in the special sense I have defined—is responsible for the heavy drowsy condition of the patients, and for the congestive headaches from which they suffer. They have too much blood, but it is all of a poor quality. Notice how they sleep with their shoulders high, and their head, nevertheless, thrown back. They have too much blood in their brain, yet they have cerebral anæmia. To get more blood for their brain they instinctively put their arms above their head, the dreaming position so romantically described by the late George Du Maurier in *Peter Ibbetson*. Their sleep is heavy yet troubled, and, as they say, does them no good.

The morning finds them with a headache, generally dull; but sometimes it is more violent and of the migraine type. This is especially in the hysterical "Hysteria," says Sydenham, "often-times attacks the exterior of the head, creating intolerable pain between the cranium and pericranium, so isolated, however, as for the thumb laid across to cover it. Here it keeps fixed. Violent vomitings accompany it. This is the clavus hystericus—preminently common with the chlorotic."

This brings me to the point where the secondary results of chlorosis must be very briefly mentioned. Hysteria I have already touched on, and it undoubtedly finds in the chlorotic a prey made to its hand. Melancholia is one of the saddest results of this combination; and, even short of it, a prolonged chlorotic condition often impresses its victims with a permanently jaundiced view of life. The world, seen through chlorotic spectacles, must be a very dreary place.

The connection between chlorosis and disturbances of digestion is very close. Gastritis is very common; and perhaps the large majority of chlorotics are, to some degree, constipated. The disease also plays an important part in the aetiology of acute gastric ulcer. The elaborate researches of the Fenwicks have led them to this view. They say (*Gastric and Duodenal Ulcer*, p. 93), "There appears to be an intimate connection between anæmia and gastric ulcer. In 72 per cent. of our cases of the acute complaint in young women there was a definite history of pallor and breathlessness before the first symptoms of the disease manifested themselves, while in a large proportion of others it was highly probable that the patient had suffered from chlorosis shortly before the occurrence of the hæmatemesis or perforation."

Their idea of the exact connection between the anæmia and the ulcer is as follows (Fenwick, *Gastric and Duodenal Ulcer*, p. 129):—"Acute primary ulceration often commences as a hæmorrhage into the inner coats of the stomach during the hypæcæmia which takes place at each menstrual epoch, and under other conditions. If the extravasation is small and superficial the resultant erosion rapidly heals; but if the hæmorrhage is deep and extensive, or if the oxidising power of the blood is deficient, owing to diminution in the quantity of hæmoglobin, repair will be delayed, and the erosion may be converted into a definite perforating ulcer." (The italics are mine.)

Be this as it may, a chronic gastritis, a foul mouth, a furred tongue, foul breath, carious teeth, pains after food, waterbrash, heartburn, pyrosis, pica or eccentric and bizarre longings and appetite for strange foods, and above all, constipation, are far from uncommon in this disease. It is to be especially noted that when these things occur they intensify the chlorosis, or, rather, they superimpose upon it an anæmia which would occur even if the patients were not chlorotic. They are specially liable to these complications because they are chlorotic. The complications add to the primary anæmia a further degree and different kind of anæmia, secondary to themselves. Hence the red corpuscles are reduced in numbers, whilst the further diminution of the hæmoglobin is proportionate to that reduction.

Chlorosis lays its subjects open to the attack of any infection, lowering their vitality, and hence their resistance. Phtisis is the commonest and most fatal of these enemies of the chlorotic. The pre-phtisical anæmia, however, is to be carefully distinguished

from chlorosis by the fact that it is marked by wasting of the patient, whilst pure chlorosis is attended by an opposite tendency.

Trousseau held strange views on phtisis and chlorosis. He imagined that the latter was a kind of protection against the former, and that to fall into the green-sickness was the kindest fate that could happen to a girl with a phtisical family history, and that to attempt to cure such a patient of her chlorosis was a professional crime. In fact, he thought of it as protective in the same way that modern authorities suppose gout and rheumatism to be antagonistic to the tuberculous process.

Many other anæmias besides the phtisical have to be distinguished from pure chlorosis, though they may accompany it, modifying its characteristics, diminishing the count of red corpuscles, and often causing a leucocytosis. I have already mentioned some causes of such secondary anæmias—dyspepsia, gastric ulcer, lead poisoning. Rheumatic anæmia and Bright's disease are important additions to the list.

I have left the most important complication of chlorosis with but scant mention, and have put off dealing with it because, though its connection with the disease is undoubtedly intimate, I know not whether to class it as a cause, a symptom, or a secondary effect. I refer to amenorrhœa. The patient's mother generally regards this as the cause of all the trouble—a point worth noting. Many physicians have done the same; but the balance of present opinion is in the contrary scale. The older view is well illustrated by a passage from Graves, the discoverer of the disease called after his name.

"We are consulted," he says, "in the case of a young woman affected with various hysterical symptoms for several months, and during that period more than usually subject to headache, languor, loss of spirits, diminution of appetite, and irregularity, usually constipation, of bowels; she is pale, and complains of various pains and uneasy sensations, and has not menstruated since the accession of these symptoms. Here it is evident that the constitutional treatment must be strengthening and tonic; the practitioner will therefore recommend regular hours, much exercise in the open air, a nutritious diet, tepid and afterwards cold shower-baths; he will regulate the bowels, and afterwards prescribe a course of tonic medicines, chalybeates, preparations of bark, strychnia, etc.; he will likewise inquire carefully when the last period happened, and when and how often since that occurrence menstrual molimina were observed."

"He thus ascertains when they should again recur, and contents himself with enforcing the constitutional treatment until about six days before the calculated time; then he lays aside the other medicines and has recourse to those means which determine to the uterus. Two leeches are applied to the inside of the thigh near the labium every second night until they have been three times applied. The bleeding is encouraged by stuping. On the intermediate days the bowels must be actively moved by aloetic pills, and for three nights before and after the day of the molimina, hot pediluvia, rendered stimulating by mustard seed, may be used; during the same time, also, frictions with stimulating liniments should be applied to the feet and legs every morning, and oil of turpentine and tincture of cantharides may be exhibited internally, while the necessity of more active exercise is inculcated. The intention of the leeching is to produce a tendency of blood to the part, which tendency is increased by each repetition of the application, and it is still further augmented by these applications being made only about the time that the menstrual discharge should have taken place. If these means fail they must for the moment be laid aside, and the constitutional treatment must be again resumed until the same number of days before the next period, when the list of remedies above spoken of must be again tried, and in few cases indeed shall we find them to fail."

That, gentlemen, is Graves's description of an old way of regarding and treating chlorosis, amenorrhœa being looked upon by him as the *fons et origo mali*. Now hear Matthews Duncan's opinion to the contrary. He recognises the value of such emmenagogue treatment as Graves describes, or some modified form of it in cases of amenorrhœa due to suppression, as, for instance, where "a girl in the early days of menstruation, or in the days immediately preceding, is exposed to cold, and it may be she has had wet and cold feet. The flow of menses is quickly and prematurely arrested, or does not come on; there is more or less pain in the lower belly and sacra; there may be more or less of fever. Amenorrhœa thus suddenly begun may not recur, or it may persist for many months." But the distinction which he draws between such cases and those of ordinary chlorotic amenorrhœa is very clear. The former, he says, "are of quite another pathology" from the latter. In chlorosis, therefore, the physician "trusts almost exclusively to means for restoring and main-

taining general health, and in particular to remove the chlorotic condition or restore the function of blood formation." He recognises "the restoration of the menses as the harbinger of cure of all the inter-twined disorders. His plan is to re-establish the general health, being sure that when this is done menstruation will reappear and the connected disorders disappear."

Gentlemen, I have now completed an attempt to review the more striking features of this wide-spread but little understood disease; and the question arises, what guidance have we gained, what indications have been suggested as to the line of treatment to be adopted? I am bound to confess that I have no very illuminating suggestions to make.

A good regimen of life is the first indication. A generous diet, suited to the caprice of the patient, with a regulation of the disorders of digestion, and removal of constipation, form the elements of the second indication.

The treatment with medicines favouring blood formation is the third and grand indication.

That usually ends the list, but a fourth falls to be suggested. It is founded upon a recognition of the enormous increase in the volume of blood which, as we have seen, occurs in this disease. The indication is to diminish this volume by suitable means. Dr. Drysdale told me that when he first heard of Dr. Lorrain Smith's work he asked himself, "Can I cure chlorosis with digitalis alone?" He was relying partly on the diuretic effect of that drug to lower the blood volume, partly on its tonic action on the flabby dilated heart. Alone it failed; but it is a valuable adjuvant.

Whilst on this subject of the most striking effect which digitalis produces in its power in removing anæmic headaches. But as far as my short experience goes I am strongly inclined to think that the drug, coupled with iron, has a general value in the disease. Five minims of the tincture thrice daily continued for three weeks is not too much. Cases of uncomplicated chlorosis with loud hæmic murmurs and a loud *bruit à double courant* in the neck are the cases in which it is of most value.

I am inclined to suppose that this fourth indication is often unwittingly fulfilled by the purgatives prescribed in chlorosis. If the favourite Epsom salts be chosen, given in the sulphuric mint draught of this Hospital, I think that two doses a day given for a week are enough. Continued beyond that, the remedy will generally be too depleting. It is surprising to note how quickly the puffy, over-fat appearance of the patients diminishes under this treatment. On the whole I like better a dose of house physic at the onset, or, as Allbutt suggests, of blue pill followed by salts, and after that I think it preferable to rely on such "warm" purgatives, as Matthews Duncan calls them, as aloes combined with myrrh.

The regulation of the alimentary function is our second indication. The purgatives suitable we have just mentioned, and I need not enter into detail about the use of gentian and bicarbonate of soda.

Now we come to the grand indication—the use of hæmatines, above all iron. On this subject I have nothing original to say. I like draughts better than pills. One never knows whether pills dissolve. If they are not hard and coated Blaud's pills do not keep. When you cut them into two you find them brown from the oxide of iron, and as a further proof they fail to turn green on being moistened—a change which ought to happen in a fresh Blaud's pill owing to the formation of the valuable but unstable carbonate of iron. On the other hand, if they are hard and coated they fail to dissolve at all, the patient might as well swallow bullets. There are two good ways of giving Blaud's pills: Duncan and Flockhart put up the liquid carbonate in tiny flexible gelatine bags, different from ordinary capsules, and air-tight, so that the carbonate has no means of getting oxygen to turn into the oxide. Even these turn brown, however, after several months. A better way is Oppenheimer's, which is to make a capsule with two compartments, in one of which is the iron sulphate, whilst the sodium carbonate is in the other. The capsule being dissolved, the contents of the two compartments are supposed to combine in the stomach itself.

But both these ways are expensive, and draughts are quite as good in their effects. The objection to them is that they blacken the teeth; but that is easily overcome by a little lemon-juice mouth wash. The best draught is Griffith's mixture, but here I must make one proviso: as it keeps very badly—the contents of a bottle turning from green to brown in a week—it must always be made freshly. This is easily done by dispensing it in two bottles, the second bottle containing the whole of the iron sulphate, gr. iiss to ʒj of water, and nothing else. The patient then mixes a teaspoonful of the iron solution with her tablespoonful of the other at the time

of taking each dose. Thus she gets the carbonate of iron perfectly fresh. A trace of sulphuric acid in the iron solution bottle prevents the formation of iron oxide, which otherwise slowly takes place.

The simplest plan is to mix the Griffith's mixture with the compound decoction of aloes, as is so commonly done.

Sometimes, and especially early in the treatment, such a draught is ill borne. It is then that the scale preparations of iron are of especial value. The tartrate and the iron and ammonium citrate are both good, but I am inclined to think, judging by the few cases taking one or other of these forms in which I have made blood-counts, that the tartrate is the better of the two.

Dr. Shrubsole called my attention to the especial value of the iron and quinine citrate combined with potassium citrate in those cases of chlorosis where there is a marked rheumatic element.

If scale preparations cannot be borne, the saccharated carbonate on bread and butter, or the Hospital confection, best taken on porridge, can usually be tolerated. The latter is also usefully taken in convalescence. It has absolutely no taste of iron, and would be mistaken for golden syrup with one's eyes shut. Patients will readily take it for months daily with porridge, a dish which, on the aperient action it possesses, forms an ideal breakfast course for a convalescent chlorotic, staying off the relapse which is so likely to occur. The only ill effects I have heard of from the Hospital confection were when it had not been properly stirred up, and the iron having sunk to the bottom of the pot, the last dose was extremely strong and nauseating.

Arsenic appears to act in chlorosis as a stimulant to blood making. Cases which will not get well on iron alone, will sometimes begin to improve when arsenic is exhibited. It can either be added in the form of *Wij* or *iv* of Fowler's solution to a gentian and soda draught, or it can be given as a tiny pillule containing gr. ʒ of the arseniate of sodium twice or thrice a day. It is best to give it in the midst of a meal, as it is then less likely to cause nausea, always a symptom easily brought out in a chlorotic.

The diet should be generous and wholesome, and *suavis et cæciv* should be paid to the patient's fancies. Ceylon and Indian tea should be abjured on account of the horrible proportion of tannin. Much of it is grown on the sea level, whilst the Chinese know that the tea lands are 3000 feet higher. Tea, if drunk at all, should be Chinese, and a fresh infusion of that.

Fats and oily salads are theoretically good for chlorotics; but the latter, at any rate, they refuse to touch as a rule.

A little green vegetable should somehow be daily introduced into the diet. The fanciful notion that chlorophyll is good for hæmoglobin making is attractive; but so far as I know has not been proved. Anyhow, cellulose increases peristalsis.

Of fats, as such, I like bone marrow best. There is also a fanciful notion about that, namely, that it contains the quintessence of hæmatopoietic stimulus. That is also unproven. Messrs. Burroughs and Welcome tell me that they have analysed it, and find in it only the minutest trace of iron. Its chief constituents they say are a white, almost crystalline kind of fat, highly phosphorised like lecithin, and a clear, yellow oil not unlike olive oil in appearance. The mediævals had a deep belief in this article of diet. Here is what Rabelais says (*Gargantua*, Bk. 1, *Prolog*): "But did you ever see a dog encountering some marrow-bone? He is, as Plato says, the most philosophical animal in the world. If you have seen him, you have noted with what devotion he watches it, with what care he guards it, how fervently he holds it, with what prudence he gobbles it, with what effect he brooks it, and with what diligence he sucks it. What induces him to do this? What is the hope of his research? What good does he set before him? Nothing more than a little marrow. True it is that this little is more delicious than quantities of all other sorts of meat, because the marrow is an aliment perfectly elaborated by nature, as Galen saith (*Facult. Nat.*, iii, and *De usu partium*, xi)."

Whether marrow deserve this eulogy has yet to be proved; but it is emphatically a most nutritious dish, and it appears to be of special value in severe anæmias. Tablets and other preparations of it are probably of little good or useless. Scraped out raw and melted on to toast before a fire, it is extremely appetising.

With regard to regimen, the ordinary rules of health must be strictly enforced. Nine hours' sleep at night, to bed by ten of an evening, a rest of an hour after the midday meal if there be much dyspnoea and palpitation, open air and, in milder cases or convalescence, exercise short of fatigue. Troubles like protraction of an engagement of marriage greatly emphasise chlorosis; but the physician cannot always do much to mitigate them. A morning tub

is good. It cannot usually be borne cold; but the patient should sit in hot water, meanwhile sponging herself with cold. Flannel should be worn next the skin. In addition to its general advantages, the diaphoresis which it promotes may help to reduce the over-abundant blood-plasma. Stays are a great nuisance. They aggravate dyspepsia, and, according to Dr. Gee, often contribute to the promotion of gastric ulcer. Moreover they impede respiration, so that the hæmoglobin, already at a disadvantage on account of its dilution, is further hampered. Knitted wool stays, with bones only enough to keep them from crumpling, are free from these objections. A satisfactory form is made by the "Warpur" Company, and its price is within reach of all but the very poorest patient.

Finally, chlorotic patients ought, like the rest of mankind, to sleep with their windows wide open, and without a crushing weight of bedclothes. The latter, I feel convinced, emphasise the symptoms of morning headache. By bed socks or a hot water bottle, their cold feet must be warmed.

The prognosis of chlorosis is good. This is the case in spite of the many dangers of secondary illnesses. Most cases get quite well in two or three years, or under energetic treatment in as many months. Treatment must be prolonged in convalescence, for there is a great liability to relapse. Chlorosis generally ceases after marriage, though relapses occasionally occur in a married woman. These cases, however, are quickly cured.

On the other hand, we must not forget the type of the disease, which, in a modified form, accompanies the patient throughout her menstrual life, and leaves her a gaunt, shrewish spinster at the end of that period. That is one of the most wretched aspects of the malady.

Finally, gentlemen, we come to the theories of chlorosis. In the facts which I have endeavoured to lay before you this evening I can find nothing in support of the notion that the disease is due to congenital narrowness of the aorta. That theory was put forward by the greatest of pathologists, and whatever Virchow said must be received with respect. Moreover, it was based on post-mortem examinations. Still, considering how few chlorotics die of disease, and how general it is in otherwise well-developed girls, I think his theory of mesolastic, and especially aortic, hypoplasia can only apply to a very minute proportion of cases of anæmia, and in no sense explains chlorosis.

Sir Andrew Clark's famous theory that chlorosis is due to absorption of poisons from the constipated bowel, and is, in fact, copræmia, is beside the mark, for the obvious reason that every habitually constipated person ought then to have chlorosis, which is not the case. Middle-aged women, the most constipated class, extremely seldom have it.

Bunge's hypothesis seems also beside the mark. It is that sulphuretted hydrogen, in the gut of a constipated girl, forms insoluble sulphides with the iron, both that of food, and that which is excreted in the upper part of the gut, and is normally reabsorbed in the lower, thus preventing its reabsorption into the organism. He explains by this theory the value of iron as a medicine, saying that it acts as a sort of whipping-boy to the organic iron, allowing itself to be attacked in its place by the sulphuretted hydrogen, so that the organic iron remains free to be absorbed as in health. Were this theory correct, manganese would do equally well as a whipping-boy; but we cannot cure chlorosis with manganese, and we therefore conclude that Bunge is wrong.

Meinert thinks that tight lacing is at the root of the matter, causing enteroptosis—a theory which appears as inadequate as the rest.

There are many other theories, such as that of disordered ovarian internal secretion, which, like the above, contain elements of truth; but which are similarly incomplete and unconvincing.

If chlorosis be an idiopathic anæmia, it seems rather futile to search for some obvious primary condition, such as constipation, as its cause. What is an idiopathic anæmia? Dr. Hunter's criteria are—

1. *During life*.—(1) The detection of certain definite changes in the blood, the changes being more marked than the concomitant change in any other tissue.

(2) The existence of a definite causal relation between these changes in the blood on the one hand, and the clinical features on the other.

II. *Post mortem*.—The demonstration that the special morbid phenomena present must be referred to disorder of the great processes, hæmogenic and hæmolytic, on which the condition of the blood depends, and to these alone. He contrasts, in illustration of

secondary and primary anæmia, that which occurs in phthisis, with chlorosis (Hunter, *Pernicious Anæmia*, p. 30). These criteria he considers are fulfilled by chlorosis. "Therefore," he says (loc. cit., p. 31) "chlorosis may . . . be considered an idiopathic anæmia, hæmogenic in its origin, due probably to a deficient supply of assimilable iron at a time when the recent onset of menstruation has removed a certain proportion of the already small supply of that element in the body." He accepts Bunge's theory.

Thus he combines Bunge's theory with the old theory of the patient being unable to stand the loss of the first menstrual discharges.

But in chlorosis the trouble is usually not metrorrhagia, though the latter exceptionally takes place, but amenorrhœa—an obvious consideration, of which his theory takes no account.

Sydenham with more right, and many after him, have laid stress on the absorption of poisons from the suppressed menses. If the functions of the organs of the kidneys, bowels, and uterus, be impaired, he says, "vast collocations of impurity must accumulate. Had the organs done their duty these would have been eliminated and the blood purified accordingly. To this cause I attribute the cachexy, the anorexy, and the chlorosis (a truly hysterical complaint) of hysteria a sea of troubles whence such unfortunates as have long been afflicted have to struggle." But if this old theory were the whole story one would expect that in young women with imperforate vagina the degree of chlorosis would be appalling. As a matter of fact they are not specially chlorotic, a fact which appears to me to be a serious obstacle to the theory.

I now recall you to the point from which we led off. Chlorosis, we early agreed, is only an exaggeration of a certain condition of the blood which in young women is normal and natural. What this condition is I have described at length. The hæmoglobin is not altered in amount, but the bulk of the blood is markedly increased. When this increase oversteps the bounds of health, the hæmoglobin is too dilute to be used properly; all the muscles and tissues faint for lack of oxygen; and the condition is one of chlorosis. Why it should overstep the bounds of health I cannot tell, but I may point out that the condition of health during the establishment of the function of menstruation is a less stable one than at more settled times. It may be compared with the puerperium, undoubtedly a period of health; but equally undoubtedly a period of especial liability to disease.

Now let us consider what is taking place during puberty. The girl is being prepared for the duties of maternity. It is easy to imagine that immense metabolic changes are involved in the transition from child to woman. We see plainly enough similar metabolic states in other divisions of the animal kingdom. Once at Naples I was keeping some strange green worms of the *Chloro-rhæmid* family in a tank. At a certain season they began to look very miserable. They live inside an envelope of jelly, and this, instead of being firm and transparent, began to get slimy and stringy. I applied to Dr. Lo Bianco for fresh supplies. He got me more; but warned me that at that I should find them all the same, for that time of the year was just before their breeding season. I mention this merely as a striking instance of the profound influence which the preparation for reproduction involves in the metabolism of the organism. Undoubtedly in human beings at puberty a similar change is taking place. It is easy to suppose that a change once under way, may go too far, and run up into disaster. Look what happens, or probably happens, in Molities ossium. A process appears to be inaugurated during pregnancy, by which lime salts are taken from the mother and handed to the child; but, in molities, the process gets the bit between its teeth, and ceasing to be physiological, runs headlong into a state of profound disease.

It is an easy step to suppose that chlorosis is a similar exaggeration of a normal process. I have reserved to the last a fact strongly in favour of this view. Dr. Lloyd Jones points out that chlorosis is hereditary, and moreover that it occurs, especially, in large families. His conclusion is that chlorotic blood is fertile blood; in Allbutt's words, that chlorosis is "the exaggeration of the condition of blood which has for its end the storage of nutritive material for the fetus during pregnancy." In view of this, the fact that the specific gravity of the plasma, apart from the corpuscles, is unaltered or raised in spite of the increased volume of the blood, which I mentioned before, becomes of great interest, suggesting that the extra material present is designed for such a purpose. The blood, so to speak, is being too rouscous ready for married life.

Gentlemen, whatever truth there may be in these fanciful suppositions, I feel impressed with the probability of the statement with

which I began and will finish—that chlorosis is, after all, only an exaggeration of a certain condition of the blood which in young women is normal and natural.

### A Case of Traumatic Hæmorrhax.

Reported by S. HEV and R. T. WORTHINGTON.



L. at 32, was admitted to Harley Ward in the afternoon of March 7th, 1902, under Mr. Walsham, suffering from severe pain in the right side and collapse.

The history was as follows:—Late in the morning of March 7th the patient fell from a ladder, a distance of twenty-five feet, on to some soft mould, falling chiefly on to his right side. He was able to rise, and with assistance walked to a house, complaining only of pain in his right ankle. Later, while being conveyed to St. Bartholomew's Hospital in a cab, he first experienced pain on the right side of his chest during respiration. When seen in the surgery about 2.30 p.m. he was suffering from collapse; his face was dusky, his lips blanched, and his pulse hardly perceptible; he complained of very severe pain on the right side of his chest. After admission his condition improved somewhat, but at 6 p.m. he began to have frequent attacks of retching followed by marked dyspnoea, during which attacks his pulse became uncountable and almost imperceptible; on two occasions slightly blood-stained mucus was coughed up.

On examination there was a small depressed bruise over the eighth rib on the right side in the anterior axillary line. The whole side was intensely tender, especially over the bruise, but no actual fracture could be made out. Movement was absent in the lower right chest. On percussion there was absolute dullness in front, extending as high as the nipple. This dullness was about an inch lower in the anterior axillary line, and two inches lower in the posterior axillary line. Vocal vibrations were absent, and no breath-sounds could be detected over the dull area. The apex-beat was not displaced, and the breathing on the left side was normal.

It was decided that his condition was too bad for surgical interference. A hypodermic injection of *Liq. Strychn. wj* and *Liq. Morph. Tart. wj* was given, which relieved the dyspnoea and pain. Oxygen was also given, and was continued throughout the night at intervals, and his condition rapidly improved. On March 13th nearly all pain on respiration had ceased, but the physical signs remained unaltered. On March 14th, about 10 a.m., the attacks of dyspnoea recurred; the face became dusky, the condition almost simulating that on admission.

On examination the dullness had increased upwards for about two inches, and the apex-beat was displaced outwards to the left about an inch. An exploring needle was inserted in the eighth space in the mid-axillary line and dark fluid blood drawn off. It was then decided to aspirate, the trocar being inserted in the same spot. Two pints of old fluid blood were drawn off, which instantly relieved the dyspnoea. Better movement of the right side was observed, and the dullness disappeared about a hand's breadth downwards, although the apex-beat was not materially altered. Within forty-eight hours of the aspiration the dullness again increased suddenly, but was unattended by any dyspnoea. After the aspiration the temperature rose to 102° on the following morning, remaining with the occlusion normal on the 24th, when it gradually fell, reaching by April 6th his condition steadily improved. The physical signs on his discharge were as follows:—The apex-beat had returned to its normal position; there was slight impairment to percussion at the extreme base in front, the breath-sounds being audible though weak; behind there was impairment from the angle of the scapula, gradually increasing to absolute dullness at the base, where the breath-sounds were inaudible. On April 6th an exploring syringe was inserted into the same spot as before, and slightly blood-stained serum was withdrawn.

Remarks.—The interesting points in the case are—

1. Firstly, the rarity of large traumatic hæmorrhax due to indirect injury without apparent fracture of ribs; secondly, the instantaneous effect of oxygen inhalation; and thirdly, the recurrence of symptoms after a week's interval. Large effusions of blood into the pleura are very rare, except in cases of bullet wounds in the

chest. Authorities state that in such cases it is usually the lung that is injured. The diagnosis of hæmorrhax in this case was easy to make, although the source from which the bleeding was coming, whether from an intercostal artery or some vessel of the lung itself, was doubtful. It seems in this case more probable that a vessel of the lung was ruptured, for never at any time was a fracture of the rib discovered, and for an intercostal artery to be torn across and at the same time no fracture of a rib present, would probably be without precedent; the blood-stained sputum is not of much help, as the amount was exceedingly slight, and in an injury to the chest of this sort there would be almost certainly some bruising of the lung. An incident in the history, that of the pain and dyspnoea coming on in the cab and not at first, points rather to the lung theory, as if the jolting and movement had caused the sudden rupture of an unsupported vessel, and, on the other hand, had a rib been fractured pain on respiration would have been an early sign, although of course bleeding from an intercostal artery might come on later.

As regards treatment, the doubtful point was whether the effusion was getting larger, and so rapidly as to indicate an operation—either aspiration or resection of a rib. The condition of the patient was very serious during the attacks of retching and dyspnoea, and would have hardly allowed of an operation of the second kind; in fact, it was so bad that even aspiration, had it been indicated, was thought to be too severe. It was decided not to aspirate for these reasons:—(1) The uncertainty of how much of the dullness was due to blood effused, and how much to bruised and so non-inflating lung. (2) That the effused blood would of itself probably form the best pressure on the bleeding point, and (3) the urgent symptoms came on at intervals and were not continuous. The actual cause of the attacks of retching and dyspnoea is not clear; practically, however, since the condition of the patient between the attacks improved immeasurably, aspiration was contra-indicated.

2. The relief from all symptoms by the inhalation of oxygen was nearly instantaneous; in half an hour the patient was comfortable, and later in the night had some little sleep.

3. The recurrence of the dyspnoea after an interval of a week might be accounted for by an increase of pressure caused by the exudation of serous fluid. The blood drawn off was evidently old blood, being thin and dark, and had lost the power to clot.

We have to thank Mr. Walsham for his permission to publish these notes, and also for his kindness in overlooking them.

### Note on the Onset of Cerebral Thrombosis in a Pregnant Woman who had been taking Acetanilide (Antifebrin) in Advertised Headache Powders.

By LIONEL JAMES PICTON.



AT the present time there lies in John Ward, under the care of Sir Dyce Duckworth, a woman of 32, who recently, under peculiar circumstances, had a stroke of palsy. She was pregnant. About three weeks before her full time headaches, to which at any time she is liable, began to trouble her. She took for their relief "Daisy" and "Fairy" powders. Nine or ten days before the actual date of her confinement the headaches grew worse, and sometimes were well-nigh intolerable. These persisted for about a week, and at nights the patient would get up and walk about the room as if half demented. On April 5th she took about half a dozen of the headache powders at one dose. Next morning she was found unconscious. Still unconscious, she went into labour on April 7th. She was attended by the officials of Mackenzie's, who noted that she was hemiplegic on the right side; and on the same day, without untoward accident, the child was born. On April 8th the patient, still comatose, was admitted to the hospital.

One or two remarks about her condition, then and subsequently, will suffice to complete the story. The right side of the face was flattened. The right hand and right foot were almost completely palsied. The knee-jerks were both absent. Babinski's sign of extension of the great toe, on irritating the sole of the foot, was

obtained on the right side. The pulse was 80, "thready," or of small volume and low tension. There was great cardiac debility. The sounds of the heart were very weak. A faint blowing murmur followed the systolic sound at the apex. The diagnosis of left middle cerebral thrombosis was made. The patient was fed nasally and given brandy.

She has gradually regained consciousness, but remains hemiplegic. She has also a marked degree of aphasia. The heart has regained its tone, and the murmur is no longer heard.

In view of the depressing action on the heart which is shared by acetanilide and the other analgesic and antipyretic derivatives of coal-tar, it would appear not improbable that in a woman about to be, or recently, delivered, a period when the coagulability of the blood is increased, the cardiac debility produced by large doses of such drugs may act as the determining factor in the production of thrombosis.

With regard to exact composition of the particular powders taken by this patient nothing is known, but at an inquest held in 1896 on a case of poisoning by "Daisy" headache powders, evidence was given by the analyst to the Home Office to the effect that powders examined contained from 4 to 10.6 grains of almost pure acetanilide (vide *Pharmaceutical Journal*, July 4th, 1896).

### A Case of Bleeding.

By J. C. SALE, M.R.C.S., L.R.C.P.

**T**HE following case seems worthy of notice from the rarity of the condition as a cause of epistaxis, and the absence of any symptoms giving a clue to the real nature of the case.

W. T. D—, æt. 56, was admitted to St. Bartholomew's Hospital on February 27th, 1902, complaining of bleeding from the nose and gums. The history of the case is as follows:—The patient had been quite well till November, 1901. Early in November he had an attack of bleeding from the nose and gums. The attacks recurred about once a fortnight till the middle of January, 1902. During the attacks there was continual oozing from nose and gums, lasting sometimes for sixteen or seventeen hours. During January bleeding took place more frequently, until at the end of February they occurred every two or three days.

Except for the hæmorrhage the patient remained in good health till February 1st, on which day he had a severe headache and vomited a large quantity of "bile." He vomited again one week later, but not since; the headache persisted until just before admission.

He had had a purpuric eruption on the legs for some months, and had also noticed that he bruised very easily, after even slight knocks. Whether he had noticed the rash or the bruising before the epistaxis began he could not say. He had lost half a stone in weight in the last two months. Had always lived in England, and had plenty of good food. He had had no hæmatemesis, hæmaturia, or melæna, and had not noticed any profuse bleeding after a cut.

There was no family history of hæmophilia.

*Condition on admission.*—Anæmic; nose bleeds slightly when he sits up, not when he lies on his back. Gums red and inclined to bleed; not spongy. No headache; fundus oculi natural. No hæmorrhages.

Slight purpuric eruption on front of both legs between knees and ankles. Discoloration like old bruises over bony prominences on legs. Urine natural.

Blood examination: reds 3,780,000, whites 10,000; hæmoglobin 45 per cent.

Course of disease: almost every drug recommended in cases of bleeding was tried both locally and internally. The application locally of solution of adrenalin 1 in 1000 stopped the bleeding of the gums temporarily, but there was always some trickling of blood from the nose down the back of the naso-pharynx. The bleeding became by degrees almost continuous; it was never profuse. There was general oozing from the gums, and especially from one spot close to the left upper canine. On one occasion there was hæmorrhage from a spot on the floor of the left auditory meatus. No fresh purpuric spots appeared. Several times his arms were bruised from the slightest possible knocks. He complained of deafness and buzzing in the ears, but never of headache, nor did he ever vomit while in hospital. Fundus oculi when last examined on April 7th was natural.

On April 29th blood-count was—reds 1,640,000, whites 12,000; hæmoglobin 21 per cent.; differential count showed no variation from normal. Bleeding from the prick in the ear made to obtain blood for this count lasted thirteen hours. The man gradually got paler and weaker, and died on May 8th, six months after the onset of the first symptoms.

The result of the post-mortem examination was as follows:—Numerous small new growths in bones of the skull. In the skull-cap these were circular in form, the largest being the size of a florin. The larger growths were adherent to the dura mater, but many of the smaller ones had not penetrated the inner table. There were growths in the cavernous sinus and the ethmoidal sinus on the left side. The bones of the base showed growths, and there were hæmorrhages into the dura mater over the left temporal bone.

No lesion in brain. No growths in any other part of the body. The kidneys and heart were fatty, and there were some subpericardial hæmorrhages.

There was no growth in the gums.

The bleeding from the nose was evidently from the ethmoidal growth.

Microscopical section showed the growths to be a rounded sarcoma.

### NOTICE.

OWING to the Coronation, the Eighth Decennial Contemporary Club Dinner, which in ordinary years is held on the last Wednesday in June, will take place on Friday, July 11th, at the Café Royal.

### In Memoriam.

ARTHUR NESHAM WEIR.

**E**VERY old Bart.'s man who knew Dr. Arthur Nesham Weir will bear with the deepest regret of the sad accident which caused his death on the 25th January, 1902, at the early age of thirty-two. On January 24th he was going by rail to Croydon. Between New Cross and Brockley, at about 2 p.m., a lady in the same train saw the door of the compartment next to the one she was travelling in open suddenly, and poor Weir fell from the train. The lady stopped the train at once by the communicating cord, and he was picked up by the side of the line, placed on a goods train that had been stopped for the purpose, and he was taken to London Bridge station, and from there to Guy's Hospital. He was conscious when admitted, and told the house surgeon, Mr. C. H. Glenn, that he was an old Bart.'s man, and that he thought his right humerus was broken below the insertion of the deltoid. He was suffering from a badly bruised right shoulder and a large scalp wound, disclosing a fissure of the right frontal bone. At 4 p.m. he was becoming

drowsy, and an effusion of serum appeared in the conjunctivæ. By 5.30 p.m. he was comatose, and was trephined. Some clot was removed, and his respirations improved for a time, but he never regained consciousness. He passed away quietly at 4 a.m. on January 25th, 1902. A fracture of the anterior fossa of the base of the skull with effusion at the base of the brain was found.

At the inquest on January 28th there was a verdict of accidental death, with an expression of condolence with his relatives. Needless to say, everything that could be done for him had been done with the utmost care. Dr.

Waldo, the coroner for the City of London, an old acquaintance of Weir's, did everything that lay in his power to lessen the burden that had fallen on the poor fellow's relatives.

He was buried on January 29th, 1902, at Kensal Green Cemetery. Many Bart.'s men and representatives of the Stanmore Golf Club and Old Merchant Taylors' Football Club were present, and the wreaths sent by old friends were very many.

Weir was born on June 12th, 1869, at the house of his grandfather, a physician practising in Newcastle. Soon after his birth his family took him to Singapore with them,

his father being a merchant there, and they remained for some two years. They returned to Scotland, and lived at Glasgow for about four years, Weir's first school being the Kelvinside Academy. He was there for about two years; but beyond breaking his arm on a vaulting-horse we have no record of what he did there.

His family then came to London, and Weir went to a private school, and from there to Merchant Taylors' School, where he stayed for three years on the classical side. His power of work and sane keen intellect soon showed themselves, and he left the school at sixteen years of age, the youngest boy in the sixth form.

It was good at singlestick and boxing, very good at five, rowed bow at 8 st. 2 lbs. in the school four, a fact which in itself speaks eloquently as to his watermanship, and he played forward in the school Rugby football team in his last year.

But these were not his only, or indeed his chief distinctions. Early he had been recognised by his schoolfellows as a keen sportsman in the best sense of the word, and a fine, upstanding, honourable lad whose word was as good as his bond; and for any friend, it is a great pleasure to talk to one of his old schoolfellows, and hear how well liked and appreciated he was. His influence seems



to have been large, and always exerted on the right side.

He went straight from school to Bart.'s, taking the Open Scholarship in Science in 1887. The same qualities that had brought him to the front, and made him so popular at school, soon produced a like result at Bart.'s, and but few words as to his career are necessary to anyone who knew him at the dear old Hospital we all love so well. He took the London B.Sc. and the Junior Scholarship in 1888, and won the Brackenbury Scholarship in Surgery, and qualified in 1892. After having been House Surgeon to Sir Thomas Smith and Extern Midwifery Assistant, he became a Fellow of the Royal College of Surgeons, England, and an M.B. Lond. with honours in obstetric medicine in 1894.

He was an Assistant Demonstrator of Anatomy in the Medical School for three years, and finished his academic career by taking the D.P.H. in 1898 and the M.D. in State Medicine in 1899.

He was universally known as "Ike" Weir. The nickname arose from some of his friends attending a professional boxing competition at Lambeth. One of the competitors, not a beauty, but a namesake of Weir's, figured on the programme as "Ike" Weir. It was bestowed upon our Weir next day, and passed into general use; so much so that a friend sending a telegram to Weir's family for him signed it "Ike," and as his relations heard the name then for the first time it quite puzzled them.

He took a very active part in all the phases of a medical student's career, and lived a clean, hard, strenuous life. As often as not, in the summer, the day's work was begun with a swim in the Serpentine, and he played in the first Hospital Water Polo team. He was secretary to the Boxing Club, and a keen lawn-tennis player and golfer. He played for the Hospital for three or four years at

Rugby football, and was captain of the team in 1890-91. He also played "rigger" for the Old Merchant Taylors', United Hospitals, and Middlesex County, while he was at the Hospital.

He finally left Bart.'s in 1899, and all who knew him will agree that very rarely has the old Hospital sent out a better representative. He was a Fellow of the Royal Medical and Chirurgical Society, and a member of the Abernethian and Anatomical Societies. After a holiday in Italy Sir William Church got him a Medical Inspectorship at the Home Office, which he held for about eight months.

He was captain of the Stanmore Golf Club in 1899-1900. The senior civil surgeoncy to the Princess Christian's Hospital was the next work he took up. He went out six months after the hospital was started, and just before it was moved from Cecil Rhodes' garden at Cape Town to Pine-town, ten miles from Durban. Working the hospital with Col. Mathias, R.A.M.C., and Worthington, an old Bart.'s friend, it was a great success; and though the relationships between some of the members of the R.A.M.C. and the civil surgeons were strained at other places, at this hospital everything went perfectly smoothly. Weir stayed with it for six months, when it was broken up, as the fight-

ing line had passed on. He came back to England in charge of a transport in January, 1901, but only stayed at home for a fortnight, as his former military chief, Col. Mathias, R.A.M.C., the brother of the Dargai hero, persuaded him to go out for a second time as a "civil surgeon." In February, 1901, he joined Col. Mathias at Harrismith in the Orange River Colony. The work was very hard, as for a time four surgeons had to run a hospital of 300 beds, the cases being nearly all typhoid fever ones. Weir was mightily proud of the efficiency of their transport service. On one occasion he received an order to bring in some

men wounded at an engagement twenty-four miles away. He started at once at 4 p.m., and got back at 8 a.m. the next morning, forty-eight miles in sixteen hours with an ambulance—a very smart piece of work. Notwithstanding all the hard work, he found time to lay down three dust tennis courts: they were so well patronised that he could hardly get a game himself. He stayed for six months, and came home on July 17th, 1901, in charge of the convalescent transport "City of Vienna," with about 750 patients and three surgeons on board. After a holiday at Barmouth, with golf at Harlech, and a short trip to Switzerland, he was, in October, 1901, appointed temporarily as Medical Officer of Health to Tottenham, and stayed there for four months. He urged the erection of an Isolation

Hospital, and with great difficulty got his scheme partially carried out. He had decided finally to go into practice, when the sad accident before mentioned closed his most promising career.

Weir was a man of great natural refinement, with an unusually keen sense of honour. These two factors combined to make a most lovable character, but one not so fitted to succeed in the struggle for existence as those of a coarser and more pushing type. Successful as his career was, it might have been even more so if he had "advertised" himself. But in getting to the heart of a friend modern business methods do not count, and all who really knew dear old "Ike" will miss him always, and feel that they and the world are poorer by his death.

### Amalgamated Clubs.

#### BALANCE-SHEET, 1900-1901.

|   | £           | s.       | d.        |  | £           | s.       | d.        |
|---|-------------|----------|-----------|--|-------------|----------|-----------|
| To Members' Subscriptions ... ..            | 623         | 16       | 0         | By Grants to Clubs ... ..                            | 177         | 0        | 3         |
| „ Grant from Medical School ... ..          | 100         | 0        | 0         | „ Subscription returned ... ..                       | 6           | 6        | 0         |
| „ Paid by Medical School for Repairs ... .. | 74          | 9        | 6         | „ Abernethian Society ... ..                         | 91          | 7        | 0         |
| „ Profit on JOURNAL ... ..                  | 1           | 2        | 5         | „ Musical Society ... ..                             | 20          | 0        | 0         |
|   |             |          |           | „ Transferred to Maintenance and Reserve Fund ... .. | 506         | 14       | 8         |
|   | <u>£801</u> | <u>7</u> | <u>11</u> |  | <u>£801</u> | <u>7</u> | <u>11</u> |

Audited and found correct,

H. MORLEY FLETCHER.  
L. E. RAWLING.  
H. E. GRAHAM.

#### MAINTENANCE AND RESERVE FUND.

|                                       | £           | s.       | d.       |  | £           | s.       | d.       |
|---------------------------------------|-------------|----------|----------|--|-------------|----------|----------|
| To Balance from 1899-1900 ... ..      | 179         | 13       | 1        | By Rent ... ..   | 300         | 0        | 0        |
| „ Funds as per General Account ... .. | 506         | 14       | 8        | „ Rates, Taxes, and Water ... ..   | 44          | 1        | 11       |
|                                       |             |          |          | „ Coal, etc. ... ..  | 10          | 4        | 0        |
|                                       |             |          |          | „ Refreshments ... ..  | 24          | 11       | 4        |
|                                       |             |          |          | „ Wages of groundmen and boy, keep of horse, and general maintenance of ground and pavilion ... .. | 132         | 13       | 0        |
|                                       |             |          |          | „ Band, Past & Present ... ..  | 5           | 5        | 0        |
|                                       |             |          |          | „ Cheque Book 8s. 4d., Receipt Books £1 5s. ... ..   | 1           | 13       | 4        |
|                                       |             |          |          | „ General Secretary's petty cash ... ..  | 9           | 0        | 0        |
|                                       |             |          |          | „ Madden (clerk) ... ..  | 5           | 0        | 0        |
|                                       |             |          |          | „ Printing ... ..  | 7           | 12       | 6        |
|                                       |             |          |          | „ Expenses of Club Dinner ... ..   | 11          | 16       | 0        |
|                                       |             |          |          | „ Repairs and Draining at Winchmore Hill ... ..  | 85          | 19       | 3        |
|                                       |             |          |          | Balance at bank ... ..   | 48          | 11       | 5        |
|                                       | <u>£686</u> | <u>7</u> | <u>9</u> |  | <u>£686</u> | <u>7</u> | <u>9</u> |

Audited and found correct,

H. MORLEY FLETCHER.  
L. E. RAWLING.  
H. E. GRAHAM.

## THE RUGBY FOOTBALL SEASON.

The first fifteen wound up the season on March 14th with a win against Swindon. On the whole, though the Cup still remains on the south side of the river, the team has good reason to be pleased with the results, which not only show a decided improvement in point of view of matches won on the previous season, but were also brought about in the face of very great difficulties, of which frequent changes in the composition of the team, bad weather, and injuries were a few. They were as follows:

| Points. |       |      |          |
|---------|-------|------|----------|
| Won.    | Lost. | For. | Against. |
| 7       | 5     | 75   | 75       |

The beaten teams were—London Irish, Croydon, Park House, Upper Clapton, Old Leysians, Bedford, Swindon; and we succumbed to the Harlequins, R.N.C., Streatham, Catford Bridge, Northampton. Several other matches were arranged, but had to be scratched on account of frost, etc.

In the Cup ties the team was beaten in its first match, but that was against Guy's, who won in the end, and certainly had one of the best teams in town.

Turning to individuals, our old weakness behind the scrum was not overcome; in the scrum we were stronger than ever—could we be anything else with O'Neil and Fosswill in their best form? One looks forward with dismay to next season, when both will be out of their year. When again will Bart's be able to boast of two international forwards?

The Caps went to H. E. Stanger Leathes, the hard-worked secretary and most untiring forward in the team, and to W. H. Hamilton, whose defence at half has been invaluable.

The second fifteen did well, though not so well as last season; out of the twenty matches played they won twelve and lost eight.

The team suffered much from the draughts made on it by the first fifteen. It is strange that out of the biggest medical school in London it should be difficult to find thirty men who are able or willing to play Rugby.

The United Hospitals were going to do great things, but it all came down to one match, v. Edinburgh University, at Edinburgh. Only a weak team could be got to make the long journey, and as the University team contained all the Scotch backs of the year, it was not surprising that they won by a dropped goal and six tries to nil. The U.H. team was as follows:

E. S. Marshall (Bart.'s) (back); A. O'Brien, P. V. McEvedy (Guy's); J. Corbin (Bart.'s); C. Blackstone (University) (three-quarters); W. Wetherell, L. Louison (Guy's) (half-backs); A. O'Neil (capt.), L. R. Tomswill, H. T. Wilson, A. R. Neligan (Bart.'s); H. D. Traill, A. E. Wall, Glendinning (Guy's), Bingham (Thomas's) (forwards).

## CRICKET PROSPECTS, 1902.

It is always dangerous to prophesy, and perhaps in no case is this truer than about a cricket side. Still the Hospital ought to be able to find a fairly good eleven this summer. Two members of last year's team—L. Orton and G. H. Adam—are "out of their year," and their loss will certainly be felt; but we may reasonably expect to receive some assistance from members who have joined the Hospital since last season. K. S. Singh has of course a great reputation, and it is to be hoped he will find time to assist the Hospital in the cup ties this year. Doubtless the trial game on May 7th will disclose some further fresh talent. Of last year's team C. A. Anderson, H. N. Burroughes, and W. S. Nealar should do very well in the batting line; in fact, the team promises to be very strong in batting all through. But, as in most amateur teams, the bowling is by far the weakest point, and unless a new bowler or some new bowlers are discovered many weary hours may be confidently expected in the field. It may not be out of place here to express the hope that this year's eleven may be able to overcome the almost hereditary taint in St. Bart.'s cricket teams of recent years. We refer to the tendency such teams show to becoming demoralised when anything like a crisis arises in a match. If they can overcome this tendency we may hope to get one round further through the cup ties than last year.

## OFFICERS.

President.—Sir William Selby Church, P.R.C.P.  
 Captain 1st XI. C. A. Anderson.  
 Hon. Secretaries.—C. M. H. Howell, H. N. Burroughes.  
 Captain 2nd XI.—A. C. Sidgwick.  
 Committee.—G. G. Ellett, H. E. Stanger-Leathes, W. S. Nealar, C. F. Nicholas.

## SWIMMING CLUB.

## OFFICERS.

President.—Howard Marsh, Esq., F.R.C.S.  
 Vice-Presidents.—W. P. Herringham, Esq., M.D.; W. Fay Bennett, Esq., M.R.C.S., L.R.C.P.; E. M. Niall, Esq., M.R.C.S., L.R.C.P.; W. H. G. Thorne, Esq.  
 Captain. D. M. Stone.  
 Vice-Captain.—A. H. Bloxsome.  
 Hon. Sec.—J. G. Watkins.  
 Committee.—A. M. Amsler, C. Dix, F. E. Taylor, R. C. P. McDonagh, H. M. Hanschell, G. T. Verry, W. H. Scott.

H.Q. quarters.—Paddington Baths, Queen's Road, W.  
 The above club has held the Inter-Hospital Water Polo Cup for the last four years, and if it is to continue to do so more men must become active members. Freshmen are particularly requested to do so. It is disappointing to see the very small number of Bart.'s men who turn up to watch even the cup tie matches.

## RIFLE CLUB.

President.—H. J. Waring, Esq., F.R.C.S.  
 Vice-Presidents.—Mr. Howard Marsh, Mr. Mites, Mr. Mundy, Mr. Rawling.  
 Captain.—A. C. Brown.  
 Committee.—R. Fuller, P. Andrews, P. A. Dingle.  
 Secretary.—N. Bennett-Powell.  
 Rifle Range at Runnymede.  
 First practice on Thursday, May 8th. Other days Wednesday, May 14th; Wednesday, May 28th; Wednesday, June 11th; Wednesday, June 18th.

## TENNIS CLUB.

The courts at Winchmore Hill are always available. A considerable number of matches have been arranged, and a tournament will be held during the summer session.

## OFFICERS.

President.—Howard Marsh, Esq., F.R.C.S.  
 Captain.—E. H. Hunt.  
 Secretaries.—A. C. Hamilton, C. A. W. Pope.

## Correspondence.

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

DEAR SIR,—During my year on the Junior Staff, which has just ended, I noticed with regret that the dressers and clerks were dropping the custom of being photographed with their respective physicians and surgeons. The reason for this I did not find out; but I would like to advise future students to maintain the custom, and for the following reason:—They will all at some time or other need to apply for testimonials and help from the physicians and surgeons they have worked under, which will be of the greatest value to them; and these photos, "with the names attached," constitute the sole book of reference that the Senior Staff have to guide them, since, with the number of men that pass through their hands during their course of study, it is quite impossible to recollect each individual without some such guide.

Yours, etc.

ARTHUR H. BOSTOCK.

CHICHESTER;  
 April 17th, 1902.

## Notes.

MR. JESSOP has been appointed Ophthalmic Surgeon to the Foundling Hospital.

DR. GARROD has been appointed Demonstrator of Chemical Pathology.

MR. GASK has been appointed Demonstrator, and Mr. F. A. Rose Junior Demonstrator, of Surgical Pathology.

THE Senior Scholarship has been awarded to J. G. Atkinson, and the Junior Scholarships to (1) H. E. Quick and (2) P. L. Giuseppe.

THE Medical Brackenbury has been awarded to A. E. Thomas, *prox. acc.* W. W. Jendwine and E. G. Pringle; and the Surgical Brackenbury has been awarded to F. P. Connor, *prox. acc.* R. C. Elmslie.

NOWADAYS the medical and legal profession have many points of contact, and the medical man finds it advisable to know something of jurisprudence if only to safeguard his professional interests. But it is only quite recently that a medico-legal society has been founded, which has for its object the extension of medico-legal knowledge. There can be no doubt that the Society will do very valuable work, and we are glad to see that this Hospital is well represented in the list of officers. Dr. W. J. Collins, the President, and Dr. Henslowe Wellington, one of the Secretaries of the Society, are both old Bart.'s men; and the Council includes among its members Mr. S. B. Atkinson, who has already contributed more than one interesting paper on medico-legal subjects to this JOURNAL.

AN extremely unfavourable criticism of the nursing profession appeared in the April number of the *Nineteenth Century*. The writer of the article did not scruple to accuse nurses of being "offensive in their general behaviour," "shoppy," and "callous to suffering;" and she was at some pains to emphasise her opinion that they applied not to a few individuals, but to nurses as a whole. It could not be expected that such mischievous and misleading statements would pass unchallenged. And we read with extreme pleasure a vigorous protest on the part of Miss Stewart in the May number of the *Nineteenth Century*. No one is in a better position to respond to such an attack than the Matron of this Hospital, and Miss Stewart had no difficulty in refuting statements based rather on prejudice than on knowledge.

We have no sympathy with those who make it their business to decry a profession which they fail to appreciate. Such people have it in their power to do a great deal of harm; and, for our own part, we have always associated them with the other groups of misguided faddists, who are nowadays only too common.

## Reviews.

SURGICAL DISEASES OF THE KIDNEY AND URETER (including Malformations and Displacements). By HENRY MORRIS, M.A., M.B., F.R.C.S., Vice-President and Chairman of Board of Examiners, Royal College of Surgeons; Senior Surgeon to the Middlesex Hospital, etc. Two coloured plates and upwards of 200 engravings. Two volumes. (London: Cassell and Co., 1901.) Price 42s. net.

This large and comprehensive work is stated to be largely based upon personal experience, and also upon a long and extensive study of the writings of others. Vol. I is devoted to the surgery of the kidney, and is in some respects an extensively amplified, modified, and enlarged edition of the author's *Manual of the Surgical Diseases of the Kidney*, which was published in 1884. The first half of Vol. II continues the account of the surgical affections of the kidney and its pelvis, and the operations which are performed upon them, whilst the remaining portion of the work is entirely reserved for a detailed discussion of the surgery of the ureter. This latter is entirely new, and was not referred to in the original work. When Mr. Morris's first book appeared it was almost entirely a record of personal observations and experiences, the literature on the subject being very small or almost non-existent when the book was written. Since then, however, a large number of treatises, text-books, and original papers have been published on the subject of "Renal Surgery." More than one thousand publications have been read by the author in preparation for this work, and many of them abstracted.

The terminal portion of the kidney sections is devoted to a very detailed account of the operations of abdominal and lumbar nephrectomy. Mr. Morris strongly favours the lumbar procedure, and emphatically states, "The lumbar operation ought to be chosen in all cases except (1) for tumours of very large dimensions; (2) after accidents when it cannot be told without caeliotomy whether or not the injury involves other organs besides the kidney; and (3) in those rare cases of disease of a floating or misplaced kidney requiring nephrectomy. The lumbar operation ought not to be regarded merely as the operation of choice; with the exceptions stated, it is the only operation which ought to be considered justifiable. The kidney, as an extra-peritoneal organ, ought to be attacked from behind, and not across the peritoneal cavity." We think that the old fear of opening the peritoneum still too much pervades the author's views on the relative merits and demerits of the two forms of operation. There appears to us to be no doubt that in all cases of malignant disease of the kidney in which a septic condition has not been established the most justifiable operation is one through the antero-lateral abdominal wall, since this enables the operator to make

out definitely the presence or absence of secondary growths in the liver and the lymphatic glands along the renal pedicle, and also is less liable to give rise to the after development of a hernia at the seat of the scar. Mr. Morris also says, "In the cases of renal tumours in which colicotomy is indicated I prefer the combined incision, lumbar first and abdominal afterwards, for the following reasons:—By the first or lumbar stage of the operation two things are accomplished before the peritoneal cavity is opened, viz. (1) the exact condition of the kidney, and the necessity of proceeding to nephrectomy rather than limiting the operation to nephrotomy or nephroptosis is decided upon; and (2) all the posterior adhesions and connections of the kidney are detached without any forcible traction or forward dragging being exercised upon the kidney or the renal pedicle: in this way the risk is avoided of tearing the large vessels."

The latter portion of the second volume comprises a very good and comparative account of the different conditions which necessitate direct surgical interference on the ureter. A comparison is made between the advantages and disadvantages of endoscopic and cystoscopic examination, and of ureteral catheterisation, in which Mr. Morris says "endoscopic and cystoscopic examination of the ureteral orifices and catheterisation of the ureters are indicated (1) in cases in which it is doubtful whether a disease of the urinary tract is situated in the kidneys or the lower urinary organs; (2) when it is doubtful whether both kidneys exist and are in good functional activity; (3) in cases in which we know that the disease is renal but are uncertain as to whether it involves one or both kidneys, and if only one, which one; (4) in cases in which we are quite certain that one kidney is diseased, but are uncertain as to the state of the second kidney; and (5) when it is required to break up a clot of blood or mucus impacted in and obstructing a ureter." The author strongly protests against the routine employment of ureteral catheters and bougies for diagnostic purposes, and emphatically condemns ureteral catheterisation and irrigation as a mode of treating hydro- and pyonephrosis and ureteral stenosis. In most cases of nephrectomy the other means of investigation at our disposal are thought to be sufficient to diagnose the presence and functional activity of the second kidney.

The account of the other procedures in connection with the ureter are full of interest, and ought to be read by anyone who wishes to be informed of the present state of knowledge of this branch of surgery.

The work as a whole may be recommended to the student as a systematic, clear, detailed, and modern account of the subjects dealt with.

OUTLINES OF GYNÆCOLOGICAL PATHOLOGY AND MORBID ANATOMY.  
By C. HUBERT ROBERTS, M.D., F.R.C.S. Price One Guinea.  
(J. & A. Churchill.)

Few books dealing solely with the pathological side of gynæcology have hitherto been published in the English language; nor, so far as we are aware, had any recent attempt been made to collect together and put into a form convenient for reference the results of recent work in the science. This Dr. Roberts has essayed to do, and he has done it in such a manner as to deserve the gratitude of all interested in this particular branch of our profession. The book bears evidence of wide and extensive reading, and of much patient labour; it is admirably printed, and abounds in beautiful illustrations.

Of this latter feature it is impossible to speak too highly. Dr. Roberts has made a series of drawings which in clearness of delineation, in truth to nature, and in artistic merit are unsurpassed in any modern text-book we have seen. In spite of these many admirable qualities, as a text-book of pathology the work is not to be commended. As a work of reference to teachers, and to others who may wish to consult original papers, it will prove of the greatest value.

The volume opens with chapters on the vulva and vagina, carefully compiled, and for the most part clearly written. These are followed by an account of pelvic inflammation, a subject which always presents difficulties both to the student and to the teacher. The author wisely prefaces his description by some account of the anatomical distribution of the pelvic peritoneum and pelvic veins, but, curiously enough, no reference is made to the important part played by the pelvic fascia in determining the course of a parametric effusion. Surely it is of the first importance to recognise that it is limited by this structure below as definitely as by the peritoneum above. Again we read, "Vessels, nerves, and lymphatics are embedded in it, and tracts of cellular tissue accompany them in their exit from the pelvis, e.g. into the buttock with the great sciatic nerve." This is an error; the nerves lie outside the pelvic fascia, and by it are separated from the pelvic cellular tissue. A parametric effusion may track out of the pelvis along the course of the sciatic or gluteal artery, but not along the great sciatic nerve. Dr. Roberts has followed in the main the teaching of Matthews Duncan and his successors in our hospital, and has drawn freely in this (as, indeed, in almost every other chapter) upon Herman's admirable book. His conclusions are for the most part safe and reliable, but the value of the work is lessened by much loose writing and bad English. Take, for instance, the following sentence from the last paragraph on page 52:—"Such lumps do not need operation, they do not kill; in fact, the prognosis of perimetritis is very good indeed; its mortality is low, removal of the appendages is rarely needed, and the limits of the justifiability of operation rare, as an uncomplicated disease."

Surely the prognosis of perimetritis must always be, to a great extent, dependent upon the cause; it is an error to speak in this way of perimetritis as a disease *per se*. Pelvic peritonitis, like general peritonitis, is but a manifestation or sequela of some pre-existing lesion. What the concluding portion of the sentence quoted means we have been quite unable to discover.

The chapter on "Menstruation and its Disorders" opens with a somewhat startling misstatement. "The mucosa, as pointed out by Williams, really consists of the whole thickness of the uterine wall to the peritoneum, the muscle of the uterus being really an enormous muscularis mucosæ, for the human fetal uterus shows a distinct sub-mucous layer just beneath the peritoneum." This, of course, shows a lack of appreciation of the true significance of Sir John Williams' observations and the deductions he drew from them.

The minor displacements of the uterus are disposed of in four pages. It is true that in many text-books far too much attention is paid to them, but Dr. Roberts has made the pendulum swing a little too far the other way.

"Neither do flexions and versions cause congestion of the uterus; . . . the tightest constriction would not impede the blood-supply above or below it. How much less would a mere flexion do so?" This is perfectly true, but Dr. Roberts fails to mention that important group of cases in which the body is not merely flexed, but is grasped tightly by the utero-sacral ligaments (structures, by the way, which throughout the book are treated with far too little respect); and not only is the fundus of the uterus grasped, but also the tops of the broad ligaments, and thus the veins which run outwards in these structures are occluded. It is impossible to deny that uterine congestion may be produced in this way. No attempt is made to seriously discuss the pathology of the condition in a scientific spirit. This is deeply to be regretted, for with a subject on which many text-

books still in common use teach erroneous doctrine, special care should be taken to give the student right views. This cannot be done by such unscientific writing as the following:—"Pressure symptoms are not, and never will be, produced by mere flexion. The weight of the normal uterus is small enough; it can be bent by post for a penny; yet within the healthy abdomen its weight is still less. The uterus is a floating organ like a cork; the abdominal pressure is negative; everywhere the womb is supported. What pressure symptoms can it cause if it be healthy? It causes none."

Perhaps the best chapters in the book are those which deal with the various forms of new growth of the uterus and ovaries. In these the present state of our knowledge is well summarised, and many new and beautiful illustrations are given.

The chapters on the bladder and urethra and the one on micro-organisms are also worth careful attention.

The value of this book as a work of reference to those engaged in teaching gynæcology is very great, but it is marred by a lack of critical acumen and of balanced judgment. Moreover there is a tendency to support every statement made by a reference to some authority, as though the author disclaimed all responsibility; this makes the book too strongly suggestive of the past-pot and scissous.

We are sorry not to be able to accord this volume a warmer welcome. It lies before us a monument of patient industry, but as a text-book of pathology it is found wanting.

HUMAN EMBRYOLOGY AND MORPHOLOGY. By ARTHUR KEITH, M.D. (Aberdeen), F.R.C.S. (Eng.), Lecturer on Anatomy, London Hospital Medical School. Illustrated, 1902. (Edw. Arnold, London.) Price 12s. 6d. net.

In Dr. Keith's book on embryology there are 315 pages of very interesting material, which to a great extent supplies what is required by the student of anatomy.

The arrangement of the chapters differs from other works on morphology, and the author begins with the development of the face, followed by a description of the nasal cavities and olfactory structures, the development of the pharynx and neck, of the organs of hearing, of the teeth, and of the skin and its appendages. In the latter chapter a concise account of the mammary gland is given, and the lymphatics of that organ are described in detail, especial reference being made to their importance in cancer. There is then a short account of the ovum, its early development, the formation of the membranes, the placenta and umbilical cord, and much has been condensed into a very short space.

After this follows one of the best chapters in the book—on the uro-genital system. Here the prevailing views are very clearly expressed, and there are numerous diagrams, which render the text very easy to understand. In addition great importance is attached to those points that are of surgical character.

A short chapter on the pubo-femoral region, with the formation of the pelvic floor and pelvic fascia, only suffers from being too brief.

In successive articles the author describes the spinal column and back, the segmentation of the body, the cranium, the eye, the brain, and the spinal cord; and here again are some good diagrams, notably one to show the relationship of the cranial nerves to the primitive segments of the head.

The organs of circulation, respiration, and digestion are fully described, and the book ends with an account of the development of the body-walls and limbs.

Throughout the book there are many excellent paragraphs, and the fact that special stress has been laid on the points that are of practical importance to the medical student adds greatly to its value. As Dr. Keith himself expresses it, "clinical utility was the criterion employed."

A word must be said for the diagrams, which, although somewhat roughly produced, are numerous and excellent—many of them original and far superior to those of other books, because the names of the different structures have been added instead of the usual numbers and letters.

The arrangement of the chapters seems at first sight unnecessary, but with regard to the text there is much to praise, and a great quantity of work has been condensed into a short space. We venture to suggest, therefore, that it is a book that is suitable for advanced students rather than for those who are beginning the subject of morphology.

In conclusion, Dr. Keith is to be congratulated on the production of a book with very good type, excellent diagrams, one that to a great extent supplies a pressing want, namely, a book that gives to the medical student a complete and, at the same time, a short account of human embryology.

A MANUAL OF SURGICAL TREATMENT. By W. WATSON CHEYNE and F. F. BURGHARD. Part VI, Section I.

The authors originally desired to complete their work in six parts, but it has been found necessary to subdivide this part into two. This section, comprising the surgical affections of the tongue, mouth, alimentary canal, etc., we consider one of the best of the series.

The article on cancer of the tongue is concise and up to date with regard to the most modern views as to the complete examination of the lymphatic area and removal of all affected glands. For advanced cases a modification of Langenbeck's operation is recommended.

The use of bougies in carcinoma of the œsophagus is denounced, except for purely diagnostic purposes. With this we are quite in accord.

In the after-treatment of torticollis, after division of the sternomastoid, a modification of Sayre's apparatus is recommended, with one strap only from the region of the mastoid process to the anterior axillary region. Experience has proved to us that this band alone is quite insufficient to keep the head in the desired position.

The usual method of opening the abdomen by a median incision is abandoned in favour of one slightly laterally situated, on the ground that better union occurs in a muscular area than in a fibrous one. Each layer of the abdominal wall is sewn up separately.

Those chapters which deal with the surgery of the stomach will perhaps be received with the greatest favour. "Gastric ulcer" alone occupies fifty-seven pages, and the illustrations in connection with this part are above the average. The best methods of intestinal anastomosis are well and clearly described.

In intussusception the authors recommend that laparotomy should be combined with the injection of hot milk. This fluid is preferable to water because it leaves a nutritious material in the bowel, which may help to overcome the shock. It is stated that the injection will occupy ten to fifteen minutes before any distinct effect is seen. This waste of valuable time will not commend the method to many surgeons.

Under chronic intestinal obstruction from fecal impaction it is said that the most efficient agent for the expulsion of the accumulated material is the faradic current, one electrode in the rectum, the other over the fecal mass. Failing this, laparotomy is advised with kneading of the colon and forcible expulsion of its contents. Neither of these methods will be regarded favourably.

Appendicitis and hernia receive rather scant attention; each, however, will repay the reading.

Dr. Otto Grünbaum contributes excellent articles on rectal feeding, test-meals, and leucocytosis.

The Bahere Lodge, No. 2546.



MEETING of the Bahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, May 13th; W. Bro. P. S. Abraham, M.D., W.M., in the chair. Bros. Harke, Yetts, and Dunn were raised to the degree of Master Mason; Messrs. Thomas B. A. Haggard and Charles James Ogle, M.R.C.S., L.S.A., were initiated into Freemasonry; while W. Bro. F. T. Vaisey, M.R.C.S., L.S.A., was elected a Joining Member of the Lodge. W. Bro. G. H. R. Holden, M.D., was unanimously elected W.M. for the ensuing year, while W. Bro. Clement Godwin, M.D., was re-elected Treasurer. A grant was made of One Guinea to the Home for the Dying. A number of brethren afterwards dined together.



## Calendar.

- May 20.—On duty. Sir Lauder Brunton and Mr. Cripps.  
 21.—S.B.H. Tennis Club v. Gravesend, at Winchmore Hill.  
 22.—S.B.H. Christian Association, Rev. Preb. Webb-Peploe.  
 23.—On duty. Sir Wm. Church and Mr. Langton.  
 23.—Clinic by Sir Dyce Duckworth.  
 24.—S.B.H. Tennis Club v. Dulwich Park at Dulwich.  
 24.—S.B.H. Cricket Club v. M.C.C. at Winchmore Hill.  
 26.—Special lecture by Dr. Ormerod.  
 27.—On duty. Dr. Gee and Mr. Marsh.  
 28.—S.B.H. Tennis Club v. R.I.E.C., at Egham.  
 28.—Clinic by Mr. Rutlin.  
 29.—S.B.H. Christian Association Annual Meeting.  
 29.—S.B.H. Tennis Club v. Hornsey, at Hornsey.  
 30.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 30.—Clinic by Dr. Hensley.  
 30.—Examination for Matthews Duncan Medal.  
 31.—S.B.H. Tennis Club v. Wimbledon, at Wimbledon.  
 31.—S.B.H. Cricket Club v. Ealing, at Ealing.  
 June 2.—Special lecture by Mr. Bruce Clarke.  
 3.—On duty. Dr. Hensley and Mr. Walsham.  
 4.—S.B.H. Tennis Club v. Albemarle, at Beckenham.  
 4.—Clinic by Mr. Butlin.  
 5.—S.B.H. Christian Association, Col. Wroughton.  
 6.—On duty. Sir Lauder Brunton and Mr. Cripps.  
 6.—Clinic by Sir Lauder Brunton.  
 7.—S.B.H. Tennis Club v. St. Andrews, at Winchmore Hill.  
 7.—S.B.H. Cricket Club v. Waldegrave Park, at Winchmore Hill.  
 9.—Special lecture by Mr. Bowly.  
 10.—On duty. Sir Wm. Church and Mr. Langton.  
 11.—S.B.H. Tennis Club v. Dulwich Park, at Winchmore Hill.  
 11.—S.B.H. Cricket Club, Past v. Present, Winchmore Hill.  
 11.—Clinic by Mr. Walsham.  
 12.—S.B.H. Christian Association Missionary Meeting.  
 13.—On duty. Dr. Gee and Mr. Marsh.  
 13.—Clinic by Sir Lauder Brunton.  
 14.—S.B.H. Tennis Club v. R.I.E.C., at Egham.  
 14.—Cricket Club v. Addlestone, at Addlestone.  
 16.—Special lecture by Dr. Lewis Jones.  
 17.—On duty. Sir Dyce Duckworth and Mr. Butlin.

## Examinations.

## First Examination.

*Chemistry.*—J. M. Eckstein, M. B. Griffin, R. H. Haines, S. Vosper, L. D. Ching, D. E. S. Davies.  
*Practical Pharmacy.*—K. D. Bell, E. S. Ellis, W. H. Harvey, H. P. Margetts, J. Morris.  
*Elementary Biology.*—J. M. Eckstein, M. B. Griffin, R. H. Haines, M. Onslow Ford, C. E. H. Adam, R. M. Donnys, H. M. Grey, J. H. Gurley, T. A. Izard, W. R. Kigone, F. W. O'Connor, R. D. O'Connor, G. F. Page, L. L. Phillips.

## CONJOINT BOARD.

The following have completed the examinations for the diplomas of M.R.C.S., L.R.C.P.:  
 H. J. Slade, R. A. S. Gunderland, E. W. Almont, A. M. Amsler, J. Corbin, Saul W. W. Wingate, G. Pereira, N. E. Waterfield, A. Levy, W. P. Miles, T. Howell, A. K. H. Pollock, J. H. Wroughton, H. H. Butcher, G. H. Low, J. M. Bennion, W. W. Jeudwine, R. M. Ranking, G. E. Loveday, C. L. Nedwill, E. L. Farncombe, R. C. Wilmot.

## Second Examination.

*Anatomy only* (four years' regulations).—J. W. W. Hogan.

## UNIVERSITY OF CAMBRIDGE.

## Third Examination.

*Surgery and Midwifery.*—H. W. Atkinson, E. A. A. Beck, H. N. Burroughes, H. H. Dale, J. F. H. Dalby, G. G. Ellett, H. N. Gould, C. H. Gregory, B. Hudson, P. W. Leathart, H. D. Ledward, H. Satham, F. Whitaker.

*Medicine.*—C. F. Alexander, J. M. Bennion, F. R. Carrol, R. L. V. Foster, W. W. Jeudwine, G. E. Loveday, J. McBryde, C. de C. Palfier, G. H. L. Whale, W. W. Wingate Saul.

Dr. Sykes, of Barnsley, has passed the examination for the Fellowship of the Royal College of Surgeons, Edinburgh.

## Appointments.

CARPENTER, E. G., F.R.C.S., appointed Civil Medical Officer to the South African Field Force.

COOK, J. B., M.B., Ch.B. (Vict.), M.R.C.S., L.R.C.P., appointed Junior House Surgeon at the Oldham Infirmary.

JESSOP, W. H., F.R.C.S., appointed Ophthalmic Surgeon to the Foundling Hospital.

LEONARD, N., M.R.C.S., F.R.C.P., appointed Surgeon to the R.M.S. "Rakaia."

SLADE, H. J., M.R.C.S., F.R.C.P., appointed Junior House Surgeon to the Wigan Infirmary.

STONE, G. W., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Hospital, Portsmouth.

WEST, J. A., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Royal Free Hospital.

WHITING, R. G., M.R.C.S., L.R.C.P., appointed Surgeon to the St. Illaro.

## New Addresses.

BENNETT, F. D., 20, St. James's Place, S.W.  
 CRUME, J. A., Park Lane, Welshpool.  
 HOLST, D., 6, Brook Street, Hanover Square, W.  
 HUGO, Capt. J. H., Nepal, India.  
 LAWRENCE, L. A., 9, Upper Wimpole Street, W.

## Birth.

MEAKIN.—At Cambridge, on the 25th March, the wife of Captain Harold Meakin, M.D. (Lond.), Indian Medical Service, 2nd Bengal Lancers, of a son.

## Marriages.

ADDISON—GRAY.—On Tuesday, 25th March, at Trinity Presbyterian Church, Kensington Park Road, by the Rev. Hugh Falconer, M.A., B.D., Christopher Addison, M.D., F.R.C.S., youngest son of the late Robert Addison, sen., of Stallingborough, Lincolnshire, to Isabel, youngest daughter of the late Archibald Gray, of 37, Holland Park, W., and of Mrs. Gray, St. Mary's Tower, Birnam, Perthshire.

HUGO—DEMPSTER.—At the Cathedral, Calcutta, on the 10th March, 1902, by the Rev. Canon Lockman, Capt. James H. Hugo, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P., D.S.O., Indian Medical Service, to Muriel, eldest daughter of Col. C. Dempster, late Commanding 4th Sikhs Punjab Frontier Force.

SMITH—COLTHURST.—On April 10th, at St. Thomas's Cathedral, Bombay, by the Rev. Canon Hill, M.A., Capt. Frank Addinell Smith, M.B., B.S., M.R.C.S., L.R.C.P., Indian Medical Service, eldest son of George Richard Smith, of Torquay, to Mary Bernard Dorothy, younger daughter of the late James Colthurst, LL.D., of Cork.

## St. Bartholomew's Hospital



## JOURNAL.

VOL. IX.—No. 8.]

MAY, 1902.

[PRICE SIXPENCE.]

## NOTICE.

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

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

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

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

## St. Bartholomew's Hospital Journal,

MAY, 1902.

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

## On Bonesetters and Displacements of Tendons.

*A Clinical Lecture delivered by Mr. HOWARD MARSH on  
 May 7th, 1902.*

(Reported by J. D. HARTLEY.)



ENTLEMEN,—In practice you will encounter disappointments, checks, and worries. "Man is born to trouble as the sparks fly upward." One great bugbear that you will meet is the bonesetter. He is always at the surgeon's elbow, and no one can get away from him. It is well to look this question in the face, and to see how we stand in regard to it; and it will at once

be seen that the regular practitioner is at a disadvantage. He is a member of a profession which is made up of scientific responsible men, who have the honour and credit of their profession at heart, and their own personal character and ability to vindicate. The surgeon wishes to do the best that he can for his patient. The bonesetter is a free lance; he has no profession, no trammels, and he is held back by nothing. He delights in saying, "I know no anatomy." A famous bonesetter used to say, "I know nothing about anatomy. I can cure you, what more do you want?" The bonesetter not rarely makes cures in cases in which the careless surgeon fails. He is haphazard in his method, and trusts to fortune. He goes at it straight; and for one case that he cures he perhaps damages three or four. Yet he may be perfectly conscientious. He considers that there are two separate and distinct branches of healing,—1, surgery; 2, bonesetting. His view is that he knows bonesetting, the surgeon knows surgery. He is fond of saying that the surgeon knows all about the big bones, but he knows nothing of the little ones; and he often makes his position secure and assured by asking the patient for a certificate of indemnity, so that if anything goes wrong he will not be held responsible. A patient comes with an injury to the ankle which has been treated by a surgeon without much benefit. The bonesetter says "the small bone of the ankle is out," and he will put it in, but the foot has been so improperly treated that it is now a very bad case. If he (the bonesetter) had been consulted at first all would have been well, but now something very serious is the matter; so the patient signs the paper, and thinks it is quite fair. In this way, you see, the bonesetters have the advantage.

What sort of people are these bonesetters? They are often well-meaning and honest, but they are quite untrained. A few years ago a bonesetter made statements which induced a patient to bring an action against a doctor for malpraxis. The counsel for the defence handed the bonesetter a tibia and fibula, and asked him to articulate them. This the bonesetter could not do. So he was asked, if he

had been to a bonesetter, who had put something "in," and the boy was quite well in a week. A year after the patient was again seen in the same condition as at first. Taking the cue from the bonesetter the limb was manipulated under an anæsthetic, and he was soon quite well.

This was probably a very rare instance of slipping of one of the tendinous divisions of the obturator internus muscle.

The long tendon of the biceps, you remember, passes between the two tuberosities of the humerus. The lesser of the tuberosities is the more prominent. If in the act, for instance, of wringing clothes, the humerus is forcibly rotated out, by the biceps acting as a supinator, the tendon may slip over the inner tuberosity. If not replaced it may acquire a new attachment to the bone. The points in respect to diagnosis are—

1. The forearm is kept flexed in order to relax the muscle.
2. The arm cannot be rotated inwards.
3. Much pain, and sometimes tenderness on pressure over the tendon.

I have never seen one of these cases in practice.

A patient complains of something slipping over his knuckle. This is the extensor communis digitorum slipping to one side or the other as the finger is flexed and extended. In a recent injury the prognosis is usually good if the finger is kept extended on a splint for three weeks.

A girl was looking out of a second-floor window when she suddenly twisted her head in order to look up at her brother at a third-floor window. Her head became suddenly fixed in that position.

A boy was washing one morning, and on twisting his head it suddenly became fixed, and he was unable to move it.

A man was riding a horse in a race, and was leading. He turned his head for a moment to see how near his opponent was, when his head became fixed, and he finished the race looking back over his shoulder.

In all these cases, what happened was that one of the small tendons which are inserted into the prominent tubercles of the transverse processes of the cervical vertebrae slipped out of place.

The treatment consists in putting the patient under the influence of an anæsthetic, and kneading the deep muscles in the side of the neck, and moving the head freely in all directions. I have set right two cases of the kind in this manner.

The muscles mentioned are those which are likely to become displaced. They are muscles which do not run a straight course.

Muscles such as the brachialis anticus, the rectus femoris, and the adductor longus, and many more which run in a straight course, cannot become displaced.

## Hepatic Uræmia and Fibrous Degeneration of the Heart.

A Clinical Lecture by DR. GEE.

(Reported by F. A. BAINBRIDGE.)



Fibrous degenerations (or scleroses), which are the commonest of all morbid changes, the proper parenchyma of the organs wastes, and the interstitial connecting fibrous tissue increases. Examples of such changes are to be found in cirrhosis of the liver, granular kidney, grey induration of the lung, fibrous degeneration of the heart, arterial sclerosis, and sclerosis of the nervous organs.

The first instance of this change which I shall describe is a case of cirrhosis of the liver. The patient, J. A.—, aged 49 years, was admitted to Luke on January 28th, 1902, and died on February 28th. The post mortem examination showed that the liver weighed 38 oz., was very small, and showed very advanced cirrhotic changes. Its surface was much hobnailed, with green and blue discoloration in places. The section revealed many interlobular strands of fibrous tissue; the portal vein was entirely free from clot; the gall-bladder contained thin bile; no gall-stones were present. The spleen weighed 23 oz., and was very large and soft. The kidneys weighed 16 oz.; their capsules were not adherent, and there was no interstitial change.

The morbid changes in the liver were very extreme, and must have been going on for years, yet the man did not notice anything wrong until his feet began to swell, six weeks before admission. These sclerotic diseases are very insidious in their onset, very slow in progress, and very latent as regards symptoms; thousands of people going about their business have cirrhosis of the liver, contracted granular kidney, and so on.

The patient, however, had noticed that his urine had been dark for six months; and in the earlier stages of cirrhosis it is common for the urine to be scanty, with an abundant deposit of urates, highly coloured by urobilin, which is often passed in large amount.

The swelling of the feet, which was otherwise the first symptom, is not infrequent as an early symptom of cirrhosis of the liver, and often precedes the ascites. The oedema begins about the ankles, and spreads upwards until all the parts of the body below the navel are swollen. It may be described as *lyposarva*. It is probably due to stagnation of blood in the inferior vena cava; but one does not know why this occurs.

Four weeks before admission the belly swelled, and the ascites gradually increased.

Two weeks later the patient had an epileptiform attack, in which he lost consciousness and fell down. When he regained his senses his hands were very weak, and trembling

violently. His speech was affected for two days, but he understood what was said to him. At the same time his skin was noticed to be yellow.

On admission.—The conjunctivæ were slightly yellow. The urine was of a deep colour, and contained much urobilin, but no bile. The abdomen was much swollen, and dilated veins were visible. The navel was protuberant, but no fluctuation could be detected, and there was only slight percussion dulness in the flanks. No organ was palpable. The legs, penis, and scrotum were dropsical. Small ecchymoses were visible in the skin of the neck.

On the day after admission the patient passed into a state of coma without convulsions.

These nervous symptoms, namely, coma and convulsions, exactly resembled those met with in kidney disease, and were undoubtedly due to impurities in the blood. It may be noted that the serum of uræmic blood, when injected into healthy animals, is said to be very poisonous. On the other hand, the urine in cases of chronic nephritis is less poisonous than healthy urine.

The difficulty in supposing that uræmia is due to arrest of the excretory functions of the kidney is found in the fact that in mechanical suppression of urine (anuria) the symptoms which occur do not resemble those of uræmia, and especially noticeable is the absence of coma or convulsions. We must conclude that the nature and source of the uræmic poison are unknown.

In the case of this patient, although he presented the symptoms of uræmia, yet his kidneys were healthy. It seems, therefore, that disease of the liver may lead to uræmia; this condition has been called by Debove "hepatic uræmia." Perhaps it may be partly explained by the fact that one function of the liver is to arrest poisons absorbed from the alimentary canal.

Hepatic uræmia is quite distinct from the malignant jaundice (icterus gravis) which occurs in some liver diseases, e.g. acute atrophy of the liver and hypertrophic cirrhosis. In icterus gravis there occur deep jaundice, delirium, hæmorrhage from all parts of the body, albuminuria, pyrexia. The patient (J. A.—) was not febrile during his attacks of coma; indeed, his temperature was subnormal throughout the disease until a few hours before death. He was treated as if uræmic, and with temporary success, on the principle that the treatment should be directed to the elimination of the supposed poison.

The abdomen was tapped, and about six pints of fluid were withdrawn. He was fed on as much whey as he would take. Pilocarpine was several times injected subcutaneously, and aperients were given. When the liquid was drawn off the liver and spleen could not be felt.

In three days the patient became much more conscious. His urine, however, was still passed involuntarily, so that its total quantity could not be estimated; but what was saved

contained 4 per cent. urea, so that probably there was no failure in the excretory power of the kidneys.

A fortnight later he again became comatose; he was treated in the same way, and in a day or two became quite conscious and better in all respects. A week later, February 24th, he became half comatose for the third time; pilocarpine was injected; the patient sweated profusely, and on February 26th was quite conscious. On February 27th he became drowsy, and by the following morning he was quite comatose for the fourth time. His temperature, which had hitherto been 97° or 98°, rose to 101° just before death.

The abdomen, which was much distended, was again tapped, but only a few ounces of blood-stained serum were withdrawn. Treatment was unavailing, and the coma continued, with laboured breathing, until death occurred on February 28th.

The second case was W. C.—, æt. 47 years, who was admitted to Luke on February 15th.

On admission he was suffering from orthopnoea, with constant shortness of breath, and occasional attacks of severe dyspnoea; pain in the front of the chest, and occasional palpitation of the heart. The fits of dyspnoea sometimes were at intervals of a few weeks, sometimes were twice a day, sometimes woke him up in the night, and were brought on by flatulence or exertion, or without obvious cause. They began suddenly with epigastric pain, followed by a suffocating feeling in the same region, and lasted three or four minutes, but complete recovery did not occur for several hours; there was no pain.

His pulse was irregular, very weak, and sometimes hardly perceptible.

The patient stated that the dyspnoea and palpitation began eighteen months previously.

There were hardly any physical signs relative to the heart; the impulse was impalpable, the sounds weak and irregular, no murmur was heard, and there was no evidence of dilatation.

There was no evidence of any valvular obstruction, and the symptoms clearly pointed to inability of the heart to do its work. It was therefore a reasonable conclusion that the active power of the heart was at fault; and this power resides in the muscular tissues of the heart. A diagnosis was made of "degenerated myocardium."

There are two main forms of myocardial degeneration—fatty and fibrous; the former is more common, but there is no means of distinguishing between them.

The symptoms related mainly to the left side of the heart, and there was no dropsy or other evidence of stagnation in the right heart or venous system. The arteries were rigid and tortuous, and post mortem the cardiac arteries were in the same condition of arterio-capillary sclerosis which had possibly caused the degeneration of the myocardium.

His urine was scanty, very albuminous, and contained casts, and the patient was presumed to be the subject of chronic nephritis, such as is almost always associated with arterio-sclerosis. He had been subject to gout for fifteen years, and had a tophus in the pinna of one ear. He died suddenly.

The post-mortem examination showed that the walls of the heart were very thick, pale, tough, and fibrous; its cavities were much dilated. The valves were natural and competent, the aorta natural, and there was very little atheroma anywhere.

Microscopic examination of the heart showed that the bulk of the heart was made up of fibrous tissue with muscular fibres scattered through it. The kidneys were large, very firm, and the surface was slightly granular.

There is a diathesis (or tendency to some special form of disease) which is very common, but for which it is difficult to find an appropriate name, because we do not understand its nature or its essence. Among the diseases related to or dependent upon this diathesis are gout, gravel, obesity, diabetes, eczema, emphysema of the lungs, chronic nephritis, and arterio-capillary sclerosis. For want of a better name these diseases are often called gouty, but gout is only one form of this diathesis.

The sequence of events in the patient was gout, arterial sclerosis, chronic nephritis, fibrous degeneration of the heart.

### The Treatment of Chronic Suppurative Disease of the Middle Ear by the Complete Mastoid Operation.

A Clinical Lecture by A. E. CUMBERBATCH, F.R.C.S.

**W**ING to our increased knowledge of the exact anatomical relations of the parts involved, and to the great improvements in the details of the operation itself, it is now much easier than it was some time ago to decide when it is advisable to expose the mastoid antrum, and throw the iter, attic, and tympanum into one cavity for the cure of chronic suppurative disease of the middle ear.

Theoretically the operation should be performed in every case of chronic discharge in which all simpler means of treatment have been fairly tried and have failed. For what length of time these simpler means should be tried will depend largely on the temperament and experience of the surgeon, and on the special conditions of the individual ear. But although theoretically the question of an operation seems easy enough to answer, yet practically it is not so easy.

Hence, in the present state of our knowledge, it may be useful to mention certain groups of cases in which, speaking generally, radical measures are either inexpedient, or should not be undertaken too hastily.

1. There is a group where the whole or greater part of the membrana tympani has been destroyed, and the mucous lining of the tympanic cavity is greatly hypertrophied (polypoid in fact), but there is no obvious bone disease.

Irrigation, astringent lotions, drying powders, as well as the application of caustics, frequently fail to arrest the discharge; yet a considerable proportion of these cases can be cured by the judicious application of the galvanic cautery.

2. There is another group, in which there is frequent recurrence of the discharge on slight provocation, although the discharge is on each occasion readily arrested. Sometimes there is a permanent perforation of the membrana; in others the perforation closes as soon as the discharge ceases.

Notwithstanding the readiness with which the discharge yields to treatment, many surgeons are of the opinion that the lives of such patients are in considerable danger, and that in all such cases the right treatment is to operate without delay. The majority of the patients here referred to are young, and each recurrence is in the nature of an acute attack. By careful attention to the general health, and by appropriate treatment of the naso-pharynx and ear, the discharge recurs at longer and longer intervals, and ultimately ceases altogether. I have never in a single instance seen grave symptoms arise where such patients were skilfully looked after. Let me add that the frequent recurrence of discharge in those no longer young is a source of grave danger, but here there are generally other indications which determine the advisability of an operation.

3. There is another group where the question for or against an operation is a more difficult one to decide, and should not be too hastily answered in the affirmative.

These are cases of discharge from both ears, in which the hearing is excellent, and there are no symptoms calling for operative interference beyond the discharge. This is neither abundant nor offensive as long as the ears are kept clean, but all attempts to entirely arrest it fail. A simple opening into the mastoid antrum will probably not stop the discharge, and in unskilful hands will considerably impair the hearing. If a complete mastoid operation is performed, it may, and probably will stop the discharge, but it will almost certainly impair the hearing. In such cases, in the absence of positive proof of disease of the bone, it is wiser not to operate.

It must not be imagined that the difficulty under consideration is more or less academic. Such patients are fairly numerous, and the surgeon, in his eagerness to effect a cure, may occasionally forget that, after all, the primary use of an ear is for hearing.

Having briefly referred to the group of cases in which on

the whole I deem it inadvisable or unnecessary to operate, I now turn to the easier task of indicating those in which an operation is not only advisable, but often imperative. No one, I imagine, would hesitate to perform a complete mastoid operation, as a preliminary to further operative measures, where well-marked symptoms of threatened intracranial mischief were present; and yet, if such mischief is to be prevented, the operation must be undertaken in many instances where no urgent symptoms exist, for such operation is meant to be preventative as much as curative.

For instance, in some of the cases of the second group the onset of the discharge is invariably preceded by malaise, slight headache, and rise of temperature, and occasionally mastoid tenderness or discomfort. Although these symptoms usually subside on the establishment of the discharge, they yet indicate very clearly the probability of deep-seated mischief, which may at any moment lead to fatal complications unless radical measures are adopted. When, therefore, there are recurring attacks of this nature, operate.

Again, one sees a certain number of patients who, having experienced no trouble from a "spoilt ear" for many years, beyond an occasional discharge, comparatively suddenly develop marked symptoms of labyrinthine vertigo. It is evident in such cases that either inflammation is spreading to the labyrinth, or some accumulation is exerting undue pressure in that region. If, therefore, simpler remedies fail to afford relief, operate.

There are yet other cases of intermittent discharge where an examination of the meatus reveals masses of sodden epidermis, on the removal of which small granulations are often seen. Inquiry also elicits the information that white shreddy particles are constantly removed by syringing. If this condition is found recurring, though the usual methods of treatment have been pursued, there is great probability of the presence of cholesteatomatous accumulations in the tympanic cavity, and possibly in the mastoid. The danger of delay in such cases is obvious.

It is in "attic" disease, perhaps more than in any others, that the greatest difficulty arises in deciding as to the advisability of an operation. Where a granulation protrudes through the perforation, and is not speedily destroyed by cauterisation or curetting, we should probably best consult the safety of the patient by early recognising the slender chance there is of effecting a cure by any measures short of the radical one. In this class of cases a cure is often effected by ossiculectomy with curetting of the diseased area. This may, therefore, be tried before more radical measures are adopted. Finally one is consulted, at long intervals, for periodic attacks of severe mastoid pain following an attack of purulent catarrh. The cases to which I am referring are peculiar in that the pain commences some time after all signs of mischief in the ear have ceased. There may be a perforation of the membrana, more often there is not, nor is there any proof beyond the

patient's word that there ever has been any discharge from the ear; the hearing, too, may be good. Sometimes the patient affirms that at intervals there is a sensation of discharge passing into the throat from the region of the Eustachian tube, at times offensive to taste. These patients are invariably neurotic, and it is extremely difficult, and sometimes impossible, to be certain whether the pain is only neuralgia chiefly confined to the region of the mastoid, or is due to sclerosing otitis of that bone. When it is possible to make approximately an accurate diagnosis of sclerosing otitis, relief is afforded by a radical operation.

The laws governing vital processes, unlike physical ones, are at present too obscure to permit anyone to dogmatise on the exact course inflammation in a particular area will pursue. Each of us, while drawing largely on the experience of others, must ultimately decide from his own experience what line of treatment seems best in any given case.

I have tried in the remarks I have made to point out the chief indications for your guidance—when to operate and when not to. In the present state of our knowledge it is not possible to lay down definite rules.

In conclusion, let me say that the operation, perfect as it is, is not so easy as it looks. It is often difficult even in skilled hands. It requires lightness of touch, as well as knowledge of anatomical relations. The antrum, although present, is often deeply situated, and if small may be missed; and sometimes the floor of the cranium is so much depressed that it is well-nigh impossible to avoid opening the cranial cavity when removing the outer wall of the attic and aditus. The two chief dangers are wounding the lateral sinus and injuring the facial nerve.

[Mr. Cumberbatch then described in detail the complete mastoid operation, including subsequent skin-grafting, illustrating the various stages of the operation by lantern slides. He also showed by dried specimens and lantern slides the various anatomical relations of the tympanic cavity.]

### On Ophthalmic Treatment and Therapeutics.\*

An Introductory Lecture by WALTER H. JESSOP.

**I**N taking the subject of ocular therapeutics for my introductory lecture this year, I wish to present it to you on the broadest lines possible. It has always seemed to me that "treatment" is never enough taught and classified on anatomical and physiological principles. We are too prone to invoke a simple for every disease,—nay more, two or three for each. To some practitioners it would seem that the only drug known in ophthalmic work is atropine, and it is used as a heaven-sent specific for all diseases or conditions of the eyes.

\* Introductory Lecture to Course on Ophthalmic Medicine and Surgery, May, 1902.

It has certainly the merit of making the patient appreciate the fact that something is being done for him, as the inconvenience of not being able to use the eye for three or four days for near work is unpleasantly apparent to every one treated with atropine. But this inconvenience to the patient is as nothing compared to the evils its indiscriminate use may entail in the production of glaucoma, which I have seen several times follow its application to an eye affected with slight conjunctival congestion. The worst case of glaucoma I have ever seen was induced by one such application.

The eye, from the ease with which pathological changes can be seen in it, is perhaps the organ on which the effect of drugs can be best appreciated and the action of most of the so-called specifics demonstrated failures. I remember, as if only heard yesterday, one of Dr. Gee's terse clinical sayings on specifics, delivered when I was clerking for him: "I know only two drugs worthy of the name of specifics—mercury for syphilis and quinine for ague,—and the latter is not always a specific."

First I will ask you to consider the methods of giving rest to the eye. The greatest, perhaps, and, as far as I know, the shortest lecture ever delivered in this Hospital was given by Abernethy one evening. Entering the crowded theatre and sitting in silence for a minute or two in his celebrated arm-chair, he looked up and said, "Gentlemen, keep diseased parts quiet; that is all," and then left the theatre, amidst a storm of applause from the assembled students. Those few words were the origin of Hilton's famous work on *Rest and Pain*, and are the Key-stone of Conservative Surgery. To apply them to ophthalmic medicine and surgery I would ask you to consider the local and general conditions to be overcome. Locally, we have to limit and stop the movements of the lids and of the extrinsic and intrinsic ocular muscles, and to shut out light from the sensitive nervous portions, as the retina and the optic nerve.

I would impress on you that, owing to the great activity and close association of the co-ordinated movements and reflexes of the eyes, it is impossible for one eye to be absolutely at rest unless its fellow-eye is so also.

The main factors to be attended to in the general constitutional treatment are primarily the circulation, especially that of the head, and also any condition inducing nerve irritability.

To ensure complete rest to an eye it is necessary that both eyes should be bandaged carefully, so as to prevent the working of the extrinsic muscles of either eye. Light must be kept from entering the eyes, and to do this as far as possible, a graduated pad of cotton wool must be placed over each eye before the bandage is applied. The days of dark rooms are past, I hope, as a routine in the treatment of eye disease; one can always subdue or cut off light by tinted glasses, goggles, or a proper bandage. Light and

air are as necessary for the welfare of the ophthalmic patient as they are for patients suffering from other diseases.

But bandaging and exclusion of light does not necessarily give complete rest to the eye. The intrinsic or intra-ocular muscles, the pupillary and ciliary muscles, may still be active, and these must be placed at rest by atropine or some other mydriatic. Also the circulation of the eye ought to be rendered as far as possible equable, and this can only be done by putting the patient in bed and controlling the general circulation and condition. You should always remember that many of your worst hospital cases come here tired out from want of sleep, exhausted from need of proper and wholesome food, and scarcely able to keep body and soul together. The change that even a night's rest in the healthy and genial atmosphere of our wards, assisted often by a dose of house physic and followed by nutritive food, can make in a broken-down patient is extraordinary. No class of case demonstrates this better than commencing glaucoma, and I have often seen all the symptoms disappear by the morning after such treatment.

This, of course, is an extreme way of inducing complete ocular rest, but it will remind you that in treatment you must remember the general condition of the patient as well as the local methods of treating the eye. It would be almost useless to treat a case of iritis by instilling atropine into the eye unless the general conditions of the patient were at the same time attended to.

In cases needing less complete rest the treatment may be efficaciously carried out by keeping only the affected eye at rest. Take, for example, a case of slight corneal abrasion, which is as a rule a very painful condition; here a carefully applied bandage will give often complete relief without any other treatment.

Less complete rest than that afforded by bandaging the eye may be obtained by the use of shades, tinted glasses, or goggles. Shades are frequently of great service where subdued light is needed. The most efficacious are those shading both eyes, and made of cardboard covered with silk, of stout dull paper, or of black plaited straw. They ought to cover and protect the eye above, in front, and at the sides.

Tinted glasses afford great relief and rest to the eyes in many diseases, and are usually a neutral grey or blue in colour. They vary in tints from a very slight shade of grey or blue to an almost black (electric), and very dark blue. The blue tints make everything appear very cold in hue, and are chiefly used when the quality of the light is to be subdued. The grey have not such a depressing effect, and are ordered when the quantity of light needs reduction. A special kind, called peacock-green or spectrum-blue spectacles, are to be recommended in diseases of the retina, choroid, and optic nerve.

(To be concluded.)

### A Case of Severe Internal Hemorrhage.

A NOTE ON THE BILATERAL SWELLING OF THE PAROTID AND SUBMAXILLARY SALIVARY GLANDS DURING THE INTRA-VEINUS INJECTION OF NORMAL SALINE SOLUTION.

By S. R. SCOTT, M.B.(Lond.).



T—was a page boy in an hotel. According to his mother he was an active and clever boy, for he had won a scholarship worth £25 when at school. Owing to strained circumstances at home, however, he had to give up the scholarship, and seek employment as a page boy. About half an hour before admission into the Hospital he stepped into a lift as it was moving. He slipped, and his body at the waist was jammed between the car and the shaft of the lift. On being extricated he was carried to the Hospital, and admitted to Sitwell Ward under the care of Mr. Butlin, who was on duty.

When admitted into the ward at 7.30 p.m. the patient was very blanched, and was unable to move his lower extremities. The lips and conjunctiva were bloodless. There was no pulse felt at the wrist. The respiratory movements were regular, but were performed with difficulty. He said he could not breathe, and kept saying, "Doctor, can't you make me breathe?" He lay on his back tossing his head and arms restlessly, but never moved his legs. He was, however, very talkative, and asked that his legs might be moved for him. He was able to give his name and address, and to give an account of the accident. He could not feel a needle thrust into the skin of the abdomen below the umbilicus, or when it was thrust into the legs. Although the back felt unusually supple, there was no deformity of the spinous processes of the vertebrae, and no crepitus was found. The skin over the lower part of the back and buttocks was abraded, but there was no actual external wound anywhere.

In the head, neck, and thorax no lesion could be found. There was no wound in the mouth. The abdomen was a little distended, and there was a transverse contusion at the level of the umbilicus. In front the percussion note was natural, but there was dullness in both flanks. The liver and spleen were not palpable. The bladder was not distended. Rapidly the signs of shock increased, the extremities felt cold and clammy, and the respirations became irregular. He once complained of thirst, and asked for a drink. At 8.45 p.m. normal saline solution (one drachm to the pint of water), at a temperature of 110° (Fahr.), was injected into the left median cephalic vein. By 9 p.m. nearly three pints of the fluid had been injected. The skin felt warm and dry. The pulse at the wrist was 136 per minute, and there was a trace of pink colour in the lips. The parotid and submaxillary salivary glands began to swell rapidly, so that they formed prominent firm tumours perfectly symmetrical, and the outline of the glands could be distinctly seen on the surface. But the patient did not get well. At 9.15 p.m., when four and a half pints of solution had been injected, the cannula was removed and the vein ligatured. Soon after this the arms ceased to move, the character of the respiratory movements changed, becoming irregular, and he appeared to become unconscious. Almost suddenly breathing became arrested, then he gave a few sighing gasps, and at 9.30 p.m. he was dead.

The post-mortem examination two days later showed extensive intra- and retro-peritoneal hemorrhage, and a transverse division of the spinal cord at the level of the seventh dorsal vertebra. The enlargement of the salivary glands persisted after death, and their outline was plainly visible on the table. No viscous was lacerated. There was no fracture or dislocation of the spine or pelvis, but the spinal canal was full of blood external to the dura mater. There was a complete division of the cord at the level of the seventh dorsal vertebra. The adjacent part of the cord was quite soft, though its contour was preserved. The rest of the cord was firm, and appeared uninjured. The membranes were intact.

This case is published by Mr. Butlin's kind permission, on account of the peculiar swelling of the salivary glands during the intra-venous injection of the saline solution. Whether it was due to the accumulation of secretory products or to increased blood-supply it is not possible to say; but it would appear to be much more likely due to

the osmotic changes resulting from the large intra-venous injection, and if so may possibly be accounted for in much the same way as is the increase in the activity of the kidneys after infusion.

### A Case of Lipoma of the Ance.

By E. H. HUNT, M.B.(Oxon.).



H—, a woman æt. 53, was admitted to President Ward on April 29th, 1902, complaining of pain in the right ankle and a swelling in front of the right knee. History.—Fifteen years ago she injured the right ankle. Since January, 1902, she has had pain in the foot and ankle. For fifteen years she has also noticed a swelling in front of the right knee. This has given her no pain, and has steadily increased in size.

Present condition.—Both legs are œdematous below the knees. There is slight flat-foot on the right side, and some albuminuria.

Right knee.—There is a globular swelling, about three and a half inches in diameter, extending upwards to the middle of the patella, outwards to the head of the fibula, inwards to half an inch beyond the inner border of the patella, and downwards to the tubercle of the tibia. The skin is normal, and not adherent. The edges of the swelling are well defined. The surface is smooth. The consistency is firm and elastic, and there is a sense of fluctuation all over. The movements of both knees are natural, but there is some creaking. With the right leg extended, on contracting the quadriceps extensor muscle the swelling moves upwards, and is firmly adherent to the ligamentum patellæ.

Diagnosis.—Pre-patellar bursa. Operation.—Vertical incision over swelling. The subcutaneous tissue was readily separated from the capsule of the swelling except for an area about one inch across to the outer side of the ligamentum patellæ. There the capsule was so intimately adherent to the surrounding structures that an opening was made into the swelling with a view to dissecting it out from the inside. The swelling was found to be a lipoma, surrounded by synovial membrane. The pedicle of the lipoma passed upwards under the patella and arose from one of the ligamenta alaria. The pedicle was ligatured and the lipoma removed. The protruded capsule was then cut away, leaving only sufficient to cover in the opening into the joint.

Recovery was uninterrupted, but the pain in the right foot and ankle continues when the patient is up, and the legs are still œdematous after standing.

I have to thank Mr. Harrison Cripps for his kind permission to publish this case.

### On a Case of Post-diphtheritic Stenosis of the Larynx, cured by Thyrotomy.

By H. F. PARKER, M.D.(Cantab.), late House Physician to the Wolverhampton and Staffordshire General Hospital.



SOME notes on the following case may be of interest as illustrating some of the difficulties that are liable to be encountered in the after treatment of a case of diphtheria, where tracheotomy or intubation has been performed.

S. T—, a girl of 11, was admitted into hospital on August 4th, 1901, having been ill for a week previously.

On examination she was found to be suffering from a severe attack of diphtheria, the fauces being swollen and covered with membrane; the glands in the neck were enlarged and tender, but there was no evidence of laryngeal obstruction.

The general condition of the patient was poor, the temp. 103°, the pulse quick.

The urine contained a considerable quantity of albumen—about one third—on boiling.

Shortly after admission she was injected with the anti-diphtheritic serum of the Jenner Institute, receiving no less than 38,000 units between August 4th and August 12th.

In spite of this somewhat heroic treatment her condition became worse, and on August 14th tracheotomy was performed, as a last resort, in order to relieve the exhaustion that was now being caused by obstruction to respiration in consequence of the swelling of the fauces. Though collapsed at first, the patient subsequently rallied; two days later the tube was removed for four hours, and on August 19th it was left out entirely.

She then improved rapidly in general health, but, unfortunately, some two weeks later began to have great dyspnoea, with recession of the chest walls during sleep. This became so serious that on September 4th, after an ineffectual attempt to intubate had been made, it was found necessary to reopen the tracheotomy wound and to insert a tube.

On September 18th intubation was again tried without success, the failure being apparently due to the existence of some stenosis of the larynx. So on this and the following day the stricture was dilated under chloroform by passing various sizes of Lister's urethral silver bougies from below upwards, a fair-sized vulcanite intubation tube being then inserted.

A fortnight later this tube was removed, the patient having been first anaesthetised; on her recovering consciousness, however, spasm of the glottis ensued, and a tracheotomy tube was therefore again introduced.

This process was repeated on more than one occasion with a similar result, the stricture having to be first dilated with flexible pewter bougies, which were found to be more efficient than the silver ones previously employed.

On November 26th it was decided to open the larynx. This was performed under chloroform anaesthesia by prolonging the old tracheotomy incision upwards through the cricoid and thyroid cartilages, the former of which (it may be added) was uninjured at the original operation.

The little hæmorrhage that occurred was easily controlled by pressure.

It was then found that there was considerable stenosis of the larynx opposite the cricoid cartilage, together with much swelling of the mucous membrane close to the vocal cords, and also some cicatrisation at the upper aperture of the larynx. With a small pair of curved scissors all

obstructing tissue was then cut away, including a considerable portion of the vocal cords, it being felt that spasm of the glottis would be likely to again occur were these left intact. A large intubation tube was then inserted, but was found to be valueless, since the lower end of it projected forwards through the wound. It was therefore replaced by a long rubber tube which fitted the trachea tightly, and the upper end of which was brought out through the mouth. A few superficial sutures were then inserted, and the patient was sent back to bed, being able to breathe fairly comfortably through the tube. Three days later the tube was coughed out, but the patient was now able to dispense with it, and, moreover, could phonate fairly well.

Subsequently there was some recurrence of the dyspnoea, necessitating a return to the tracheotomy tube for a few days; but on December 12th this was finally removed, and on January 5th the patient was discharged cured after a stay of five months in hospital.

At this time the wound was soundly healed, respiration was perfect, and phonation was remarkably good, consisting of a loud and somewhat raucous whisper, that could be heard at a considerable distance. The patient, when seen a month later, had had no further trouble.


*Remarks.*—The case presents many features of interest. In the first place the child received no antitoxin until seen at the end of a week from the commencement of the illness, and though it cannot be said that any visible improvement was caused by the 38,000 units that she ultimately received, yet it may have just turned the scale in favour of her recovery.

Secondly, it is interesting to notice that the dyspnoea did not appear until the tracheotomy tube had been left out for a fortnight or more; also that the stenosis (unlike what I believe to be usually the case) was not a consequence of a division of the cricoid at the operation for tracheotomy.

Thirdly, the case is noteworthy for the fact that intubation alone failed to effect a cure. Though ultimately success by this method might have been attained, it was considered best to proceed at once with the more radical operation. The idea of passing a rubber tube from the mouth to the lower part of the trachea is a new one (so far as I am aware), and was found a distinct advantage, enabling the parts to regain their natural relations to some extent.

I am indebted to Dr. MacMunn for kind permission to publish the notes of this case.

### View Day, May 14, 1902.

ACH one who reads the title of this paragraph will doubtless picture to himself those View Days at which he himself has assisted, or call to mind the accounts of previous ones recorded year by year in the JOURNAL. He will perhaps scan these lines without hope of gaining fresh knowledge of this old institution (for all View Days resemble one another as closely as do successive Bank Holidays on Hampstead Heath, and render the task of making readable copy of this subject year by year one of increasing difficulty), but with a desire of renewing acquaintance with the times when as a proud member of the Junior Staff he escorted a bevy of admiring friends round "My Wards," or, as a keen dresser pointed out, "My Patients" to his tender and sympathetic relatives.

The Annual View Day was held on May 14th. The weather, which during the early part of the afternoon was fine and fairly sunny, induced a greater number of visitors to turn up and take their share in what is certainly one of the events of the Hospital year.

The usual round of the Hospital was made by the Treasurer and Governors, one of whom, we hear, has created what must be a record by appearing at forty-three of these functions, but noticed with interest the fact that the roll call for Coborn and Radcliffe was taken on the landing instead of in the wards as has usually been done. So far are we advancing on the road to asepsis.

Following the inspection by the Governors came the even more critical inspection by the many visitors and by the representative of the JOURNAL, who set out with a firm intention of inspecting all the wards of the Hospital, and of conferring without fear or favour the palm on the ward most deserving of honour for its decorations. We must in fairness confess that we failed in our object. Suffice it to say we are convinced that during the afternoon as many different opinions were expressed as to which ward was best decorated as there are wards.

Amongst others may be noted, as much for the beauty of the flowers as for skill in their arrangement, Mary, with white narcissi; Lawrence, pink geraniums; Matthew, yellow tulips in the front ward, violet irises and white narcissi in the back; President, beauteous with sweet-smelling roses and arums; Charity, lovely with massed forget-me-nots; and Coborn, beautifully decked out with buttercups.

One omission we noticed, not altogether with regret, and that is the attempt at colouring the water of the fountain, an attempt which has so often failed in its object, but has resulted in staining the cherubs, who so patiently bear their burden, with Pot. Permang. or methylene blue.

### Notes.

THE annual dinner of the Cambridge Graduates' Medical Club was held on May 28th, in the Balmoral Hall, Trocadero Restaurant, and was presided over by Prof. Clifford Allbutt. The dinner was preceded by the annual general meeting for the election of officers. After the toast of "The King" Prof. Allbutt proposed that of "The Club." He made reference to the system of examination for medical degrees at present in existence at Cambridge, and discussed at some length the new regulations recently introduced there. He coupled the toast with the name of the retiring senior secretary, Dr. Morley Fletcher. The latter responded to the toast in a very entertaining speech. Dr. Moore's speech was most amusing, and he proposed the "Health of the Chairman" with his usual wit and felicity of expression.

The attendance was well up to the average, and about sixty members and guests were present.

\* \* \*

GRANTED fine weather, one of the most delightful of the Hospital functions is the Summer Concert, which has been arranged for July 7th. The summer concert brings with it a sense of informality, a suggestion of Cambridge during the May week, to which, no doubt, much of its charm is due.

\* \* \*

CONTRARY to our experience of the last two or three years, there was no rain on View Day until quite late in the afternoon. Possibly this accounts to some extent for the unusually large number of visitors. An intelligent patient counted a hundred and fifty in one ward alone in the course of the afternoon.

\* \* \*

ALMOST every one has read Sir James Paget's essay on "What becomes of the Medical Man?" and a very interesting article was recently published by the *London Hospital Gazette* on the causes which induce men to enter the profession. It appears that about 30 per cent. are the sons of doctors, and breathe the medical atmosphere almost from their birth; another 30 per cent. become medical students almost by chance, or because no other means of making a living is open to them; and a third smaller group adopt the profession from deliberate choice; in fact, some are born to medicine, some achieve medicine, and some have medicine thrust upon them. The article is full of interesting observations, and the writer considers that nowadays the percentage of successes in medicine is higher than Sir James Paget was inclined to believe.

\* \* \*

We beg to congratulate those Bart.'s men who have just completed the final Fellowship Examination of the College of Surgeons.

We understand that the west block is shortly to be closed for two months to allow of various repairs and structural alterations.

THE Hospital Sports will be held on the L.A.C. Grounds, Stamford Bridge, on Tuesday, June 17th, commencing at 2.30 p.m.

The United Hospitals Sports are also to be held at Stamford Bridge, on Wednesday, June 25th.

OUR ancient institution will be well represented at Henley this year, as R. B. Etherington-Smith is sculling for the Diamonds, and H. U. Gould and H. E. Graham are rowing for Kingston.

We were so unfortunate as to lose the Inter-Hospital Fours this year; no doubt this can be partly attributed to the difficulty of getting together a representative crew.

We hear that the following incident occurred in a recent examination in pharmacology at one of our older uni-

versities. A student was asked how he would ascertain whether a patient was improving under treatment by iron. He replied that he would remove a portion of the liver, cut sections of it, and test for iron by means of the Prussian blue test.

Amalgamated Clubs.

CRICKET NOTES.

THE Hospital XI so far this season have not been very successful and we can record only one match as having been won.

On Saturday, May 24th, there was a good game against M.C.C. at Winchmore Hill, although the bowlers had much the best of the day.

Appended is the score of the match.

SCORES.—1st Innings.

Table with 2 columns: ST. BART.'S and M.C.C. listing players and their scores for the 1st Innings.

SCORES.—2nd Innings.

Table with 2 columns: ST. BART.'S and M.C.C. listing players and their scores for the 2nd Innings.

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

Played at Honor Oak Park on May 20th, and resulted in an easy win for St. Bart.'s. For the winners L. V. Thurston played a fine innings of 101 not out, and found a useful partner in J. Eckstein.

SCORES.

Scorecard for St. Bart.'s v. King's College, showing runs, wickets, and extras for both teams.

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart.'s v. King's College, including overs, maidens, runs, and wickets.

ST. BART.'S v. EALING.

Played at Ealing, May 31st, and resulted in a win for the home team. As usual the Hospital eleven were rather unlucky.

SCORES.

Scorecard for St. Bart.'s v. Ealing, showing runs, wickets, and extras for both teams.

BOWLING ANALYSIS.

Table showing bowling analysis for St. Bart.'s v. Ealing, including overs, maidens, runs, and wickets.

LAWN TENNIS CLUB.

ST. BART.'S v. NORTH KENSINGTON.

Played at Winchmore Hill on May 10th, resulting in a win for the Hospital by 6-3.

- List of tennis matches and results between St. Bart.'s and North Kensington, including names of players and scores.

ST. BART.'S v. DULWICH PARK.

Played at Dulwich Park on May 24th, and resulted in a win for the Hospital by 8-1.

- List of tennis matches and results between St. Bart.'s and Dulwich Park, including names of players and scores.

ST. BART.'S v. WINCHMORE CLUB.

Played at Winchmore Hill on May 14th, and owing to weather the match was left drawn greatly in favour of Winchmore Hill by 4-1.

- List of tennis matches and results between St. Bart.'s and Winchmore Club, including names of players and scores.


ROWING CLUB.

The annual Inter-hospital Four-oared Race took place on May 27th over the usual course, from Putney to Hammersmith.

Starting at rather the faster stroke, Bart.'s led by a little at first, but St. George's drew clear after three minutes' rowing, and eventually won by three lengths in spite of a good spurt by Gould at the Soap Works.

There were no entries for the Junior Race, which consequently fell through.

## Ex Infernis.

 HE devil looked up and the devil looked down,  
And his tail he twirled  
And his tail he curled  
And the devil he frowned a frown.

His Flor d'Inferno he puffed away  
As he gazed around—it was New Year's Day—  
At his fine new pavement, a brave array,  
Supplied by Good Resolution and Co.;  
And he muttered aloud,  
"What a terrible crowd!  
Plenty to come but none to go."

"Oh where, oh where is the room to be found  
I meant to take over the Underground?  
But I'm told the works  
Of a Mr. Yerkes  
Have dashed my ingenious hopes to the ground."

"If there's no more room I have yet a plan;  
And he chuckled and sucked his thumbs:  
"I'll pose as a horrid examiner man;  
In horrid suspense at my postern gate,  
For eternity waiting, they wait and wait,  
For a Viva that never comes."

Then a whispering fear  
Rustled close in his ear:  
"If the folks who think that it's fine to sin,  
But knew the crowds that you have within,  
There's a chance, you know, that they might begin,  
If they thought, to see  
That sin is a coarse mediocrity,  
And you won't get so many of them down here."  
J. R. R. T.

## Reviews.

MEDICAL LECTURES AND APHORISMS. By Dr. GEE, Fellow of the Royal College of Physicians; Honorary Physician to the Prince of Wales; Physician to St. Bartholomew's Hospital. (Smith, Elder, London, 1902.)

"He was a scholar, and a ripe good one."

The manifold discoveries made in bacteriology, chemistry, and morbid histology have turned men's eyes of late rather to the laboratory than to the bedside, whereby, as clinical physicians, we have lost while we have gained. We have, indeed, learnt much of the nature of disease; we have grown able to distinguish what was before confounded; but we have also been led to neglect general views by dwelling much on minute changes, have considered less the patient than the bacteria he entertains, and in training ourselves to the laborious use of unprecise instruments of precision have left educating our naked sense.

It is still true that in far the greater part of cases the older methods of examination, and the patient's constitution, which clinical experience alone can gauge, supply the grounds of the decision. We are right in pursuing the

best and newest methods, wrong in neglecting the older, for they are the more difficult and the surer.

Against this tendency no protest is stronger than the example of Dr. Gee's teaching. It is conspicuous for its reliance upon those signs of disease which ear, eye, and hand can appreciate, and which still inspire a confidence not given to complicated and indirect evidence. Read the essays on bronchitis, asthma, and peritonitis. The types of disease are drawn vividly and accurately. They give confidence. We feel that if he has positively said 'tis so, it will not prove otherwise. Yet he uses but the old tools, and, though he mentions the minuter pathology draws nothing from it for his present purpose. The descriptions are lessons which show how great effects can be produced by a master of simple means, and how subordinate a part is played by minute distinction of causes.

It is another virtue in this little book that it is an education in reasoning. We are often told that medicine has lost its position in the public estimation by willingness to serve without wages. It has lost it still more by our ignorance, prejudice, and folly. Our soft hearts have wrought less harm than our softer heads. Not to count the argument of theologians, which is much warped by the charity inculcated by religion, that usual with physicians is to be compared with that of statesmen alone, for the confidence with which it builds upon the sand, and for its ignorance of all the rules of the art. We follow with the delight of an accustomed pleasure the clarity of Dr. Gee's argument, and the knowledge which defines where evidence ends and fantasy begins.

Take for instance the following:—"Willis thought that convulsive asthma might sometimes proceed from irritation of the pulmonary or thoracic nerves, or of the origin of these nerves in the brain. . . . How often have we not heard similar theories? How often have we not seen them supported by the convincing evidence of one of those fanciful designs of which Dr. Andrew used to say, 'Nature abhors a vacuum, but she abhors a diagram more?'" Dr. Gee's next sentence runs, "This is one of those recondite propositions which can be neither maintained nor refuted," and he says no more about it.

These two things, to observe accurately and to argue truly, are the part of a good scholar, and nothing needs to be added to justify the quotation which heads this review. But there is another quality of scholarship, the reverence for learning, of which this book affords copious evidence. Each page recalls to honour some teacher of past time. Each theme is illustrated not alone from the older physicians, but from the philosophy and literature of the world. And not the thought alone, but even the language of the dead is piously preserved. Dr. Gee's book is a home for lost words. He tends and cares for those which have no other friend, and when a stranger wanders down his text he points with a collector's pride to "porraceous," to "lipuria," to "idio-

syncrasy," cherished for Sextus Empiricus his sake, and to, dearest of all, "the wambeothe," or belly sickness. It is pleasant when writing has a savour of its own, and the quiet quaintness of Dr. Gee's diction adds a charm to wisdom.

It was alleged in proof of Wolsey's scholarship that he nobly endowed learning with the booty which by his king's indulgence he tore from his country. Such has not hitherto been Dr. Gee's fate. But he is now a Court official, with, no doubt, similar opportunity for public plunder. It may be he will resist the temptation, but should he not, we will remind him that pardon may be won of this world, and we will nerve our minds to risk his hereafter if he will endow for us a seat of learning worthy of that great man, St. Bartholomew. We are not ambitious; something quiet and tasteful, of about the size of Christ Church, will suit us well.

W. P. HERRINCHAM.

ELEMENTARY TEXT-BOOK OF ZOOLOGY. By A. T. MASTERMAN, M.A., D.Sc., F.R.S.E. (Second Edition, 1902. E. and S. Livingstone, 128. net.)

In this edition some fifty additional illustrations have been added, together with a description of a type of the Rotifera. The first part of the book deals with the general principles of zoology, and contains an excellent summary of such matters. Owing to the necessity for compression this part is not quite as interesting as it otherwise would be, and although quite clear to the more advanced student we expect the beginner will find it rather difficult reading. Perhaps some sections might with advantage have been left out or still further compressed. It is surely a mistake to devote nearly eight pages to Histology (which is usually learnt elsewhere), and only four and a half to the chapter dealing with Heredity and Variation, Evolution and Sexual Selection.

The plan of Part II is excellent. Throughout a number of types are taken from each phylum and described more or less in detail. Then follows a general account of the character of the phylum or sub-phylum as a whole. A good feature is the statement preceding each type, giving its exact position in the scheme of classification. Altogether great care is taken to prevent the student from regarding, as he so frequently does, the different types which he has to get up as so many animals that have no connection with one another.

It is perhaps unfortunate that the author has taken quite so many types as are to be found here. The result is that the description is scarcely as detailed as is necessary for the student who wishes to learn type thoroughly, as is usually necessary in an elementary medical examination. For instance, in the chapter on Annelata we have, in addition to a general *résumé* of the phylum, a description of the following types:—*Polygordius*, *Arenicola*, *Iliduo*, *Lumbricus*, *Nephrops*, *Blatta*, *Peripatus*, *Epeira*. Allowing for the very numerous illustrations, these form rather too much subject-matter for the eighty relatively small pages of large print that are assigned to them.

It is always interesting in a book of zoology to see how the author deals with such animals as *Balanoglossus*, *Sagitta*, etc. Dr. Masterman very wisely places all such doubtful quantities in one group of *Archicœlomata*, which includes in addition *Echinoderms*, *Brachiopods*, and *Polyoza*. The last, by the way, he calls by the Continental name of *Bryozoa*, the word *Polyoza* appearing only in the index.

A large part of the book is devoted to the consideration of types of the *Vertebrata*, the characteristics of the main groups. The *Mammalia* especially are dealt with at considerable length, and there is an entire chapter dealing with their distribution. The tendency of the elementary student of zoology to confine his attention almost entirely to *Invertebrates* has been largely due to the books he has used, and the present work should do much to remedy the fault.

Lastly, the illustrations, of which there are more than 400, are all excellent. Many have been drawn by the author himself from the actual specimens. None are included which will not be of real service to the reader.

GIBSON AND KUSSELL'S PHYSICAL DIAGNOSIS. Third edition, revised and rewritten, by FRANCIS D. BOYD, C.M.G., M.D., F.R.C.P.Ed.

The new edition of this work comprises over 400 pages. The author devotes separate chapters to each of the different systems of the body. He describes in detail the methods available for the physical examination of each system, the alterations which can be detected in disease, and the inferences which may be drawn from these changes.

In addition there are chapters on the special senses, on the examination of the blood, and on clinical bacteriology. The most recent methods of examination that have been devised are carefully described, bringing the book thoroughly up to date.

An ample description of the urine occupies sixty pages, but we are surprised that it contains no reference to the valuable calcium-sulphonic acid test for proteins and albumoses.

Other omissions occur in the section on the mouth, in which we should have expected a description of the teeth characteristic of inherited syphilis, and some reference to Koplik's spots.

The book is not free from mistakes which might have been avoided by careful proof-reading. Thus we read (p. 23), "Fat may be deficient as a constitutional habit of body, or may be a symptom of wasting disease, and if it should have appeared suddenly it points to the latter as the probable cause." We should not like to accuse the author of meaning what he says.

The following sentence also savours of the occult (p. 227):—"When this infrequent movement of the bowels becomes pathological it is termed *obstipation*." Amongst the causes of obstructive jaundice we are given (p. 21) "pressure on the bile-ducts by external causes, such as accumulation of faeces in the bowel." Surely this is a very rare occurrence even in cases of severe obstipation.

In spite of these little shortcomings the book contains such a large amount of valuable information that it cannot fail to be of use to students of medicine, qualified or unqualified.

CLINICAL METHODS. By ROBERT HUTCHISON, M.D., F.R.C.P., and H. RAINY, F.R.C.P.Ed., F.R.S.E. (Second edition, Cassell and Co.)

In the present edition this work has been brought thoroughly up to date, and new chapters have been added on clinical bacteriology and on the examination of pathological fluids. Considerable additions have been made to the chapters on the urine, the nervous system, and the clinical examination of the blood.

For the book as a whole we have nothing but praise; it is a perfect storehouse of information, carefully arranged and clearly set forth, and it cannot fail to be of the utmost value both to the student and to the practitioner.

The methods used in the clinical examination of the circulatory, respiratory, and other systems of the body are systematically described, and the chapters on the urine and on the examination of children are, in our opinion, the best parts of the book, and could hardly be improved upon.

The chapters on the blood and on clinical bacteriology, however, are more open to criticism. The haemocytometer and haemoglobinometer of Gowers are nowadays so seldom used that a description of them might well have been omitted. In describing the various kinds of leucocytes the authors do not point out that myelocytes stain very differently with Ehrlich's triacid stain and with eosin and methylene blue; this seems to us a distinction of considerable practical importance.

The chapter on bacteriology is necessarily rather condensed, but we should have thought the anthrax bacillus deserved more than eight lines; moreover it is stated that anthrax occurs principally in wool-sorters, and that the bacillus when found in the blood is as long as a red blood-corpuscle. In our experience in London anthrax almost always occurs in those who work with horsehair; it is well known that anthrax bacilli are rarely found in the blood in man, and that they have an average length of 4 to 5  $\mu$ .

Again, the authors state that the typhoid bacillus "occurs in the urine if albuminous." We must absolutely disagree with this statement; albuminuria often occurs in typhoid fever apart from the presence of typhoid bacilli in the urine.

Apart from these and one or two other such statements the book is thoroughly reliable and sound, and we have much pleasure in recommending it to our readers.

## Calendar.

- June 13.—On duty. Dr. Gee and Mr. Marsh.  
Clinic by Dr. Gee.
- " 14.—S.B.H. Tennis Club v. R.I.E.C., at Egham.  
Cricket Club v. Addlestone, at Addlestone.
- " 16.—Special lecture by Dr. Ormerod.
- " 17.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
S.D.H. Athletic Club Sports at Stamford Bridge.
- " 18.—Clinic by Mr. Walsham.  
S.B.H. Tennis Club v. Chiswick Park, at Chiswick.  
S.B.H. Christian Association, Dr. Soltau.
- " 19.—On duty. Dr. Hensley and Mr. Walsham.  
Clinic by Sir Wm. Church.
- " 21.—S.B.H. Cricket Club v. H.A.C., at Finsbury.  
S.B.H. Tennis Club v. Hornsey, at Hornsey.
- " 23.—Special lecture by Mr. Cumberbatch.
- " 24.—On duty. Sir Lauder Brunton and Mr. Cripps.
- " 25.—Clinic by Mr. Walsham.  
S.B.H. Tennis Club v. Wimbledon Park, at Wimbledon.
- " 27.—On duty. Sir Wm. Church and Mr. Langton.  
Clinic by Sir Dyce Duckworth.
- " 28.—S.B.H. Cricket Club v. Dunstable, at Dunstable.  
S.B.H. Tennis Club v. Alhermar, at Winchmore Hill.
- " 30.—Special lecture by Dr. Ormerod.
- July 1.—On duty. Dr. Gee and Mr. Marsh.
- " 2.—S.B.H. Tennis Club v. Chiswick Park, at Chiswick Park.  
Clinic by Mr. Cripps.
- " 3.—S.B.H. Christian Association, Rev. Geo. Tonge.  
Shuter Scholarship.
- " 4.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
Clinic by Dr. Hensley.
- " 5.—S.B.H. Cricket Club v. East Molesey, at East Molesey.  
S.B.H. Tennis Club v. N. Kensington, at Kensington.
- " 7.—Special lecture by Mr. Bruce Clarke.  
Summer Concert.
- " 8.—On duty. Dr. Hensley and Mr. Walsham.
- " 9.—Clinic by Mr. Cripps.
- " 10.—Mid-Sessional Address, Abernethian Society.
- " 11.—On duty. Sir Lauder Brunton and Mr. Cripps.  
Eighth Decennial Club Dinner at the "Caté Royal."  
Clinic by Sir Lauder Brunton.
- " 12.—S.B.H. Cricket Club v. R.I.E.C., at Cooper's Hill.

## Examinations.

UNIVERSITY OF LONDON.

M.B. Examination.

First Division.—P. G. Harvey.  
Second Division.—T. Aubrey, P. J. Cammidge, H. A. Colwell,  
F. M. Howell, V. G. Ward.

ROYAL COLLEGE OF SURGEONS.

First Examination for the Fellowship.

J. G. Atkinson, T. Bates, F. Coleman, A. W. D. Coventon,  
J. F. Jennings, J. C. Marshall, K. S. Wise, E. E. Young.

Final Examination.

C. G. Watson, T. C. Littler Jones, J. C. Newman, F. P. Connor  
C. E. West, F. Barnes, J. H. Henderson, W. Richards, A. Compton.

## Appointments.

BAINBRIDGE, F. A., M.B., M.R.C.P., appointed Clinical Pathologist to the Hospital for Sick Children, Great Ormond Street.

BUTCHER, H. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the General Hospital, Birmingham.

CHRISTOPHERSON, J. B., M.A., M.D., B.C. Cantab., F.R.C.S., appointed a Surgeon to the Egyptian Army.

COOKE, R. T., M.R.C.S., L.R.C.P., appointed House Surgeon to the North Devon Infirmary.

SLADE, H. J., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Wigan Infirmary.

WARD, H. S., M.B., B.S. Lond., M.R.C.S., L.R.C.P., appointed Second Assistant Medical Officer to the London County Manor Asylum, Epsom.

WILLOUGHBY, W. M., B.A., M.B., B.C., D.P.H. Cantab., appointed Boarding Medical Officer to the Port of London Sanitary Authority.

WILMOT, R. C., M.R.C.S., L.R.C.P., appointed Surgeon to the British India ss. "Golconda."

## New Addresses.

CROWTHER-SMITH, T. F., Stanford, Liphook, Hants.

DODSON, G. EVERARD, 16, Stamer Street, Stoke-on-Trent, Staffs.  
LANGFORD, C. H., 55, Crouch Hall Road, N.

MACKINTOSH, J. STEWART, "Corner House," Platts Lane, Finchley Road, Hampstead.

MAINGAY, H. B., 33, Queen Street, Scarborough.

MARSHALL, HOWARD, Cirencester, Gloucestershire.

MAYO, T. A., 6, The Parade, Cowes.

WOOD, PERCIVAL, 44, Welbeck Street, Cavendish Square, W.

## Births.

MILLEN.—On April 1st, 1902, at Milverton, Malmesbury, Wilts, the wife of Seymour A. Millen, M.R.C.S., L.R.C.P., of a son.

PRATT.—On April 13th, at 36, Windsor Place, Cardiff, the wife of Eldon Pratt, M.D., of a daughter.

WILLOUGHBY.—On May 22nd, at 2, Cumberland Villas, Gravesend, the wife of William Willoughby, B.A., of a son.

## Marriages.

DODSON—WELLS.—On April 21st at St. Matthew's, Thorpe Hamlet, Norwich, by the Rev. H. Boyden, B.A., Vicar, George Everard Dodson, second son of George Dodson, Thorpe Hamlet, Norwich, to Emmie Lucy, only child of the late Randall Henry Spencer Wells, Horsham Lodge, Twyford, Hants.

MAINGAY—LEMPRIERE.—On June 3rd at St. James's, Scarborough, by the Rev. J. Hopkin, Henry Bertram Maingay, F.R.C.S., to Kathleen Edith, youngest daughter of the late Captain George Reid Lempriere, R.R., and of Mrs. Lempriere, of Scarborough.

## St. Bartholomew's Hospital



## Journal.

VOL. IX.—No. 9.]

JUNE, 1902.

[PRICE SIXPENCE.]

## NOTICE.

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

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

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

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

## St. Bartholomew's Hospital Journal,

JUNE, 1902.

"Æquum momento rebus in arduis  
Servare mentem."—Horace, Book ii, Ode iii.

## Some of the Results of Infantile Paralysis.

A Clinical Lecture by Mr. BRUCE CLARKE.



ENTLEMEN,—I have chosen for my title to-day "Some of the Results of Infantile Paralysis," because the cases which may be arranged under this title form a well-marked group, and often lead to deformities for which instrumental as well as general surgical treatment is urgently demanded, and they form a large proportion of the cases that are met with in the Orthopaedic Department.

I do not propose to say much on the pathology of such cases, because I am dealing with the results of the disease and not with its earlier stages. But I may preface my remarks by reminding you that the disease in question usually occurs during childhood, though it is by no means absolutely confined to this period of life. As an Irishman would express it, there is such a disease as infantile paralysis of the adult.

The onset of such an attack is often overlooked both by patients and by those who attend to them. It comes on much in the same way as an ordinary cold, with some slight symptoms of malaise, and in all probability it is not until the child shows some disinclination or inability to move its legs that the true nature of the attack is discovered. It is usually the legs that suffer, though the attack may involve the arms and even some of the trunk muscles as well. It is rarely that the disease falls with equal severity upon all the parts affected. If such a patient is subjected to no treatment whatever a tendency to recovery begins usually a few days after the onset of the attack, but the recovery is rarely if ever a complete one. When it has reached a certain stage it comes to a standstill, and the child is commonly left with a more or less paralysed leg. The paralysis may be complete or confined to certain muscles or muscular groups. Leg paralysees more commonly persist than do those of the arm, but it is almost certain that some of the arm paralysees which one meets with and recognises for the first time at or about the age of puberty are in reality the sole remnant of an attack of infantile paralysis earlier in life, which has entirely passed out of recollection, and perhaps was never detected. The term anterior poliomyelitis points to the actual seat of the lesion which is associated with this disease, but it affords us no clue to its origin. It is commoner in summer than in winter, and is most probably dependent on some specific organism.

The symptoms of the disease when the paralysis is well established rarely offer much difficulty in diagnosis. The affected part (which I have already pointed out is usually



one of the legs) is smaller than its neighbour, livid, and subject to chilblains in winter. The skin is rough and harsh, and rarely hairy. It feels cold to the touch, and is usually shortened and deformed, with weak, loose joints that are quite insufficient to support the weight of the body. If the foot alone is paralysed it has probably assumed some position of talipes rendering walking difficult or impossible, and it is for this reason that the patient applies for treatment. A very brief examination of the foot and leg will probably show that the ankle and knee joints can be over-extended, and that their lateral ligaments are so weak that they can with difficulty be made to retain their natural shape and position. A loose condition of the ankle is more common than lateral movement at the knee. The side of the foot will probably be in the position of *cavus*, combined perhaps with that of *equinus*, *equino-varus*, or *calcaneus*. The extensor or flexor muscles, possibly both sets, are paralysed. And it may be as well to remark at this stage that *complete paralysis is generally far more easy to treat than partial, because there are no opposing groups of muscles to prevent the replacement of the limb in its natural position.*

There are but two conditions with which such cases are liable to be confounded, viz. infantile hemiplegia and hysteria. Of the causes of hemiplegia in early life we are entirely ignorant. It is usually assumed that they are dependent on some cerebral clot, due perhaps to the rupture of some vessel, perhaps in an attack of whooping-cough, and analogous to the subconjunctival hemorrhages which are familiar in the course of such attacks, but there is no absolute proof that this is the case. In such a condition the corresponding arm and leg are affected, though not always to the same extent, whilst in hysterical conditions the electrical reactions of the muscles in the affected limb show no deviation from the normal. At the present time I have under my care in Lucas Ward a woman who well illustrates these mistakes in diagnosis. She is just twenty, and with the exception of her paralysed leg enjoys the best of health, and bears all the marks of good health on her countenance. Some years back she was seized with an attack of unconsciousness, from which apparently she recovered in a few minutes, but her left arm and leg have been paralysed ever since. The arm has all but completely recovered its power, and can only be described as slightly weakened; but the leg is so flexed at the knee that it is practically useless, and she can only get about by means of crutches. There is also some loss of sensation in the leg. She was sent some time back to Dr. Lewis Jones as a case of hysteria for electrical treatment, but he soon appreciated the true state of the case, and handed her on to me to give her some apparatus which could enable her to walk. Her condition is both interesting and instructive from many points of view. The diagnosis was in the early stages attended with some

difficulty, and the resulting paralysis, as you will see if you look at the case, has fallen almost entirely upon the quadriceps extensor femoris group of muscles. The muscles below the knee are not strong, but the opposing groups are about equally powerful or equally lacking in power, whichever way you like to put it. In consequence of this condition the leg below the knee, though not strong, is quite movable and useful, but the limb as a whole is all but useless because the comparatively strong hamstrings are pulling the knee into a state of flexion, and there is no extensor group to counterbalance them. I am dwelling with considerable fulness on this, firstly, because you can look at it; and secondly, because though it is not a case of deformity resulting from infantile paralysis it will illustrate very vividly to you the problems which such a case presents, and what means must be taken to find an adequate solution for them.

At first I endeavoured to put the leg straight by dividing the hamstrings, and putting the leg upon a back splint. Some improvement took place, but was only of short duration; after a day or two it completely relapsed. I next attempted to make use of some of the hamstrings for the purpose of extensors, and made a long incision on either side of the thigh. I cut away the biceps and semitendinosus from their insertions, and attached them along with the sartorius and gracilis to the tendon of the rectus just above the patella. The operation left nothing to be desired, excepting only that it did not enable her to straighten her leg. The leg is straighter, but it is a long way off being a useful member. I have now advised her to consent to arthrodesis,—that is to say, to have her knee-joint fixed by removing the cartilage from the femur and tibia, so that a stiff joint may result. There is no other alternative but amputation, unless she is to go about on crutches all her life dragging a useless limb after her. You could not, I think, wish for a more complete picture of the damaging effect of paralysis, and much, if not all of it might have been prevented had an accurate diagnosis been made and suitable treatment applied in the earlier stages of the disease.

If suitable treatment is to be employed a knowledge of the means by which deformity is produced must be thoroughly understood. Up to some forty years ago the antagonistic theory of Delpech held its ground unchallenged. The facts which we have before us in this girl's knee may seem, at first sight, to prove the correctness of Delpech's views. The extensors of the thigh are paralysed, therefore it must be the antagonistic action of the hamstrings that has produced the deformity. *That they help to keep up the deformity may be readily conceded, but there is no evidence that in the first instance they produced it.* Such deformities are in reality brought about partly by the force of gravity, partly by pressure, and partly by the inability of the paralysed muscles to get the limb straight.

Added to this there is the well-known fact that muscles, ligaments, and indeed all the soft tissues readily undergo permanent weakening and shortening if their extremities are brought closer together for any considerable period. Perhaps the best instance of this law of growth is afforded by the results of, say, a fractured femur, in which three quarters of an inch of shortening has taken place. The muscles that surround the bone have accommodated themselves to the shortened bone long before the patient is able to walk.

The series of changes, then, by which this condition of permanent knee shortening was induced were as follows:

It was easy to bend the knee, whether the patient was sitting in a chair or lying in bed, but impossible to straighten it. The pressure of bedclothes and the force of gravity all helped in the same direction. There was no need for the posterior ligament of the knee joint or the hamstring muscles to lengthen themselves out as they do under healthy conditions, and *after a while they ceased to have the capacity for being straightened*, and that is the condition in which we see our patient to-day. It is not the hamstrings that have produced the deformity, they have only accommodated themselves to circumstances, and had they been paralysed as well as the extensors the same deformity *might* have ensued. Mark, I use the word *might*, not *would*. The deformity would not have come about so easily, because nutritive shortening does not occur so readily in a paralysed as in a healthy muscle, and when the patient started to walk with crutches the force of gravity, unopposed by healthy hamstrings, would have helped to keep the leg straight.

If these facts had been correctly appreciated when the deformity first began to appear, the limb would have been kept straight by splints and daily movements, and the hamstrings and adjacent structures would have been prevented from undergoing nutritive shortening. Had this line of treatment been pursued, a couple of steel supports, one on each side of the affected leg, would be all that would be required,—at any rate the knee-joint would have been straight if it was not strong.

But let us turn our attention for one moment from a case of paralysis which affects the knee-joint to one that affects the muscles in the neighbourhood of the ankle, because the problem from an instrumental point of view is a far simpler one. If the muscles that pass over the front of the ankle-joint are paralysed, a tendency to toe-drop is almost certain to be present. The calf muscles have undergone nutritive shortening, and the patient becomes less and less able to walk with either comfort or safety, because every time the foot is moved forward the toe catches the ground, and is liable to trip him up. In other words, we have to do with a case of paralytic talipes equinus, in which the calf muscles have undergone shortening because the extensors are not strong enough to

put the flexors on the stretch, and the tendency of pressure and gravity combined has assisted in the same direction. If the calf muscles are cut so as to bring the foot up beyond a right angle, an instrument must be employed to keep it there, and for this purpose one of the best instruments is a boot with an outside iron to the calf, and with a toe-raising spring attached to it. It is perhaps hardly necessary to call attention to the fact that care must be taken to ensure that the spring is of suitable strength, neither too weak on the one hand nor too strong on the other.

But the effects of paralysis are often not confined to muscular paralysis alone; the bones and ligaments are usually greatly weakened, and the ankle is liable to move laterally. To obviate this condition it may be necessary to employ two irons, one on each side of the leg, and perhaps a varus and valgus T strap to steady the ankle. By the aid of these appliances it is often possible to make walking so easy that no deformity can be detected until attention is called to the surgical boot.

If the paralysis has affected the flexors of the calf instead of the extensor muscles, a toe-depressing spring must be substituted for the toe raiser.

If both sets of muscles are destroyed, no spring will probably be needed at all, as the tendency to deformity is far less even if the weakness is much greater.

Where the weakness is such that the leg, even when irons are employed, is useless for purposes of progression, and painful by reason of its bloodlessness and liability to chilblains, there is no alternative but amputation, but it is only as a last resource that this mode of treatment should be employed. When the leg is more extensively affected, and the muscles round the knee-joint are so far involved as to render it practically useless, the results of treatment are not so satisfactory as in the case of the ankle. Two irons are generally required, one on either side of the knee, and a draw-back knee-cap to keep the leg straight in extension. But the fact that the knee-joint must be flexed at least to a right angle, both in the kneeling and sitting posture, gives the flexors a chance of becoming permanently shortened, and with what disastrous results the case I have shown you gives ample proof.

If there is one thing which I hope I have made clear, it is that instrumental treatment must be begun early; in other words, that prevention is better and far easier than cure.

### Tubercular Meningitis.

A Clinical Lecture delivered by Dr. GEE on June 13th, 1902.

(Reported by C. F. HADFIELD.)

ON May 15th a boy was admitted to this Hospital with tubercular disease of the hip. On May 27th he developed tubercular meningitis, from which he died a few days later.

On May 30th a little girl entered the Hospital with headache and vomiting. On June 1st she died of tubercular meningitis.

On June 6th a young baby was admitted with the same disease, from which she died two days later.

Thus we see that within ten days there were no less than three deaths from tubercular meningitis—these in two wards only. Nor is such an occurrence at all unusual.

A disease which occurs with such frequency deserves your very close attention. Although so common it is in many cases quite impossible—I do not say difficult, but impossible—to diagnose in the early stages. Again, it is a disease which almost necessarily involves a fatal termination, and therefore mistakes in diagnosis and prognosis will be very liable seriously to injure your professional reputation.

I will distinguish between the primary and the secondary forms of the disease. When primary the patient has been quite well up to a certain date, after which he develops symptoms that can afterwards be definitely referred to tubercular meningitis.

When the disease is secondary it follows at the end of phthisis or other chronic tubercular disease. It is then very seldom diagnosed, seeing that it may only be the means of adding one or two fresh symptoms to a number of symptoms which already exist. Since, also, it only occurs in what I may call the closing scene, the diagnosis is seldom of any material importance.

Considering, then, the primary disease, I have set down five symptoms which mark the onset.

1. *Vomiting*.—This I regard as the most important symptom, as it is very seldom absent. It may be excessive; or, again, it may be slight and transient, and be put down to something indigestible which the child has eaten. Remember, then, that vomiting in a child may be the first symptom of tubercular meningitis.

2. *Headache*.—This may be absent or slight, but is sometimes very severe from the first. In babies I think that headache is sometimes the cause of constant screaming.

3. *Convulsions* are the first symptom in rare cases.

4. *Delirium*.—In the case I mentioned to you of the boy with hip disease delirium was the only symptom for two to three days, during which no diagnosis could be made. Delirium seldom occurs in young children, but only after the mental faculties are considerably developed.

5. *Fever* is nearly always present, and is sometimes the first sign.

These invasion symptoms are followed by a stage of disease marked by fever, headache, sometimes vomiting, sometimes delirium, constipation, and drowsiness. Sometimes the patient looks very ill, sometimes not. This indecisive stage of the disease, during which no certain diagnosis can be made, usually lasts for some time. The total duration of the disease is seldom more than twenty-four days, and it may be much shorter. Still I remember the case of a girl who was very ill for six weeks. She was seen by a number of medical men, but no certain diagnosis was made. This was largely owing—as it very frequently is in these cases—to the extreme restlessness and peevishness of the child, which made it impossible to use the ophthalmoscope or even to feel the pulse. To the experienced eye this restless state is often almost diagnostic. I have even given chloroform in order to examine the fundus of the eye, and have even then failed, owing to the rolling up of the eye under the upper lid. The case I speak of was the only child of a clergyman; she remained in this state for nearly six weeks. Many suggestions were made as to the cause of the condition, but it was only when the child became comatose, as they always do before the end, that I saw distinct choroidal tubercles with the ophthalmoscope. The existence of these showed that the child had only a day or two more to live, and she died forty hours after the onset of coma.

The fever is usually not high, and is seldom above  $102^{\circ}$ . It may be  $103^{\circ}$ , but is very rarely higher. Thus, to some extent, a high temperature militates against a diagnosis of tubercular meningitis. In some cases there is no fever at all, at least as often as the temperature is taken.

During this indecisive stage, whether it last two or three days or five or six weeks, the diagnosis is not certain. Then follows the final stage, when a diagnosis can be made. It may set in soon after the onset of the illness, or only two or three days before death. The diagnosis now depends on three classes of symptoms; (1) those referable to the brain, (2) those discovered by the ophthalmoscope, and (3) vital symptoms referable to the circulatory and respiratory systems.

(1) *Brain symptoms*.—Palsies are common. Sometimes the paralysis is local, and is seen most frequently in connection with the oculo-motor muscles, giving squints or dilated pupils. In other cases it is more general, and affects an arm or a leg. There may be hemiplegia. Aphasia,

which is a kind of paralysis, may be present, and is sometimes the first characteristic symptom of the disease. I remember a case showing it in an adult. (I may here say that I speak of adults as well as children. The disease is so little expected in adults that it is even more often overlooked than in children.) This case had convulsions with rigidity of the right arm and right side of the face, and a temperature of  $104^{\circ}$ . He became comatose, but after some hours the coma passed off, leaving him quite conscious but aphasic. The fundus was quite natural at this time, and there was no vomiting and no squint. Post mortem a focus of disease was found in the anterior part of the first temporal and inferior frontal convolutions on the left side, just where one would expect it to cause aphasia. I have known it to occur in children. Of other symptoms of this class, nystagmus, rigidity of the back, convulsions (especially at the end) and delirium (at any time) are all common. Coma is invariable at the end, but may come on earlier and pass off.

(2) *Ophthalmoscopic symptoms* are very important. The medical man who cannot use an ophthalmoscope cannot diagnose tubercular meningitis and many other diseases. Let me, therefore, urge you to make use of your opportunities here for learning the use of the instrument.

The two things to look for are optic neuritis and choroidal tubercles. I remember a case where there had been headache and fever at night for a fortnight. When I saw the patient the fever and cough might have been accounted for by typhoid, simple catarrh, whooping-cough, or acute tuberculosis affecting the whole body. The discovery of optic neuritis led me to diagnose the last with the utmost confidence. Ten days later there was slight paralysis of one side of the face, and the child died in a comatose condition. Post mortem tubercles were found in the meninges and most of the organs.

The optic neuritis may produce blindness. I once saw a poor Irish girl, the daughter of very ignorant parents, in whom loss of sight was the first symptom of illness. In better circumstances, and with less ignorant friends, no doubt other and earlier signs would have been noticed. She had "choked disc" in each eye, and soon died of tubercular meningitis.

If you see tubercles on the choroid, and there are any symptoms referable to the brain, the condition is quite diagnostic. Unfortunately this fact is of little use as the tubercles seldom appear more than two to three days before death, when the diagnosis has usually been already made.

(3) *The symptoms connected with the circulation and respiration* often combine, especially in the last stage, to give a flushed and heavy appearance of the face which one becomes able to appreciate. In both pulse and respirations the irregularity is the most frequent feature.

There is an almost infinite variety in the manner in

which these various symptoms are associated, and after much experience I find that no two cases are quite alike. Putting aside the choroidal tubercles, no one symptom or group of symptoms is pathognomonic. The more symptoms there are that point to the brain, the greater the probability that the brain is diseased. You are sent for to see a child with symptoms of acute brain disease. Tubercular meningitis is so far the commonest of all such diseases that it often comes to be a matter of probabilities.

As evidence of the difficulty of the diagnosis I will refer to a little child, only three months old, admitted on June 6th with a history of convulsions and great retraction of the head. After hearing the note read, and without very careful personal examination, I fear I rather jumped to the conclusion that she was suffering from *cervical opisthotonos*, a disease I was the first to describe many years ago. However, I was wrong, for the child died, and was found to have tubercular meningitis. The fact is that acute brain diseases are sometimes quite indistinguishable in children, especially in very young children in which the mental faculties have not developed.

In tubercular meningitis, then, a diagnosis of the primary form may be impossible until the patient is dying, and in the secondary form it is often not made at all.

The disease may be easily mistaken for a slight affection of the stomach. The child may be brought for vomiting and stomach disorder, and only some days later the medical man begins to suspect something far more serious. When obstinate constipation accompanies the vomiting, the condition simulates that of intestinal obstruction.

A child, two years old, suffering from these symptoms, was thought to require abdominal section. Examining the abdomen alone the surgeon could not feel satisfied that there was mechanical obstruction, and especially could find no evidence of intussusception. He therefore asked me to see the child. I thought it might be tubercular meningitis, but on examining the fundus I found no optic neuritis. Two days later, when I saw the child again, the bowels had acted well, and a highly marked optic neuritis had set in. Death resulted a week later. Such a case is not common, but it is easy to see how it may arise.

The disease at the outset may simulate typhoid. Again, it is not uncommon for a child to become weak and febrile for some time for no very apparent cause,—febricula. Early cases of meningitis may easily be mistaken for them. The presence of convulsions is of little use, as they may be connected with disease of the brain or be quite independent of it. The only course is to watch the further development of the case.

Lastly, it is important to remember that, especially in young women, tubercular meningitis may simulate hysteria.

### On Ophthalmic Treatment and Therapeutics.

An Introductory Lecture by WALTER H. JESSOP.

(Concluded from p. 120.)

**L**EAVING the more general treatment, I would ask you to consider the treatment and remedies used in inflammations and conditions of the conjunctiva and the cornea. I associate these two structures as they are continuous with one another, and form the protective parts of the anterior or more superficial parts of the eyeball.

Starting first with the conjunctiva, it must be borne in mind that it forms a mucous membrane covered by delicate epithelium, and lines the inner aspect of the upper and lower lids (palpebral portion). It extends above and below to the fornix, and is then directed over the eyeball (ocular portion) as far as the limbus. At the limbus the conjunctiva is continuous with the cornea, forming the anterior portion of the epithelial lining of that protective coat.

I would especially warn you that when the lids are in contact the conjunctival sac becomes a closed cavity, except for the small openings of the puncta leading by the canaliculi to the nasal duct. These puncta, from the approximation of the lids, tend practically to be closed, especially when any discharge glues the lids together. It is therefore one of the most important points to be observed in treatment of conjunctivitis that the eyes should never be bandaged, but that free relief should be afforded to any discharge. One way to obtain this is to apply some simple ointment along the edges of the lids, especially before the patient goes to sleep. Such ointments may be boracic, vaseline, lanolin, cold cream, etc. The best and simplest way to apply them is to take a piece about the size of a hemp-seed on the clean finger, and to smear it on the inside edge of the lower lid, which is depressed for the purpose by a finger.

On dressing cases after operation I always apply some freshly made and aseptic boracic acid ointment on a piece of sterilised linc or lint next the eye in order to prevent the lids sticking together, and thus to allow free vent to the tears or any discharge from the eyes.

The conjunctival sac, lined by delicate epithelium and having glands secreting a lubricant for the cornea, is, in the healthy state, to all intents and purposes an aseptic cavity, the secretions apparently possessing an antiseptic property. Even in disease, except when the form is very severe, as in gonorrhoeal conjunctivitis, a pathogenic microbe has slight chance of growth.

For this reason there is little use in employing antiseptics of any potency in the treatment of slight conjunctival affections. In such inflammations strong antiseptics act, as a rule, by destruction of the epithelium or irritation. I know no mucous membrane in the body that more resents the use of antiseptics. For operations on the eye as cataract I have

for a long time given up the use of anything stronger than distilled and sterilised water, and even think in most cases this might with advantage be dispensed with. For slight cases of conjunctival inflammation a solution of boracic acid (gr. 5—10 to the ounce) may be employed. Feeble as its antiseptic properties are, it seems to suit best the conjunctiva.

Lotions are easily applied by means of an eye-cup, which should be filled with the lotion and applied quite close to the eye. The eyelids are then opened under the fluid, which thus washes the conjunctival sac and surface of the cornea.

Another way is by a small ball syringe; the head should be thrown back, and the lotion should be allowed to flow from the inner canthus outwards, the lids being opened.

Failing these, a small sponge or pledget of absorbent cotton wool soaked in the lotion can be used in the same way as the syringe.

If a very efficient antiseptic lotion is needed, as in gonorrhoeal conjunctivitis, the best is nitrate of silver (2 per cent.), but even in this strength it must not be used too much, as it may produce great irritation and even destruction of the conjunctival epithelium.

Perchloride of mercury solution (1 in 5000) is a good antiseptic, but not equal to the former.

As an astringent nothing is better than hazeline, about one drachm to the eight ounces.

A lotion I would recommend in the common though very intractable irritable eye associated with a gouty disposition, well called "hot-eye," is a mixture of salicylates (salicylate of soda 40 grs., salicylate of cocaine 3 grs., salicylic acid 1 gr., distilled water 8 oz.).

Drops for the eye are made as watery solutions, and generally are of the strength of one to two grains to the ounce.

In some cases it is advisable to use an oily menstruum, as castor or olive oil. This is especially the case when the full action of a drug, as atropine or cocaine, is required. The objection to the oily mixtures is the smarting pain produced, but this is counterbalanced by the longer and stronger action, owing to the tears not being able to wash away the application.

Drops are generally applied to the conjunctiva by a small drop-tube with a piece of india-rubber at one end, by a glass rod, or by a camel's-hair brush. As an astringent for the mucous membrane, sulphate or salicylate of zinc (from one to two grains to the ounce) is the best, though alum or sulphate of copper may be used.

Quinine drops, 2 grs. to the ounce, are indicated in membranous conjunctivitis.

The conjunctiva, as the cornea, is easily rendered anaesthetic by cocaine, except when it is much inflamed. Solutions of cocaine used as drops are very beneficial in allaying irritation of the conjunctiva, and may be used up to 4 per cent. It is very important to remember that the patient should be warned not to expose the eye to dust or

foreign bodies for an hour after cocaine has been employed, as the liability to such an occurrence is increased owing to the enlargement of the palpebral fissure, the diminution in frequency of the lid wink, and anaesthesia.

*Lamelles* or *disks* made with gelatine and a little glycerine are a very convenient method of application to the conjunctiva as they are not so readily diffusible as drops. They can be very readily placed on the conjunctival surface of the lower lid by a small camel's hair brush, and the exact amount of the drug can be better calculated than with drops. For cocaine they are employed as  $\frac{1}{30}$  grain or  $\frac{1}{30}$  grain.

The *ointments* used are generally made up with vaseline (soft paraffin), but sometimes conjunctiva, as skins, will not tolerate vaseline; in such cases the basis may be cold cream, lanolin, etc. Boracic acid ointment is a very useful one for inflamed conjunctival edges of the lids; zinc ointment (30 grains of oxide of zinc to the ounce) acts also as a slight astringent.

The ointment for conjunctival troubles, as phlyctenules, and certainly the most generally used eye ointment, is compounded of yellow oxide of mercury and vaseline, and is known as unguentum flavum. Some years ago Mr. Jonathan Hutchinson said he should like to take a whole sheet of a daily paper for days, and simply print on it unguentum flavum for the eyes. It certainly acts in many cases almost like magic, especially when combined with massage of the eye. It is used of various strengths from one to ten or fifteen grains to the ounce.

Painting the lids, especially the conjunctival surface of the upper lid, in granular or purulent conjunctivitis is often necessary. This is done with a camel's-hair brush or, better, a probe covered with absorbent cotton wool. Solutions of nitrate of silver are generally used, from 4 to 20 grs. to the ounce, and after the application the conjunctival surfaces should be bathed with water containing a little chloride of sodium, in order to form the chloride of silver and stay the caustic action. Such applications should be used with care, as I have seen, from the too free use of nitrate of silver in ophthalmia neonatorum, the lids deformed afterwards from the resulting cicatrices, and entropion or ectropion produced. Another trouble is that nitrate of silver, if used too long, produces a yellowish-brown or slate-coloured staining of the conjunctiva. This is due to the staining of the elastic fibres of the sub-epithelial layers.

Other methods of treating inflammation of the conjunctiva, especially the follicular or granular variety, are by touching the surface lightly with a crystal of sulphate of copper, or by a stick called lapis divinus, composed of sulphate of copper, nitrate of potash, and alum. After these applications the conjunctival surface should be washed with water to prevent damaging the cornea by the escharotic.

The cornea has certain points in its anatomical and physiological nature that should especially be remembered in treatment. It is coated over with a soapy film from the conjunctival secretory glands, which keeps it transparent and polished, and thus prevents dust, etc., irritating it. If cocaine is much used the surface of the cornea tends to become dry, and foreign bodies much more easily lodge on it, and may produce ulceration from corneal abrasion. Hence the great care that must be taken in protecting the cornea by closing the lids after cocaine has been used. Any abrasion of the cornea and loss of the protective epithelium may be followed by serious ulceration, and hence escharotics, as strong nitrate of silver, must be applied with care.

When the corneal epithelium is abraded or ulcerated the chief symptoms are great pain and neuralgia—owing to the exposure of the nerves,—photophobia, and lachrymation.

The pain may be, as a rule, relieved by keeping the eye bandaged in order to prevent the lids rubbing over the abraded surface, and also to procure rest for the eye. In some cases cocaine drops or lotion relieve it, and atropine drops (two to four grains to the ounce) act also as a sedative.

The pain, if acute, may be much lessened by fomentations of belladonna and poppy heads.

For corneal ulceration when not acute, and nebulae left after keratitis, the best treatment is by the yellow oxide of mercury ointment (two to twenty grains to the ounce). For nebulae it should be placed on the inside surface of the lower lid, and the lids rubbed over the eye so as to produce massage of the cornea.

In conclusion I wish to impress on you the importance of properly applying heat to the eyeball in ocular diseases. There are two methods, by moist and by dry heat. The latter is best carried out by taking some absorbent cotton wool and heating it before a source of heat, or in a hot chamber, placing the wool as a pad over the shut lids, then covering it with some gutta-percha tissue or protective, and bandaging the eye; the pads should be frequently changed.

Another way is by a muff warmer.

Warm or hot moist applications are made by wringing out some absorbent cotton wool or lint in nearly boiling water, and placing it over the closed lids (care being taken that the cornea is not exposed) as hot as the patient can stand. A piece of gutta-percha tissue or protective is placed over the pad as before, and by this means the heat is kept up. Fomentations ought to be employed as hot as can be borne, and are used by soaking absorbent cotton-wool pledgets or sponges in the nearly boiling mixture, and applying them to the lids.

After doing this for five or ten minutes, the eye should be bandaged up as directed above for moist heat application.

The fomentations most commonly used are boroglyceride, boracic acid, poppy heads, or belladonna.

### A Case of Placenta Prævia.

By G. F. HOLT, M.R.C.S., L.R.C.P.

**ON** May 28th last I was called to see Mrs. S., æt. 43, the mother of thirteen children, who was expecting to be confined in July. For the last two days she had been losing freely.

On examination the placenta could be felt lying nearly centrally over the os. My partner, Mr. Shelley, who arrived shortly, gave chloroform. I then turned by the combined method; after a slight delay the membranes were ruptured, and a leg together with a small piece of placenta brought down. The bleeding, which up to now had been considerable, ceased, and within an hour the uterus was emptied. The peculiarity (to us) in this case was the toughness of the membranes (which had to be scratched through with the nail), and the excessive quantity of liquor amnii. The patient, although still very anæmic, is making a good recovery.

### Impressions of Surgical Teaching and Technique in the United States of America.

By F. K. WESSELS, M.R.C.S., L.R.C.P.

**I** SHALL only relate my experiences at the Johns Hopkins Hospital in Baltimore, the surgical routine of which is perhaps the most perfect of its kind in America.

The surgical work done at the hospital is divided into two distinct departments, viz. (1) general surgery; (2) gynaecology.

General surgery is under the direction of Professor Halstead, who is assisted in his work by two associate professors, several assistants, a house surgeon, two assistant house surgeons, and several interns. There are also surgeons in charge of the out-patient departments, and clinical assistants helping them. The professor of surgery is also chief of the clinic, and does the following teaching:—

1. A clinical lecture is delivered once a week to the junior, senior, and post-graduate students. The German plan is followed; several students are asked to examine a case brought into the clinic, and "quizzed" by the professor. The professor then gives a short account of the disease, or presents other similar cases, and delivers a course of lectures, the result of a more or less elaborate research.

2. Almost every morning the professor operates; and sometimes a short description of the operation or the tissues removed is given. The associate professor also conducts a "clinic" once a week, and operates several times a week.

One assistant has charge of the clinical laboratories, and gives several courses a year in surgical pathology. This course is an excellent one. The class is taken over all the tissues removed in the operating room, and the men are taught to prepare them for microscopical examination. A very valuable demonstration is given each week by Dr. MacCallum, the resident pathologist, on all the morbid materials collected in the course of the week from the post-mortem room. Those who cannot attend the post-mortems because of conflicting duties thus have an opportunity to study the tissues carefully under the guidance of the resident pathologist.

Each assistant and associate in surgery makes a speciality of some branch of surgery. Dr. Cushing gives a neurological clinic once a week, and also a course in operative surgery and surgical anatomy, particularly of the nervous system.

The house surgeon's office is a permanent one, and he presides over all the wards, and assists the professor in the operations. This position is a very enviable one, and is very much sought after; for not only can the graduate gain in a few years a large surgical experience, but the house surgeon at Johns Hopkins Hospital is consulted by practitioners in several of the central, eastern, and southern states. The office is usually held for several years, and so the "Chief" and his house surgeon become thoroughly accustomed to each other, and operations are performed with a dash and swing which is most fascinating.

The assistant house surgeons aid the house surgeon in his duties, and they in turn are assisted by "interns," whose term of office lasts for one year. They do the routine work, have charge of one or two wards each, and direct the students in their care of the cases.

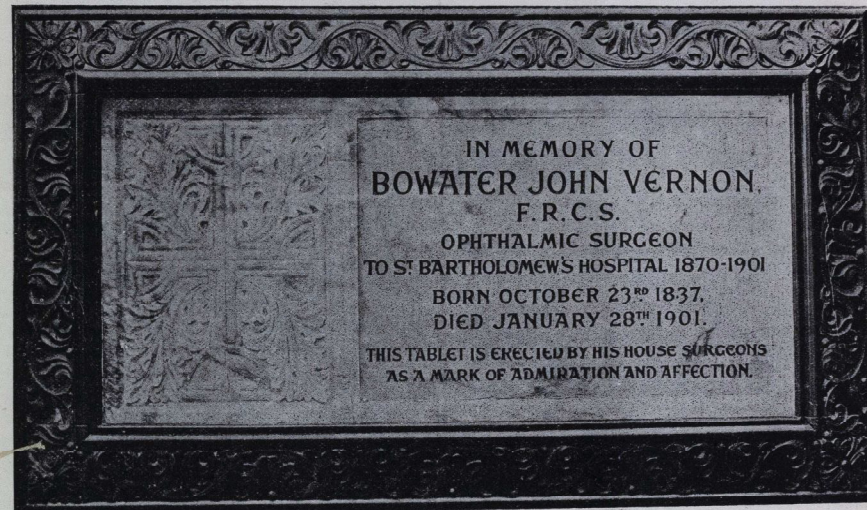
This is in brief the compact machine which governs the fourscore or more surgical cases in the hospital.

The gynaecological surgery forms a very important branch in the Johns Hopkins Hospital, under the direction of Professor Kelly. This department is conducted almost exactly like that of general surgery, but gynaecological surgery seems to embrace almost all abdominal operations in women, and so the departments overlap more or less.

The students at the Johns Hopkins Hospital are considered the ablest group of medical undergraduates in the United States; only about fifty are allowed to enter every year, and the course extends over four years of nine months each.

Before entering the candidates must have graduated from a recognised college, and have a thorough knowledge of physics, chemistry, and biology in general, and must be able to read the German and French medical journals fluently. In this way a "freshman" is prepared to begin anatomy, physiology, and bacteriology immediately after entering the school. Pathology (including surgical patho-

Reproduced from the Memorial Tablet in the Church of St. Bartholomew the Less.



logy), pharmacology, anatomy, and medical jurisprudence are taken up during the second year.

The student devotes his last two years almost entirely to clinical work in the out-patient departments, wards, and clinical laboratories.

It might be interesting to some to give one's impressions as to the excellence of the education a graduate from Johns Hopkins receives as compared with that of a graduate from one of the English or Scottish universities.

1. The Johns Hopkins men receive a far more thorough training in the purely scientific side of medicine. Under the inspiring teaching of Professors Welch, Mall, Abel, Howell, and others, each presiding over a laboratory with unexcelled equipment, and each a leader in his own department, the students gain not perhaps as thorough a knowledge of the main points from the examination point of view, but an investigative knowledge of the medical sciences.

Several very valuable researches, both scientific and clinical, are completed every year by students before their graduation. For this reason also a very large proportion of students spend one or more years after graduation in research both in Germany and in local laboratories.

Recently large sums of money have been set aside by Messrs. Rockefeller and Carnegie for the encouragement of research in all scientific branches of learning. Medical graduates in America, therefore, who have a moderate amount of ability and a sufficiently thorough training are given an opportunity to spend some time in working out problems yet unsolved free of all expense.

This zeal for scientific research reacts very disadvantageously on the practical side of the medical education.

The bedside teaching in the surgical wards is almost exclusively done by the assistants and house surgeons, and thus the student does not find his clinical training so interesting.

The teaching in the out-patient department is not so systematically done, and the student does not receive very much personal instruction.

Large "clinics," such as those conducted in Germany and the United States, are very excellent, but cannot compare with the "grouping" of students which is resorted to in the London hospitals. The ambitious student perhaps accomplishes as much in his work as is done here, but the average men cannot possibly gain as much experience in clinical diagnosis of surgical diseases.

The surgical routine at Johns Hopkins differs in only a few points from that in vogue in England.

General anaesthesia is employed as seldom as possible. If given, ether is preferred, and is administered usually by means of a sponge inserted into a cone made of an ordinary towel stiffened with paper.

2. Schleich's method of administering cocaine in normal salt solution, 1 in 3000, is very much employed, and, unless a patient is very neurotic, he is advised to choose this method of cocainisation for the less severe operative procedures. Thyroidectomies, amputations, appendicectomies, gastrostomies, operations for radical cure of hernia, cholecystotomies, and other major operations are regularly performed by this method with most excellent results.

Spinal cocainisation is not much practised.

The "Kay-Schurer system" of sterilisation of dressings and water is employed, which has been or is being introduced in several London hospitals.

Catgut prepared by the "Camal method" is used by Dr. Kelly for all ordinary ligatures of small vessels and buried sutures, and for closing the abdomen. Dr. Halstead uses fine black Chinese twist silk for ligaturing small vessels and

bringing together the cut edges of fascial planes and peritoneum, but employs mattress silver wire sutures for apposing the muscular planes. Continuous silver wire sutures are also employed for the skin, but are inserted subcutaneously as buried skin sutures.

Sterilised silver foil is placed directly over the wounds when they are intended to heal by first intention, dry aseptic gauze heaped over this, and a stiffened outer bandage usually placed over the ordinary gauze bandages.

A great deal of attention is paid to the insertion of gauze drains in septic abdominal cases. Each gauze drain is surrounded by an envelope of protective, the object being as much as possible to prevent irritation of the wound edges and intestines, which is so troublesome if naked iodoform gauze is used. The drains are very carefully inserted, and none are allowed to come between the coils of intestines, the abscess cavity being thus surrounded by a "gauze drain wall."

In renal surgery, especially in the gynaecological wards, cystoscopy and ureteral catheterisation is a regular proceeding. The wax-tipped ureteral catheter and the flushing catheter for washing out the pelvis of the kidney are apparatuses which impress the visitor very much. The

work of the gynaecological side is considered more interesting by post-graduates in general.

What impresses one much is the youth of the assistant surgeons and gynaecologists. Boyish-looking men are seen to wield the knife from morning to night with great composure and dexterity.

On the whole the students follow the German text books, and are encouraged to read these in preference to the smaller English manuals; but the average student knows more about the original work done by the London surgeons than the most widely read London undergraduates. Students are given references in each clinic and lecture to the original works on the subject under consideration.

One feature of the life and routine of Johns Hopkins Hospital is the number of medical societies which hold frequent meetings.

Dr. Osler is the idol of the hospital, and interests himself in every movement among the students. He is regularly seen at the meetings referred to above, and directs a great deal of the work.

Students and members of the staff are given every opportunity to publish research done in the many journals conducted by the various heads of departments. The *Johns Hopkins Hospital Bulletin*, published monthly, is a very fine little journal, and contains much that is interesting and profitable. Most of the papers read at the society meetings are printed subsequently in this journal.

Americans are very proud of Johns Hopkins Hospital and its teaching, and some of their great men predict that Europeans will be compelled in the near future to cross to their great centres to learn and study scientific problems, because of the magnificent facilities now promised or to be inaugurated in the near future.

### The Seventh Decennial Dinner.

THE Nineteenth Annual Dinner of the Seventh Decennial Contemporary Club took place on Wednesday, July 2nd, at the Trocadero Restaurant.

Mr. James Berry was in the Chair, and seventy members were present. The toasts of "the King" and "the Club" were proposed by the Chairman, whose own health was proposed by Dr. Rolleston.

In the course of his speech the Chairman quoted a short poem, which we reproduce in full.

#### "THE LAST SURVIVOR."

(After Oliver Wendell Holmes.)

Yes, already vacant places are showing all too fast,  
And the thought comes strangely o'er me, who will live to  
be the last?

When the twentieth century's decades through half their  
course have run,  
With his ninety winters burdened, will he dine—a club of  
one?

Will he be an ancient surgeon who will turn his feeble gaze  
To the long-forgotten methods of antiseptic days?  
Or an erudite physician, burdened with useless lore,  
When all drugs are patent extracts and prescribing is no  
more?

Will wealth have crowned his efforts, a popular G. P.?  
Have patients rich and titled dropped guineas as his fee?  
Or in a crowded suburb will our last survivor dwell,  
And listen to the ringing of a ceaseless surgery bell?

And will his name have figured 'mid those who honours win,  
Attached to learned papers or a royal bulletin?  
Or will he reach his evening with neither fame nor wealth,  
A mute, inglorious brother, who doeth good by stealth?

Here's to our last survivor, whoever he may be,  
Pathologist, physician, anatomist, G. P.;  
We'll pledge him at his banquet, where memories will play,  
And conjure up around him the comrades of to-day.

### Notes.

WE beg to congratulate Mr. Howard Marsh on his reelection to the council of the Royal College of Surgeons.

DR. DRYSDALE has been appointed Medical Registrar to the Hospital.

MR. WEST has been appointed Junior Demonstrator of Anatomy.

IN our last number we recorded the appointment of Mr. Christopherson as a Surgeon to the Egyptian Army, and we take this opportunity of congratulating him on so excellent an appointment.

THE Lawrence prize and gold medal have been awarded to R. C. Elmslie; the Matthews Duncan prize and gold medal have been awarded to A. R. Nelligan.

AT the distribution of honours in connection with the Coronation, a K.C.B. was conferred on Sir William

Church, and we beg to offer him our warmest congratulations on behalf of every one who is connected with the Hospital. We feel that this honour is only a just recognition of Sir William's invaluable services not only to St. Bartholomew's, but also to the College of Physicians and to the various Commissions which of late have claimed so much of his attention; and we look forward with the utmost reluctance and regret to the day—unfortunately not far distant—when Sir William Church will cease to be our Senior Physician.

The list of Coronation Honours also included the names of three other Bart.'s men. Sir Alfred Cooper, who is Consulting Surgeon to the West London Hospital, and Sir W. J. Collins, who is well known in connection with London University and the London County Council, received a knighthood; and a C.B. was conferred upon Mr. Ronald Ross, who has done most valuable work on malaria.

The Burrows prize and the Skynner prize have been awarded to E. G. Pringle.

The Horton Smith prize for this year has been awarded to Dr. E. Laming-Evans for a thesis on "The Bactericidal Action of the Blood of Typhoid Convalescents." The prize is given annually for the best M.D. thesis for each year at Cambridge; it was established in 1899, and has therefore been won only three times, and we are glad to say that on two occasions a Bart.'s man has been successful. We hope that our prospective M.D.'s will maintain this excellent precedent.

PROBABLY many of our readers have had no opportunity of seeing the tablet in memory of Mr. Vernon which was placed in the church of St. Bartholomew the Less by Mr. Vernon's house surgeons.

An old Bart.'s man was good enough to present us with an admirable photograph of the tablet, and we have published a reproduction of the photograph in the hope that it will interest those who had the privilege of knowing Mr. Vernon.

"THE old order changeth, giving place to new," and we are extremely sorry that Mr. Mundy and Mr. Douglas, who have resigned their appointments in the "rooms," will shortly be leaving the Hospital; we believe, however, that they are now experts on all public health matters, and we wish them every success.

The Shuter Scholarship has been awarded to J. K. Willis, of Queens' College, Cambridge.

The Past and Present cricket and tennis matches took place on June 11th at Winchmore Hill. The afternoon

was sunny and pleasant, the band discoursed sweet music, the cricket and tennis were excellent, and Mr. and Mrs. Gibbs and their attendant satellites ministered to our bodily needs. But unfortunately very few people were there to enjoy these varied pleasures. Mr. Bowly, Mr. Waring, and the Warden honoured us with their presence, and the nursing staff was fairly well represented; but the student was conspicuous by his absence. For our own part we spent a most delightful afternoon, but we must confess to a feeling of regret that larger numbers were not present to share our enjoyment.

It is with deep regret that we have to record the death of Dr. C. H. Barnes, who had only recently left the Hospital and taken up private practice at Highgate. He was taken ill on May 26th with tonsillitis, which ultimately proved to be diphtheria. He was attended by his partner and by Dr. West, but died on June 10th after an illness of about a fortnight.

FROM an athletic point of view the Hospital record for the past school year is not altogether so satisfactory as might be wished; but two recent victories have done much to retrieve our position, and we heartily congratulate those who contributed to our success in the Inter-Hospital sports and the shooting. We had hoped for a victory in the sports, but probably no one anticipated that we would win so handsomely. Our tie with St. Thomas's for the Armitage Cup is equally gratifying both in that the result was obtained after a very uphill struggle, and also that for the first time in our history the shooting cup will help to adorn the Library. We hope soon to be able to add the water-polo championship to our list for this year.

ON July 18th the distribution of prizes will take place in the Great Hall at 3 o'clock. Sir J. Dimsdale, Bart., M.P., will give away the prizes, and Sir Trevor Lawrence, Bart., will preside. There will be afternoon tea in the square subsequently.

This innovation is a very welcome one. Some years ago it was the custom to hold the prize distribution in the Great Hall, and we had the pleasure of hearing a most instructive address from Mr. Luther Holden on one of those occasions. But of late the prizes have been distributed in the comparative seclusion of the School Committee Room, no doubt on the ground that its atmosphere was most suitable to such an occasion. The School Committee Room, however, was hardly large enough, and we are very glad that a return has been made to the Great Hall. Moreover it is most appropriate that the head of the City should be present at the prize day of the only medical school in the City, especially as he is a Governor of the Hospital, and it is hoped that every one will be present to welcome the Lord Mayor.

By an error on our part the names of the winners of the Junior Scholarships were misplaced in the April number of this JOURNAL. The order should be (1) A. L. Giuseppi, (2) H. Quick.

Amalgamated Clubs.

THE Hospital Annual Sports were held at Stamford Bridge on Tuesday, June 17th, in perfect weather. The band of the T Division, Metropolitan Police, were in attendance, and played selections during the afternoon to a fair number of spectators.

The entries for the races, we were glad to notice, were considerably larger than those of last year, notably those of the 120 yards handicap.

H. E. Graham and P. Gosse shared between them the honours of the afternoon; the latter especially ran in very good form, carrying off the first prize in the half-mile and the mile, the second in the two miles steeplechase (open to all hospitals), and third in the 200 yards handicap. The prize for the mile was presented by W. Bruce Clarke, Esq., F.R.C.S., and was an exceptionally pretty silver card-tray; while that for the half-mile was given by Messrs. Benetfink.

The freshers' race (220 yards) — always an event of interest — was easily won by W. B. Griffen, who also ran very well in the 120 yards and the quarter-mile; he ought to do very well next year. The Junior Staff race was won by Whitwell, who also carried off the first in the 120 yards hurdles.

W. H. Orton was in fine form, winning the 100 yards; he ran H. E. Graham very close for first place in the 440 yards, also carrying off second prize in the 120 yards handicap, being just beaten by L. Murphy, to whom he had to give eight yards.

In the high jump D. M. Stone from scratch jumped 5 feet 4 1/2 inches, H. T. Wilson being second.

The two miles steeplechase (open to all hospitals) is a new item in the Sports, and had it not been that our Sports were fixed too near those of some of the other hospitals we might have had a larger entry. Three outsiders entered for the race, but failed to turn up. The starters were J. G. Gibb, P. Gosse, and F. A. Izard. Gibb started off in his usual fine form, and soon took the lead, which he managed to maintain to the finish; his time was 11 min. 50 1/2 sec. P. Gosse was second.

Our thanks are due to A. A. Bowly, Esq., F.R.C.S., who very kindly consented to start the races; to the judges, Dr. Drysdale, H. J. Waring, Esq., F.R.C.S., P. Furnival, Esq., F.R.C.S. (of the London Hospital); and to W. D. Harmer, Esq., F.R.C.S., all of whom rendered us most valuable assistance.

Mr. Bruce Clarke, our President, very kindly consented to present the prizes in the place of Mrs. Bruce Clarke, who, we regret to say, was unable to be present owing to ill-health. We trust that on some future occasion she will honour us with her presence. After the distribution of the prizes a hearty vote of thanks was proposed to the President by the Secretary.

- The programme was as follows:
- I. 100 yards (level) Challenge Cup (presented by A. A. Bowly, Esq.).
    - 1. W. H. Orton. | 2. B. Hudson. | Time—11 sec.
  - II. One Mile Handicap (1st prize presented by W. Bruce Clarke, Esq., F.R.C.S.).
    - 1. P. Gosse. | 2. H. E. Graham. | Time—4 min. 37 1/2 sec.
  - III. Weight Handicap.
    - 1. H. E. Boyle, 37 ft. 10 in. | 2. R. Douglas.
  - IV. 440 yards (level) Challenge Cup (presented by Mrs. Harrison Cripps).
    - 1. H. E. Graham. | 2. W. H. Orton. | Time—55 sec.
  - V. Long Jump (Handicap).
    - 1. J. R. Lloyd, 18 ft. | 2. G. M. Levick.
  - VI. 120 yards Handicap.
    - 1. L. Murphy. | 2. W. H. Orton. | Time—12 1/2 sec.

VII. Freshers' Race (220 yards level) Challenge Cup (presented by W. S. A. Griffiths, Esq., M.D.).

1. W. B. Griffen. | Time—26 1/2 sec.

VIII. 120 yards Hurdle Handicap.
 

- 1. H. Whitwell. | 2. T. M. Body. | Time—20 3/4 sec.

IX. Half-mile Handicap (1st prize presented by Messrs. Benetfink, Cheapside).
 

- 1. P. Gosse. | 2. H. E. Graham. | Time—2 min. 4 1/2 sec.

X. Throwing the Hammer.
 

- 1. H. E. Graham, 77 ft. 11 in. | 2. T. M. Body, 67 ft. 1 in.

XI. Junior Staff.
 

- 1 (2nd prize). H. Whitwell. | Time—12 3/4 sec.

XII. High jump (Handicap).
 

- 1. D. M. Stone, 5 ft. 4 1/2 in. | 2. H. T. Wilson.

XIII. Two Miles Steeplechase (open to all hospitals).
 

- 1. J. G. Gibb. | 2. P. Gosse. | Time—11 min. 50 1/2 sec.

CRICKET CLUB.

ST. BART.'S v. LONDON HOSPITAL.

Played at Chiswick Park, June 9th, 1902.

SCORES.

| ST. BART.'S.                                      |    | LONDON HOSPITAL.                                       |     |
|---|----|--|-----|
| C. F. Nicholas, b Roberts ...                     | 2  | H. B. Walters, c Nealar, b Eckstein.....               | 22  |
| C. M. H. Howell, b Roberts ...                    | 2  | J. H. J. Wilgress, c Anderson, b Stanger-Leathes ..... | 6   |
| W. S. Nealar, c Walters, b A. H. Jacob .....      | 3  | A. M. Simpson, run out .....                           | 25  |
| L. V. Thurston, c Sparrow, b Roberts .....        | 0  | A. R. Moore, b Eckstein.....                           | 0   |
| W. Griffen, not out .....                         | 24 | E. A. Ellis, b Howell .....                            | 10  |
| C. A. Anderson, c Sparrow, b Roberts .....        | 0  | N. B. V. Jacob, c Eckstein, b Nealar .....             | 26  |
| G. G. Ellett, b A. H. Jacob ...                   | 0  | F. D. Roberts, c Anderson, b Howell .....              | 5   |
| T. Eckstein, c Simpson, b A. H. Jacob .....       | 0  | A. H. Jacob, not out .....                             | 35  |
| C. Elliott, b Roberts .....                       | 1  | R. D. Sparrow, c Elliott, b Howell .....               | 2   |
| G. F. Page, b Roberts .....                       | 0  | L. M. Waldron, c Page, b Griffen .....                 | 10  |
| H. E. Stanger-Leathes, c Roberts, b Waldron ..... | 13 | H. F. Horne, c Nealar, b Griffen .....                 | 3   |
| Extras .....                                      | 12 | Extras .....   | 7   |
| Total .....                                       | 57 | Total .....  | 151 |

ST. BART.'S v. HON. ARTILLERY CO.

Played at Finchbury, June 21st, 1902.

SCORES.

| ST. BART.'S.                            |     | HON. ARTILLERY CO.                             |    |
|---|-----|--|----|
| W. S. Nealar, not out .....             | 119 | W. E. Waigh, b Griffen .....                   | 0  |
| W. Griffen, c Waigh, b Chapman.....     | 16  | W. Baker, b Stanger-Leathes .....              | 0  |
| C. A. Anderson, b Terry .....           | 33  | A. J. Adams, b Stanger-Leathes .....           | 2  |
| C. M. H. Howell, c Adams, b Terry ..... | 61  | J. D. H. Watts, b Stanger-Leathes .....        | 0  |
| L. V. Thurston .....                    | 0   | A. A. Terry, b Griffen .....                   | 0  |
| C. F. Nicholas .....                    | 0   | H. L. Chapman, c Nicholas, b Griffen .....     | 1  |
| T. M. Body .....                        | 0   | L. M. Llewellyn, b Stanger-Leathes .....       | 0  |
| H. E. Stanger-Leathes .....             | 0   | Capt. Varley, run out .....                    | 0  |
| C. Elliott .....                        | 0   | C. Baynes, c Thurston, b Stanger-Leathes ..... | 0  |
| L. L. Phillips .....                    | 0   | S. W. Leage, c Nicholas, b Griffen .....       | 1  |
| G. F. Page .....                        | 0   | E. McKechnie, not out .....                    | 5  |
| Extras .....                            | 6   | Extras .....                                   | 3  |
| Total .....                             | 235 | Total .....                                    | 12 |

## PAST v. PRESENT.

Played at Winchmore Hill on June 11th. The day was an ideal one for cricket, and a very fair number of spectators were present during the afternoon, among whom were Dr. Calvert, Mr. Bowley, Mr. Waring, and several of the sisters. Students, however, did not come in at all as many numbers as they might and should have done. It was a pity that the Present team was so weak—an operative surgery class keeping more than one away. The Past team was, however, a good one, and they won the match fairly easily for the first time since its institution. Scoones, Nimmo, Nunn, and Talbot all batted well, and the former declared with eight wickets down for 145. The Present had plenty of time to make the runs, but they all, with the single and marked exception of Anderson, failed, he hit freely and well for 60. Fank, for the Past, bowled in great form, taking 5 wickets for 18 runs—the last 4 in 4 balls. The Past, therefore, won by 2 wickets and 40 runs.

## SCORES.

| PAST.                           |     | PRESENT.                      |    |
|---------------------------------|-----|-------------------------------|----|
| H. J. Pickering, b Griffen ...  | 0   | W. S. Nealor, b Pank .....    | 1  |
| H. E. Scoones, b Elliott .....  | 24  | W. Griffen, c Nimmo, b        |    |
| F. H. Nimmo, run out .....      | 33  | Boyle .....                   | 3  |
| H. E. G. Boyle, b Griffen ...   | 8   | C. A. Anderson, b Nunn .....  | 60 |
| C. G. Watson, b Griffen .....   | 2   | C. Elliott, c and b Nimmo ... | 13 |
| J. W. Nunn, not out .....       | 20  | G. H. Adam, c Nunn, b         |    |
| E. Talbot, c sub, b Elliott ... | 22  | Nimmo .....                   | 1  |
| H. Whitwell, b Elliott .....    | 0   | B. Hudson, not out .....      | 8  |
| H. W. Pank, not out .....       | 12  | L. L. Phillips, c Boyle, b    |    |
| T. M. Body } did not bat.       |     | Nunn .....                    | 2  |
| L. B. Rawling } did not bat.    |     | C. O'Brien, b Pank .....      | 0  |
|                                 |     | A. H. Hayes, b Pank .....     | 0  |
|                                 |     | G. F. Page, l-b-w, b Pank ... | 0  |
| Extras .....                    | 24  | Extras .....                  | 9  |
| Total .....                     | 145 | Total .....                   | 97 |

## RIFLE CLUB.

The Inter-Hospital competition for the Armitage Cup took place this year on Wednesdays, May 28th, June 11th, and June 18th. On the first two shoots St. Thomas's Hospital was leading by thirty-nine points, but owing to the excellent shooting of Morris, Brown, and Read on June 18th we gained all the points we had fallen behind, and the competition resulted in a tie between St. Thomas's and St. Bartholomew's Hospitals.

It has therefore been decided that each hospital shall hold the Cup for six months, and our Library will, in consequence, contain yet another Cup from January to June next. This is the first year in which our Hospital has been successful in Inter-Hospital matches, and it is hoped that we shall continue to be so.

## SCORES.

| May 28th.                    |      | June 11th.                   |      |
|------------------------------|------|------------------------------|------|
| St. Bart.'s.                 | Pts. | St. Bart.'s.                 | Pts. |
| 1. A. C. Brown (capt.) ..... | 86   | 1. A. C. Brown (capt.) ..... | 86   |
| 2. J. Morris .....           | 82   | 2. J. Morris .....           | 89   |
| 3. P. A. Dingle .....        | 75   | 3. P. A. Dingle .....        | 76   |
| 4. E. A. Wright .....        | 74   | 4. W. R. Read .....          | 77   |
| 5. T. W. Burne .....         | 43   | 5. W. W. Joudwine .....      | 73   |
| 6. N. Bennett Powell .....   | 60   | 6. E. A. Wright .....        | 80   |
| Total .....                  | 419  | Total .....                  | 481  |
| St. Thomas's .....           | 450  | St. Thomas's .....           | 489  |
| Guy's .....                  | 420  | Guy's .....                  | 448  |
| June 18th.                   |      |                              |      |
| St. Bart.'s.                 |      | St. Bart.'s.                 |      |
| 1. A. C. Brown (capt.) ..... | 88   | 1. A. C. Brown (capt.) ..... | 88   |
| 2. J. Morris .....           | 96   | 2. J. Morris .....           | 83   |
| 3. P. A. Dingle .....        | 83   | 3. P. A. Dingle .....        | 88   |
| 4. W. R. Read .....          | 88   | 4. W. R. Read .....          | 83   |
| 5. W. W. Joudwine .....      | 83   | 5. W. W. Joudwine .....      | 80   |
| 6. S. H. Andrews .....       | 80   | 6. S. H. Andrews .....       | 80   |
| Total .....                  | 518  | Total .....                  | 518  |
| St. Thomas's .....           | 479  | St. Thomas's .....           | 479  |
| Guy's .....                  | 450  | Guy's .....                  | 450  |

The following matches were arranged, with the result that six have been successfully contested and two lost:

## SCORES.

| Opponents.                 | St. Bart.'s. | Result.   |
|----------------------------|--------------|-----------|
| Dulwich College .....      | 424          | ... Lost. |
| St. Paul's School .....    | 331          | ... Won.  |
| Eastbourne College .....   | 255          | ... Won.  |
| Whitgift Grammar School .. | 297          | ... Won.  |
| Lancing College .....      | 256          | ... Won.  |
| Cooper's Hill .....        | 330          | ... Lost. |
| Rugby School .....         | 335          | ... Won.  |
| Hilgate School .....       | 393          | ... Won.  |

## THE PRIZE MEETING.

The Rifle Club Prize Meeting, held on Thursday, June 19th, was very successful, the entries for the various competitions exceeding those of previous years. The day was fine and bright, and the wind slight; it therefore did not interfere in any way with the shooting.

The following is the result of the competitions:

|  |                 |                 |
|--|-----------------|-----------------|
| The Grand Aggregate Challenge Cup (presented by Mrs. Waring).              | 1. J. Morris.   | 2. A. C. Brown. |
| The Club Aggregate Challenge Cup (presented by Messrs. Benetfink and Co.). | 1. R. Fuller.   | 2. J. Morris.   |
| The Club Competition.  | 1. R. Fuller.   | 2. J. Morris.   |
| Rapid Firing.  | 1. R. Fuller.   | 2. J. Morris.   |
| Junior Staff.  | W. W. Joudwine. |                 |
|  | J. C. Izard.    |                 |

## LAWN TENNIS CLUB.

## INTER-HOSPITAL CUP TIES.

## 1ST ROUND.—ST. BART.'S v. GUY'S.

This match was played at Chiswick on Wednesday, July 2nd, and ended in a fairly easy victory for Guy's. Our prospects for the Cup were not very good, only two of last year's men, Hunt and Pope, being eligible.

## SCORES.—SINGLES.

|  |
|--|
| E. H. Hunt beat F. Lucas, 6-4; 7-9, 6-3.         |
| J. C. Slade lost to F. Palmer, 9-7; 1-6, 6-4.    |
| A. Hamilton lost to E. Jupp, 3-6; 6-2, 6-2.      |
| C. A. W. Pope lost to B. H. Wedd, 7-5; 2-6, 4-6. |
| F. Black lost to C. Winkworth, 8-6, 6-4.         |
| P. W. Leathart lost to A. Zorab, 8-4, 9-7.       |
| Score in favour of Guy's 5-1.                    |

## DOUBLES.

|   |
|---|
| Jupp and Zorab—                         |
| beat Leathart and Slade, 6-3, 6-4.      |
| lost to Hunt and Pope, 4-6, 4-6.        |
| Palmer and Lucas—                       |
| beat Hunt and Pope, 6-2, 6-4.           |
| lost to Hamilton and Black, 1-6, 4-6.   |
| Wedd and Winkworth—                     |
| lost to Hamilton and Black, 2-6, 3-6.   |
| beat Slade and Leathart, 6-4; 2-6, 6-1. |

## SCORE.

|                               |          |
|-------------------------------|----------|
| St. Bart.'s 3.                | Guy's 3. |
| Total in favour of Guy's 8-4. |          |

## DRAW FOR THE CUP TIES.

## 1ST ROUND.—ST. BART.'S v. GUY'S.

|              |          |
|--------------|----------|
| London       | } A bye. |
| St. Thomas's |          |
| St. George's |          |

## SWIMMING CLUB.

## FIRST CUP TIE.

## BART.'S v. GUY'S.

The first round of the Cup tie was played off at 3 p.m. on June 20th at Southwark Baths. Guy's won the toss and elected to defend the deep end first. On starting Stone was the first on the ball, and after a few passes he shot a goal for Bart.'s in the first half-minute. After this Guy's pressed, but were kept out, and by half-time Stone had succeeded in scoring twice more. It seemed as if we were going to have a walk over, but after changing ends Guy's were seen to more advantage, and Moon handed in a ball from just outside goal. The game after this was very even, and neither side scored again till nearly time, when Moon shot another goal for Guy's, thus leaving Bart.'s winners by three goals to two. For us Stone and McDonagh played a very good game, and Hanschell defended goal well. The next match for the Cup tie is Bart.'s v. Thomas's, the date of which is not yet decided.

Team.—H. M. Hanschell (goal); R. C. P. McDonagh and C. F. O. White (backs); J. G. Watkins (half-back); D. M. Stone, R. I. Douglas, and H. N. Wright (forwards).

## Correspondence.

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

DEAR SIR,—I have just read with sorrowful interest the "In Memoriam" of A. N. Weir, which appeared in the April number of the Hospital JOURNAL, and which I have been anxiously waiting for since I read the brief notice of his untimely death in the January number.

Dear old "Ike" Weir was one of the very best of "Bart.'s" men; of his kind few are known in a lifetime.

I sincerely hope that something more than a brief "In Memoriam" in the JOURNAL will be done by his old Hospital to perpetuate his memory. I am sure every "Bart.'s" man who knew Weir as fellow-student, "H. S.," and Demonstrator will be only too pleased to contribute, as his means permit, something towards such an object, and I shall be honoured in adding my small share.

I am, yours very sincerely,

W. B. MERCER.

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

DEAR SIR,—Your reviewer seems to me to have been unduly and unnecessarily severe in his critique of Dr. Roberts's book on "Female Pathology."

Surely it is the duty of a reviewer to take a much more comprehensive view of a book than he seems to have done, and to base his judgment on main rather than side issues. As an instance, Dr. Roberts states that flexions and versions do not cause congestion of the uterus, but your reviewer takes him seriously to task for not "discussing in a scientific spirit" a variety of retroflexion which only occurs in 10 per cent. of all cases of that displacement. Again, if your reviewer had attended Dr. Champneys' lectures he would understand the reference to the size of the normal uterus—"it can be sent by post for a penny." Nothing, it seems to me, could bring home to the mind of an average student the size and weight of a normal uterus better than this. The illustration may be unscientific, but it is none the less striking.

The book contains much sound teaching, and, as Dr. Roberts states in his preface, is founded on the views of the late Dr. Matthews Duncan and his successors at the Hospital. Surely to most of us this is a sufficient guarantee of the soundness and truth of the views expressed, and of its utility as a book of both reference and instruction.

Yours, etc.,

J. A. WILLETT.

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

DEAR SIR,—From the letter which you have forwarded me, Mr. Willett has evidently misunderstood the spirit in which the review of Dr. Roberts's book was written. It was not my intention to deny for a moment that the work contained much sound teaching, and had a very real value of its own. If its many excellences were touched upon too lightly it was from inadvertence and not from design.

I take it, however, that any criticisms of a just and reasonable nature will be welcomed by the author, and are of real value to him when he is called upon to prepare a second edition for the press. Bearing this in mind, I hold it is the duty of a reviewer to point out inaccuracies and defects.

If my words appear "unduly and unnecessarily severe," it can only be because I have expressed myself unfortunately and failed to convey my true meaning, and I am glad to have this opportunity of correcting an erroneous impression.

It was as a text-book of pathology that I criticised the work. A text-book of pathology for advanced medical students should be written in scientific terms, and colloquial expressions which are entirely appropriate and of the greatest value in a clinical lecture are out of place in a purely scientific treatise.

To write a book dealing with the pathology of the female pelvic organs, apart from clinical aspects, is a task of the very greatest difficulty; but as such the work was sent to me for review, and as such I criticised it.

If to any mind the idea has been conveyed that the work is not likely to prove of great value to students preparing for examinations in obstetrics I hasten to correct it; it is precisely to these, and particularly to such as are preparing for the higher examinations, that the work is likely to prove of real assistance. YOUR REVIEWER.

## Review.

A TEXT-BOOK OF PHYSICS, WITH SECTIONS ON THE APPLICATION OF PHYSICS TO PHYSIOLOGY AND MEDICINE. By R. A. LEHFELDT, M.A., D.Sc.

In this book the author has attempted, in an elementary work on physics, not only to present to the student or general reader the main principles of the subject, but also to give an account of recent advances and of applications which have lately been made to chemical and physiological questions. Moreover, in the treatment of this section of the subject, care has been taken to state clearly the results arrived at and their general bearing, rather than to describe

the methods, often very intricate and unconvincing except to the physicist and mathematician, by which these results were attained. This section is found dealing with the modern developments of the subject of osmotic pressure and its relation to the lowering of freezing-point and the raising of boiling-point of solutions. A whole chapter is devoted to the explanation of chemical equilibrium and the law of mass action, and numerous examples of the application of the latter to chemical reactions and to the conditions of equilibrium in a chemical system are considered. Thus, as a deduction from the law of mass action and the ionic theory of salt solutions, there is every reason to believe that, when aqueous solutions of two neutral salts—for example, potassium chloride and sodium nitrate—are mixed, there are present in the solution in a state of equilibrium the four salts, potassium chloride, potassium nitrate, sodium chloride, and sodium nitrate. On altering the conditions, by evaporating the solution, etc., the least soluble salt of those possibly present crystallises out; in the case in question potassium nitrate first separates.

The "phase rule" is explained, and attention is drawn to the fact that in the aëration of the blood an instance is found of this important generalisation.

Another feature of the work is the description of new methods and forms of apparatus; the Töpfer vacuum pump, Beckmann's apparatus for determining the boiling-point and freezing-point of solutions, and Sprengel's pyknometer for the determination of specific gravity are described. It is to be regretted that in all cases diagrams have not accompanied the description.

The book is free from misprints, although on p. 144, line 6, the word "solvent" should obviously be read for "dissolved substance."

Dr. Lehfeldt has maintained the reputation for lucid explanation gained by his previous writings.

### The Rahere Lodge, No. 2546.



THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital (kindly lent for the occasion by the Treasurer and Almoner) on Tuesday, June 10th. Messrs. John C. Baker, M.B., and Wilfrid H. W. Atlee, M.B., were initiated into Freemasonry, and Bros. Croës, Griffith, and Drysdale were elected members of the Standing Committee. W. Bro. Abraham, M.D., the outgoing W.M., installed his successor, Bro. George H. R. Holden, M.D., as W.M. for the ensuing year. Bro. Holden then invested the following as his officers:—W. Bro. Ernest Clarke, P.M., F.R.C.S. Eng., S.W.; W. Bro. J. H. Gilbertson, P.M., P.P.G.D. Herts, J.W.; W. Bro. The Rev. Sir Borradaile Savory, Bart., P.G.C., Chaplain; W. Bro. Clement Godson, P.G.D., M.D., Treasurer; W. Bro. D'Arcy Power, P.G.D., F.R.C.S. Eng., Secretary; Bro. H. J. Waring, F.R.C.S. Eng., S.D.; W. Bro. Haig Brodie, P.M., P.P.G.D. Surrey, M.D., J.D.; W. Bro. F. Swinford Fritzeris, P.M., F.R.C.S. Eng., Dir. of Cerms.; Bro. J. H. Drysdale, M.D., Asst. D. of C.; Bro. G. H. Robinson, Mus. Bac., Organist; Bro. H. W. C. Austen, M.D., I.G.; Bro. M. J. Anderson, Steward; Bro. W. H. Cross, Steward; Bro. C. H. Cosens, Assistant Steward; Bro. M. L. Trechmann, F.R.C.S. Eng., Assistant Steward; Bro. S. R. Scott, M.B., Assistant Steward.

The Lodge adopted a resolution approving of the formation of a Royal Arch Chapter of the Hospital Lodges to be affiliated to the Rahere Lodge, and appointed W. Bros. Holden and D'Arcy Power to serve as representatives on a sub-committee to carry the proposal into effect.

A past master's jewel was unanimously awarded to W. Bro. Abraham for his services to the Lodge during his year of office, and presented by W. Bro. Holden. Bro. Abraham, in reply, expressed his sincere thanks.

The report of the Audit Committee was received and adopted. It showed that the finances of the Lodge were in a satisfactory condition, and that the sum of £60 18s. had been given in charity during the past year.

A grant of £5, as a first instalment, on behalf of a Brother in distress owing to ill-health, was voted unanimously.

The Brethren subsequently proceeded to Frascati's Restaurant, where the banquet was held. The attendance was a large one, and a very enjoyable evening was spent, an excellent entertainment being provided by Bros. Walter Churcher and Astley Weaver and others.

### Calendar.

|   |                                    |
|---|------------------------------------|
| July 13.—On duty.                                   | Sir Wm. Church and Mr. Langton.    |
| " 18.—On duty.                                      | Dr. Gee and Mr. Marsh.             |
| " 19.—S.B.H. Cricket Club v. Surbiton, at Surbiton. |                                    |
| " 22.—On duty.                                      | Sir Dyce Duckworth and Mr. Butlin. |
| " 24.—Junior Scholarship Examination.               |                                    |
| " 25.—On duty.                                      | Dr. Hensley and Mr. Walsham.       |
| Summer Season ends.                                 |                                    |
| " 29.—On duty.                                      | Sir Lauder Brunton and Mr. Cripps. |
| Aug. 1.—On duty.                                    | Sir Wm. Church and Mr. Langton.    |
| " 5.—On duty.                                       | Dr. Gee and Mr. Marsh.             |
| " 8.—On duty.                                       | Sir Dyce Duckworth and Mr. Butlin. |
| " 12.—On duty.                                      | Dr. Hensley and Mr. Walsham.       |
| " 15.—On duty.                                      | Sir Lauder Brunton and Mr. Cripps. |

### Examinations.

#### UNIVERSITY OF CAMBRIDGE.

*Surgery and Midwifery.*—H. W. Atkinson, E. A. A. Beck, H. N. Burroughes, J. F. H. Dalby, H. H. Dale, G. G. Flett, H. N. Gould, B. Hudson, P. W. Leathart, H. D. Ledward, H. Statham, F. Whitaker.

*Medicine.*—J. F. Alexander, J. N. Benmore, F. R. Carroll, H. H. Clarke, R. L. V. Foster, W. W. Jendwine, G. F. Loveday, J. McBryde, C. de C. Pellier, G. H. L. Whale, W. W. Wingate-Saul.

### Appointments.

ATKINSON, STANLEY B., appointed Senior House Physician at City of London Chest Hospital, Victoria Park.

BAILEY, J. C. M., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

CARROLL, F. R., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Surgeon to the ss. "Umvologi" (Natal Line).

MART, W. T. D., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Junior Assistant House Surgeon to the Royal Infirmary, Sheffield.

POWLICK, A. K. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

THOMAS, C. J. M.B., B.Sc.(Lond.), D.P.H., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the School Board of London.

WILLIAMSON, H., M.A., M.B., appointed Assistant Obstetric Physician to the Royal Hospital for Women and Children.

### New Addresses.

HAMER, W. H., 1A, Bramshill Gardens, Dartmouth Park Hill, N.W.

HEMMING, J. J., 7, Eaton Road, Margate.

HOOLE, J., Parwick, Ashbourne, Derbyshire.


ROWE, W. T., 26a, Woodborough Road, Nottingham.

TALBOT, E., 10, Dentinck Street, W.

### Birth.

SCORER.—On May 29th, at St. Cuthbert's, Christchurch Road, Bournemouth, to Frank and Violet Scorer, a son.

# St. Bartholomew's Hospital



## JOURNAL.

VOL. IX.—No. 10.]

JULY, 1902.

[PRICE SIXPENCE.]

### NOTICE.

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

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

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

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

### St. Bartholomew's Hospital Journal,

JULY, 1902.

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

### The Requirements of a Modern Hospital.

The Summer Mid-session Address to the Abernethian Society, by W. BRUCE CLARKE, Esq., F.R.C.S.



WHEN I was asked to deliver before the Abernethian Society this summer the Mid-session Address I felt that if the honour which was conferred upon me was great, the responsibility which I incurred in selecting a subject was far greater. After turning over in my mind the various themes which were suitable for the purpose, I came to the conclusion that no

subject could claim fuller attention at the present time than the one I have chosen, viz. "The Requirements of a Modern Hospital." It is somewhat outside the scope of ordinary medical knowledge, and yet much of the success of our treatment of our patients, or at any rate their speedy recovery, depends upon the knowledge which we possess of what a modern hospital should be; and it is only by glancing, at any rate in a cursory manner, on what has been achieved in various hospitals, and by a right understanding of why certain methods of construction are adopted and others are tabooed, that we can hope to answer this question.

I propose to preface my remarks by defining what a hospital is,—perhaps I should say what it ought to be.

To start with, it is a place for the reception and cure of the sick poor; and such being the case, whether it is supported by endowment, out of the rates, or by voluntary contributions, the necessity for economy is obvious, and it should be so arranged and constructed as to enable a staff of medical officers, nurses, and others to attend to the needs of a large number of sick people. This necessitates the grouping of patients in wards of a certain size.

But from the point of view of the community a hospital has another important function, which has been pithily put by Galton in the following words:—"It is the technical school in which the medical student must learn his profession, and it is an experimental workshop in which the matured physician or surgeon carries on scientific research."

Some would tell us that we have abundant evidence to show that the best results of treatment are not always attained in hospitals. No experience on this point is more valuable than that which has accrued from the great wars of the last hundred years. The results of hospital treatment during these wars have been by no means uniformly successful. In the Crimean war, for example, the mortality of those treated in the badly drained and ill-ventilated hospital at Scutari was upwards of 42 per cent, whilst it was less than 3 per cent. in the wooden huts at Balaklava.



It is such facts as these that have led many in the past to declaim against hospitals altogether, and even to speak of them as a curse to civilisation. In 1812 Sir John Pringle, in his *Observations on Diseases of the Army*, says, "Hospitals are the chief cause of mortality in the army."

The faults of a hospital may be faults of construction or faults of management. The latter may be at fault in any hospital, but a hospital cannot be economically or efficiently administered where the construction is bad to start with.

A good hospital may be summed up in the two words *ventilation* and *sunlight*. All good methods of construction aim at making them as perfect as possible. We will begin by considering the ward in which the patient must be treated, as it forms the key-note to the hospital system.

#### THE WARD UNIT.

I have just pointed out that if due regard is to be paid to economy of administration the patients in a hospital must be grouped together in wards, and the first question, therefore, to be determined is what number can be treated together most advantageously. Experience has shown that when from twenty-five to thirty patients are placed together in one ward the most satisfactory condition is reached. Some writers on the subject pass at once to the question of the number of cubic feet of air required per patient, and from this factor deduce the cubic area of the ward, whilst they ignore the question of floor space. A moment's reflection will, I am sure, convince you of the extraordinary results which such a mode of calculation might produce, I might say has produced, as the following example will show. Some years ago an order was issued for the construction of a hospital in India, and the cubic space per bed was arranged for, possibly by a War Office official. The hospital was built, and the requisite cubic space provided, but when the bedsteads and ward furniture were supplied it was discovered that they could only be got into the wards by placing them so close together that it was quite impossible to bring the patients in unless they were to be handed over the beds. The floor space had been ignored, and the height was ridiculously excessive.

Floor space is the first consideration, and having once settled that there shall be twenty-five or thirty patients in a ward, the floor space which is demanded per bed must be thought out, and from this the satisfactory form of ward can be deduced.

In the Middle Ages questions of hygiene did not enter into the consideration of our forefathers, and it is interesting to recall for a moment the way in which they solved the ward unit question. At Angers, in France, is a large hall with a vaulted roof, divided by two rows of columns into three aisles. At least four rows of beds could be placed between the external walls, but it is far more likely that each aisle contained two rows, making six

in all. The windows were placed high up on the wall, the height from floor to sill being about sixteen feet. A similar arrangement exists at Ourscamp, and at Chartres. At Tonnerre is an example of a ward built towards the end of the thirteenth century. It consists of a great hall, at one end of which was formerly a staircase, an entrance porch, and a small chapel. At the opposite end was an apsidal chapel, containing a high altar with two side chapels, and the tomb of the foundress, Marguerite de Bourgogne, Queen of Sicily, the whole having been enclosed by a screen, across the top of which was a gallery affording means of communication between the two galleries which ran one along each side of the wall. The beds were placed in alcoves or cubicles, forty in number, and the side galleries referred to were intended to afford means of supervision from above. The window sills were above the floor of the galleries, and consequently must have been some twelve feet above the ground-floor. What with the wooden partitions of the cubicles, the overhanging galleries, and the great height of the window-sills above the floor, the chance of the patient getting any change of air must have been small indeed, notwithstanding that the apex of the open roof must have been something like fifty feet above the floor.

I have brought these examples before your notice in order to show you how many faults it is possible to introduce into a hospital ward, and how little regard was in these instances paid to either sunshine or ventilation. The construction of these wards was, no doubt, handed over to the architect, whose attention was largely directed to the construction of ecclesiastical and monastic buildings, and he produced a ward which was largely determined by these considerations. It was well-proportioned and extremely picturesque, but it was absolutely useless for the purpose for which it was intended. If you were to ask an architect to design for us a hospital ward to-day, without giving him special instructions as to floor space, etc., you would very possibly obtain an equally disastrous result; and when you have given your instructions you will need to exercise a keen supervision if you are to prevent the sacrifice of efficiency to considerations of architectural effect.

Our own hospital is planned upon the double ward system, and does not admit of cross-ventilation, which is now looked upon as essential. At the time at which it was constructed it was admirable, and far in advance of its time. To-day the vast consensus of opinion is in favour of the pavilion system of ward construction. A *pavilion ward* is one whose walls are in contact with the air on three sides, whilst it communicates with the rest of the building by means of doors on the fourth side. The windows should be placed directly opposite one another, the arrangement being a bed and window alternately down each side of the ward. The next question to be considered

is, how many wards is it advisable to place one above the other? In many parts of Germany and of America hospitals have been constructed of one story only, and they are cut off from the neighbouring wards by considerable intervening air spaces. Such a system is impossible in large towns where land is valuable, and it is far more costly in administration, whilst it is difficult if not impossible to prove that it is even needful. The institution of a fair comparison between different hospitals where different constructional arrangements prevail is exceedingly difficult. There are so many disturbing factors. The cases are not equally severe, and the nature of the cases is exceedingly variable. There is no doubt that the grounds which led to the condemnation of lofty hospitals were the constant recurrence of septic diseases in the upper stories of the buildings. This was especially the case in the old *Hôtel Dieu* in Paris, but further experience has shown that this condition of things was largely due to inefficient ventilation, which permitted the foul air of kitchens, laundries, wards, and mortuaries to mingle in the upper floors of the building, and produce havoc amongst the patients.

By important structural alterations and judicious attention to sanitary details septic diseases have been practically abolished in almost all hospitals, and a three-story ward block is now recognised as a reasonable compromise in this country, at any rate for a town hospital.

We have reached, then, this point in the ward unit. The wards must be constructed on the pavilion system, and should contain from twenty-five to thirty beds apiece; and three wards, one over the other, make up a single block, which will contain from seventy-five to ninety patients. Let us take the smaller number for argument's sake, and we shall be able to house seventy-five patients in each block.

Just as the ward is the unit of hospital construction, the floor space which is necessary for each patient will give us the needful area and arrangement for each ward. It may be worked out as follows:—The ordinary hospital bed is 6 ft. or 6 ft. 6 in. by 3 ft., and it should stand out from the wall about a foot in order to allow of the free circulation of air around it. It should be placed at least 4 feet from the next bed, and a greater distance is desirable if the hospital is to be used for purposes of clinical instruction.

There should be a passage up the centre of the ward, if possible, of from 10 to 12 feet in width between the feet of the beds. If the width of the ward will not permit of this, then the distance between the beds must be greater than 4 feet—a condition which obtains in most of our present wards. Thus experience has shown that a floor space of about 100 square feet is required for each bed, and if the ward is from 12 to 13 feet in height each patient will obtain a cubic space of from 1200 to 1300 cubic feet. It is impossible to lay down any absolute hard and fast rule for the floor space necessary per bed. A hundred feet is

certainly none too little, and where infectious cases are admitted is certainly insufficient. In hospitals which are employed for the purposes of clinical instruction a larger bed space will be found to be very convenient.

#### WARD ACCESSORIES.

Having shown how the ward area is obtained, we must now turn our attention to those accessories to the ward without which its proper working is impossible.

*Baths and lavatories* are the first need. Though it is customary to place the bath-rooms and w.c.s in close proximity in order to economise the plumber's bill, it is by no means necessary that they should be so arranged; indeed, there is much to be said in favour of their separation, and it is questionable whether in the long run the expense of this plan would be any greater. In the case of the baths it is unnecessary that there should be a disconnecting lobby between it and the main building; and the more it is incorporated with the main block the less is the waste of heat from the pipes by radiation, and the less liable are the patients who use them to catch cold, whilst the need for the bedside bath and the labour it entails is minimised, especially if the bath-rooms are capable of being artificially heated.

W.c.s would be all the better for being cut off even more than they are in most hospitals at the present time. It is interesting to remember the object lesson which we possess in most of the old collegiate buildings at Oxford and Cambridge. The w.c.s are placed well away from the living rooms, not even under the same roof, and as a result a college epidemic is practically unknown. A similar arrangement exists at the Homerton Fever Hospital, where it is very successful, and not found to be detrimental to the patients.

A small ward kitchen, or duty room, as it is styled in some hospitals, because the nurses who are on duty sit there when their services are not needed in the ward, must be provided. In it some articles of food will be kept, and some small culinary operations performed. The actual work that is done in the ward kitchen varies considerably in different establishments, but in none can it be entirely dispensed with. A sisters' room must be provided as well. Cupboards in abundance are needed for various purposes, for patients' clothes, linen, food, medicine, poisons, dirty linen, coals, etc. In a short account of hospital needs, such as the present must necessarily be, it is impossible to specify for the exact needs of a ward; they will differ somewhat according to the purpose for which the ward is employed; but one cannot emphasise too strongly the need that exists for an orderly arrangement in all such details of hospital management. There must be space enough to allow everything to rest in its proper place, and none to spare, which only means extra labour to keep it clean, and

absolute certainty that if it is not needed no one will look to see whether it is clean or not.

*Separation rooms.*—Quite apart from the question of the need for isolation wards, which will be considered later on, comes the need for one or two separation rooms placed near the entrance of each ward. They are urgently needed for a patient who suddenly becomes noisy and suffers from D.T., whilst for cases recently operated on they afford a means of quiet which is unattainable in a large ward. A case brought in during the night, who may very possibly be drunk, may be placed there till he has got over the effects of his carouse without endangering the peace or interfering with the comfort of other patients. Such a room may be used for minor operations, and so relieve the chief operating theatres, but their beds must be always held in hand as emergency beds, and never reckoned as part of the general service of the ward.

If balconies and day rooms can be provided in addition, so much the better; if not, it is possible to utilise these separation rooms for day rooms when they are not in use for other purposes.

A clinical workroom should form an integral part of each ward in a hospital where clinical instruction is given. In it the examination of urine, sputa, etc., can take place, and the presence of a few blinds and a lamp will enable ophthalmoscopic examinations to be readily performed in it.

In connection with each ward unit a couple of lifts should be provided, one for passengers, and another to convey soiled linen, coats, etc., in suitable pans or boxes. The service lift should preferably be situated in the open air.

Thus far, then, we have considered first the ward, and now have discussed in somewhat general terms its necessary accessories, and have decided that a three-story building is admissible. This gives us our ward unit of seventy-five beds and six separation rooms, each with a bed in it, which be it remembered is only to be used for emergency purposes, as has been already indicated.

The next question is, what are the general principles on which the ward unit should be constructed? It is desirable that it should be raised some three or four feet above the level of the surrounding ground, and if possible that there should be a free current of air passing through the basement. The exterior needs no special decorative treatment: if it is well proportioned and a simple stringcourse is run round to near the level of the floors, and the windows are placed at proper uniform distances, it will be simple in construction, and present a pleasing effect to the eye. Let me here emphasise the fact that the arrangement of the beds inside the ward depends largely on its shape, and on the way in which the windows are arranged. We have already seen that at least four feet of space must be left between the beds for convenience of working. It is this space which mainly governs the size and arrangement of the windows; and just as the beds, when placed exactly opposite each

other, contribute to internal economy of space, so the placing of the windows opposite each other is essential to efficient cross-ventilation.

There is perhaps no subject about which so much difference of opinion in detail exists as on warming and ventilation. All are agreed on the necessity of ventilation, on the general principles which determine the quantity of air to be supplied, and on the need for frequent change of air, but how best to carry out these principles is quite another matter. If an attempt is made to change the air of a room much more than three times an hour most people complain of a draught, hence the tendency in some minds to rely on artificial ventilation and warmed air. Here, again, we are met with difficulties. Air which is warmed is liable to be burnt, and become unpleasant to the senses. Even if it is not burnt, its passage over hot plates for the sake of warming through various channels does not tend to its cleanliness. The channels get foul in time, and no satisfactory plan has yet been devised on a large scale for getting at these channels for cleansing purposes, not to speak of the expense both of construction and maintenance which such a system involves. The old infirmary at Derby is a striking example of good intentions frustrated by the stern facts of everyday life. It was built in 1805, and fitted up with what was then deemed to be, and very possibly was, an excellent system of artificial ventilation. A stove was placed in the basement, over which the air passed and was distributed by a series of brick channels to the various parts of the building. The air to supply this stove was brought from the top of the tower, situated some seventy yards away, through a brick channel four feet square. There was an air inlet from this system of channels in connection with the closers and an upcast shaft, which was so contrived that every time the air door was opened fresh air was admitted, and the foul air passed along the upcast shaft. At least theoretically this was what took place. A few years ago it was discovered that rats had made their way from the drains to the air shafts, so that a free communication existed between them, and the rats had access to the whole building, with this result—that repair was practically impossible, and a new hospital had to be erected.

It may readily be conceded that no artificial system of ventilation would be constructed on similar lines to-day, and that glazed stoneware pipes are proof against the destructive habits of rats; but the moral still remains that decay is inherent in all construction, and if proper means of access are not provided to every part of a building for purposes of repair disastrous results will be sure sooner or later to follow.

The most noteworthy modern instance in this country, at any rate, of artificial ventilation is the Birmingham General Hospital, to which the air is admitted after being washed and filtered along huge subways, and driven by

fans into the wards, which depend entirely on this system for their air. At present there is no doubt it is reasonably successful, but to a stranger the hospital atmosphere is not altogether agreeable, and it is still open to doubt whether the results justify the outlay that was necessary to carry out this system.

Simplicity should be the key-note of ventilation, as of everything else that is intended to stand the test of time and experience. A natural system of ventilation which depends for its efficiency on doors and windows, the latter being carried close up to the ceilings, aided by fire-grates and some accessory openings in the walls, preferably under the beds, which openings can be closed if needed, can hardly go wrong, and if it does is easily set straight in a few minutes, and can readily be modified to suit the direction of the wind or the temperature of the outside air.

Artificial ventilation demands either a forced inflow or forcible extraction of the air by means of fans, possibly a combination of both. It may, as we shall see later, be reasonably applied to an operation theatre, but it has never been proved to be necessary in all parts of a hospital.

The *warming* of a large building is intimately associated with its ventilation, and where artificial ventilation is employed must necessarily form an integral part of it. If natural ventilation is adopted, then the warming must be considered separately. Nothing in this country, at any rate, has given place to the open fire or some modification of it. The general plan now adopted is to place the stove in the centre of the ward, supplying it with fresh air from the outside, which is passed into the ward, and forms a considerable addition to the radiant heat that is derived from the fire itself. The heat given off by the smoke flues is also utilised, and the introduction of hot water or steam coils gives additional warmth if needed.

It now only remains to consider the roof, and the ward unit is complete. There is much, it seems to me, to be said in favour of a flat roof formed of nine inches or more of concrete and iron girders, and covered with the hard asphalt which is employed in so many of the streets of the metropolis. Such a roof affords ready access for general repairs. It is exceedingly durable, keeps the top wards warm in winter and cool in summer, and affords ample space for convalescent patients, or for those whom it may be thought desirable to treat in the open air. It can be readily reached either by lift or staircase, is practically fireproof, and shuts off no sunlight or air from neighbouring buildings.

To complete our hospital so far as its wards are concerned we have only to repeat our ward unit a given number of times. Thus nine blocks, each containing a ward unit of seventy-five beds, would furnish 675 beds; and if it be supposed that one ward unit is always empty for purposes of cleaning, such a hospital would have 600 beds always available for its ordinary service.

*Isolation beds.*—The subject of isolation has already been referred to in connection with each individual ward, but in addition to these beds it is generally conceded that it is necessary to provide in one or more blocks some isolation beds for infectious cases, medical and surgical, for stinking cases, etc. It is customary to provide 10 per cent. of the whole service of the hospital as isolation beds, say seventy beds in addition to the 675 already alluded to.

The ward unit in which these beds are placed will require a slightly different treatment from the others. In the first place it has to provide for a variety of infective diseases which need to be separated from one another, and which some authorities would prefer to see in separate buildings; and in the second place, the floor space for infective cases must be larger than that allotted to ordinary hospital cases. Probably from 1500 to 2000 cubic feet of ward space is none too much, and from 150 to 200 square feet of ward area.

An operating theatre must next be considered, and where the aggregation of ward units brings up the number of beds to 600 or 700, probably four or five theatres would be required, as well as one or two small ones for eye work and diseases of women.

The general requirements of such theatres are much the same. The modern custom is to mass all or most of them together from motives of economy and efficiency. There is, however, a good deal to be said from many points of view for providing an operation theatre for each ward unit or pair of units, as this arrangement avoids the necessity for removing patients who are very seriously ill to a considerable distance for purposes of operation. It is of course only with a small minority of the cases that these difficulties occur; and another way of meeting this difficulty is either by providing accessory rooms in connection with a ward where urgent operations can be performed, or by arranging for a few extra beds in separate wards in close proximity to the operation theatres, where patients who have undergone serious operations may remain for a few days, till they can be moved with safety back into the ward.

Each theatre should have a superficial area of at least 400 feet, and be about 12 or 13 feet in height. If the hospital is used for clinical purposes a larger area must be provided, and one at least of the theatres should be large enough to contain a considerable number of onlookers. One set of washing rooms and lavatories for the surgeon, together with a similar set of washing apparatus for the house surgeons and students, serves for all the theatres; and a single sterilising room for dressings and other apparatus should be provided in close proximity to the theatres, though it will be employed for the wards as well as the theatres.

The operating theatre itself must be lined with some

non-absorbent surface,—for example, tiles, marble, glass, etc. All angles should be rounded, and every arrangement made for the complete cleansing and disinfecting of the theatre as often as may be needed.

When we were discussing the question of natural *versus* artificial ventilation in a previous part of this address, it was pointed out that a system of artificial ventilation was far more admissible, possibly we may add necessary, in an operating theatre than in a ward.

A system of this kind is already working in some of the new operating theatres of the London Hospital. Warm fresh air is admitted, after being properly washed and filtered through cotton wool, into the theatre by a forced draught, and by setting an exhausting fan to work, air can be passed through the theatre at any rate that may be desired. As a proof of the rapidity with which the air can be changed, if the theatre is filled with steam from a hose in order to precipitate the dust, it can be completely cleared and ready for operating in under three minutes, whilst the warm air that has been introduced has raised its temperature several degrees. It need hardly be pointed out that the adoption of such a system of ventilation practically necessitates the closing both of doors and windows whilst it is in operation. It is equally essential that every part of the air-passages should be open to inspection, so as to ensure that they may be periodically cleaned and repaired at once if a fracture occurs, which may become the means of drawing in foul air unconsciously into the very place where no expense should be spared to make it absolutely pure.

A disinfecting apparatus of some sort is an absolute necessity in a hospital, both for sterilising infected bedding, clothing, etc., and for the destruction of vermin. The only satisfactory apparatus for such a purpose is one which, for its efficiency, depends on hot dry steam. Five minutes' exposure in it is sufficient to destroy anthrax spores. Dr. Parsons, who was the first to call attention to this system in a Local Government Board report, contrasts amusingly the effect of hot air and steam on vermin, and points out that when hot air is used they gradually retire to centre of bedding or garment, where, as the thermometer shows, a high temperature is never reached, and as the chamber cools down return again to the surface to fan themselves in the fresh air. With steam under pressure they are killed before they have time to reach the cool and shady recesses of the interior of a down pillow.

An entirely separate department must be provided for the post-mortem room, mortuary, and pathological department. In addition to a post-mortem room, which should be of a size suitable to the hospital, a mortuary must be provided for the storage of bodies that are awaiting examination, and a mortuary chapel, which should be so treated as to indicate a reverent care for the dead. A cold storage chamber should now be provided in connection with every

mortuary, so that the changes of decomposition may not be far advanced before the leave to make an examination is obtained. This is highly necessary in the interests of the pathologist, whose health is liable to suffer from his occupation; in the interests of science, as but little can be made out in tissues that are in an advanced stage of decomposition; and lastly, in the interests of the hospital generally, as any chances of infection and foul odours are thereby reduced to a minimum.

The efficient ventilation of the post-mortem room is of prime importance; it is remarkable how efficiently it can be carried out if proper care is taken. The best results are obtained by the employment of that plan which is known as the Webb system of sewer ventilation. An extraction shaft is provided at the top of the building and provided with a Webb gas lamp, which is lighted when required by means of a pilot lamp, very similar to the small gas jet that is used in connection with the Welsbach incandescent mantles. The foul air that is drawn by the lamp through the extraction shaft is subjected to a temperature of 600° Fahrenheit, and all disease germs and noxious gases are destroyed by it. This system is at present working at the London Hospital, and most efficiently removes all trace of odour from the post-mortem room within a few minutes after the examination is completed.

Closely adjoining the post-mortem room is naturally placed the pathological department, which now forms so necessary and, I may add, an increasingly necessary adjunct to hospital treatment of every kind. Not only are examinations of dead tissues carried out in this department, but rooms have to be provided for the examination of various pathological products from the wards, and laboratories for the director of the department and his assistants as well as for the instruction of students. *Indeed, without the assistance of students to carry on some of the routine work of the department, the expenditure which must be incurred by any large and properly equipped hospital would inevitably be much larger than it is.* A museum with adjoining rooms for microscopical, chemical, physical, and bacteriological research are urgently needed if the treatment of patients is to be satisfactorily and efficiently carried out.

But no hospital nowadays is complete without well-arranged quarters for its out-patient departments. The importance of completely cutting off the various departments and sections of a hospital from one another so as to lessen the chances of conveying infection has already been referred to, but to no department does this remark apply with greater force than the out-patient department. It is always liable to invasion by chance cases of eruptive fevers in their early stages. It is obvious, therefore, that no direct communication by means of covered passages should connect it with the main building. The first essential of such a department is a large waiting room, in which the patients can be so placed that they can be readily segre-

gated and passed to the sub-departments most suitable for their special ailments. Consulting rooms will naturally be arranged in close proximity to the waiting room, and will vary in accordance with the size and nature of the hospital. Each sub-department will need in addition one or two other rooms for the examination of patients for ophthalmoscopic examinations, for minor operations, and for the administration of chloroform. In a hospital where students are admitted it may be roughly calculated that about one thousand feet of floor space will be needed for each of the sub-departments on an average. Some of these, especially when they are resorted to by lame and crippled patients, should obviously be situated on the ground-floor, but much may be done by means of lifts to minimise the inconvenience of two- or three-story buildings, which are obviously an essential where land is valuable. The exit from each of these sub-departments should be separated from the inlet, and should be conveniently placed with reference to the dispensary where the medicines will be obtained; and the size of this sub-department again must be conditioned by the number of patients which it has to serve.

The accommodation of the nurses will occupy probably another block, and must be so placed that the nurses are within reasonable distance of their work, and if they are to be fed in the same block within a suitable distance of the hospital kitchen, which will probably be placed on the top of one of the blocks, and served by suitable lifts.

The resident staff's quarters are especially important, as they must be within easy access both of the wards and the out-patient department.

Lastly, there is the general administration block to be considered, which must be within easy reach of and in telephonic communication with all the various units, in order that an efficient and economical arrangement of the component units may obtain.

We have considered so far the various units of which a hospital must consist. In the case of some of them it has been possible to lay down with more or less approach to precision the floor space that each demands. In others the floor space will have been determined by the special needs of the hospital in question, and the special purposes for which it is constructed.

But perhaps the crux of the whole question is the arrangement of the various blocks of buildings with due regard to convenience, economy, and the placing of them at such a distance from each other that there may be a free circulation of air all round them.

The various ward units would probably be grouped together, connected by covered passages so contrived that whilst access from one block to another was easily obtainable, efficient means could be adopted of preventing the air of one ward from finding access to another.

The operating theatre would be in a separate part of the

building, and the isolation and post-mortem departments thoroughly cut off, so that by no possibility could their foul air find its way into any part of the main ward buildings; and lastly, a place would be selected for the administration departments, which would enable them to keep closely in touch with all that was going on within the hospital walls.

It has sometimes been suggested that in the planning of a modern hospital, whilst the administration block should be handsome in appearance and substantially built, the modern ward should only be constructed to last fifty years, at the end of which time new counsels of perfection may prevail, and demand new and totally different appliances. This may be so. We cannot tell what discoveries the future may have in store for us, or how profoundly they may modify the construction of our towns or the arrangement of our hospitals. Even Mr. Wells cannot anticipate that for us. But the idea of building hospital wards which will be ready to tumble down at the end of fifty years is based on a misconception of the deeds and ideas of the jerry builder. By all means let a modern hospital ward be constructed, as I have already said, without lavish expenditure on any part of it, but it would have to out-Herod the works of Jerry himself, and bring itself into collision both with the district surveyor and the sanitary inspector, if it is to be a tumble-down structure in half a century.

The jerry builder is an interesting creature; he saves money in a variety of ways. Septic road sweepings are judiciously mixed up with sand in his mortar, and filthy dust with his cement when he uses any. Each door, window, fireplace, etc., is absolutely similar in form and construction, and so badly fixed to the walls that it loosens in a few years, possibly in a time which is limited only by months; but his walls do not tumble down.

If you return to your semi-detached house in the suburban row, having dined not wisely but too badly, and you are a little oblivious of the number of your door, it is of no consequence; your latch-key will fit the door of one of your neighbours as well as it does your own, and the key of your cupboard will soon disclose your neighbour's whisky, if he has any; and it at length you discover your mistake, and find your way into your own house, though you may imagine from the choice smell of viands that your wife has been entertaining visitors in your absence, you will find an easy explanation in the passage of your neighbour's cooking odours into your own kitchen.

These and many others are the pleasures of living in a jerry-built house; when once you have tasted them you will not wish to perpetuate them in hospital construction.

Rely upon it, that if a modern hospital ward is destined only to last fifty years, it will be far more economical to construct it soundly, plainly, and without ornament. A few years of experience will soon show you that nothing is so economical or so healthy in the long run as sound, simple construction.

### On Retention of Urine.

*A Clinical Lecture delivered by W. HARRISON CRIPPS, ESQ.,  
F.R.C.S., on July 9th, 1902.*

(Reported by T. J. FAULDER.)



ENTLEMEN, I propose to-day to give some account of the treatment of absolute retention of urine. It is important that you should have certain principles in your mind, because you will be sent for in a hurry in these cases; you will have no time for reference, you will have to act on the spur of the moment.

The causes of retention of urine may be classified under four periods of life: infancy, young adult life, middle life, and advanced age.

Within limits each of these periods has its characteristic cause of retention.

A. Retention in a male infant may, it is said, occur from phimosis. I have never seen such a case. It is commonly due to a calculus impacted in the urethra.

Sometimes you will get a history from the mother that the child has been fretful and peevish of late, or has passed urine at inconvenient times and places. More probably there will be no symptoms until those of retention show themselves. The child is brought to you in great distress, having passed no water for, say, eighteen to twenty-four hours, and with a full bladder reaching, it may be, as high as the umbilicus.

On examination the calculus may often be felt through the penis or perinæum. If not, a small sound passed into the urethra will afford conclusive evidence.

The treatment of this condition falls under three headings:

i. Manipulation by gentle pressure may be successful in the removal of the stone, especially if it is in the penile urethra, or even if it be as far back as the perinæum. If this procedure fails—

ii. A pair of fine urethral forceps may be passed into the urethra and the stone grasped, and an attempt made to remove it, partly by traction on the forceps, partly by pressure of the fingers outside. A stone cannot, however, usually be removed in this way.

iii. Further measures are operative, and depend on the position of the stone, whether it is in front of or behind the scrotum.

a. If behind the scrotum cut down in the middle line of the perinæum and open the urethra. Wounds in this situation almost always heal well, and practically never leave a permanent fistula.

β. If in the penile urethra it is a very different matter. Wounds here very rarely heal, and the usual result is a permanent urinary fistula, difficult—nay, often impossible—

to cure. Therefore take a sound and push the stone back behind the scrotum, and make your incision there.

I have never seen a stone so impacted in the penile urethra that it could be moved neither forwards nor backwards. In such a case you would have to cut directly down on the stone, close up the wound as rapidly and as completely as possible, and leave a catheter in the bladder for some days. There is then a chance, but no more than a chance, of healing.

B. *Retention in a young adult.*—Speaking generally, the commonest cause is an inflammatory condition of the urethra, and the usual form of this is gonorrhœa.

Curiously enough, the retention often does not occur until some time after the acute stage is past. Hospital patients frequently celebrate their recovery from acute gonorrhœa by a visit to the public-house. Subsequently they get difficulty and then inability to pass water. Their appearance in the surgery is characteristic.

Acute retention from this cause is far more uncomfortable than is retention from stricture, for the bladder is not accustomed to distension, as it is in the latter case. The patient is in great distress. The old-fashioned treatment invariably was a hot bath and a dose of opium, etc. The real treatment is to let the patient lie down and to pass a soft catheter. You must remember that in most of these cases there is no stricture. Take a No. 7 or No. 8 soft rubber catheter and empty the bladder. Instruct the patient not to wait too long before trying again to pass water by himself.

In some cases, generally as a result of bad treatment elsewhere, you will have difficulty in passing a catheter. The mucous membrane is very soft, and if a small metal catheter be used, it is extremely easy to make false passages. In such a case it is best to try a large, say No. 12, soft catheter, possibly under an anæsthetic. I have never failed to pass a full-sized soft catheter in these cases. However, if necessary, you may try a metal instrument, remembering to keep its point along the roof of the urethra. If these attempts all fail, the next thing to do is to aspirate the bladder above the pubes.

Here I must pause to discuss aspiration as opposed to puncture.

Aspiration is very simple. You take a very fine capillary aspirator, about the thickness of a hypodermic needle, and four to four and a half inches long. A small incision, about a quarter of an inch long, is made through the skin just above the pubes, and the trocar and cannula pushed into the bladder to a distance of about four inches, keeping the point sloped in the direction of the anus. Remove the trocar and turn the patient on one side, so that the urine may drip into a vessel. Allow plenty of time for the bladder to be completely emptied. On removal of the cannula the tiny puncture is completely closed by elastic contraction, and there is no risk of leakage. It is a simple

operation, but cannot of course be repeated indefinitely. If in any case you desire to leave a drain in the bladder for some time, the method to use is puncture. For this trocars are used, which run the same sizes as catheters, No. 1, No. 2, etc.

I will here digress a little to explain why puncture formerly failed so often, and resulted in extravasation of urine into the pelvic cellular tissue. The bladder, having been emptied, contracted down away from the cannula, and as soon as urine had again collected, it passed out of the puncture into the cellular tissue, in many cases with disastrous results.

The right method is to have by you a soft catheter which will pass easily through the cannula you are using, to make a short (quarter of an inch) incision, insert the cannula, and, when urine appears, thread the catheter into the bladder, finally removing the cannula over the catheter. Aim at leaving two inches of catheter inside the bladder, *i. e.* the base of the bladder being about five inches from the pubes in a not very fat person, leave about seven inches of catheter in the patient's body. Next fasten the free end of the tube to one side of the patient's abdomen by two pieces of plaster, and let him lie on his side, so that the urine may drip into a vessel. It is a very important practical point to have the catheter fastened to the abdomen in this way, and not fixed to the bed or to a vessel below the bed, as is sometimes done, by means of rubber tubing. Any sudden movement of the patient—for example, on waking from sleep—might dislodge the catheter, with fatal consequences.

c. *Retention in middle life.*—Stricture may occur at any age, but is much the most common from twenty to forty years.

The history which you get is generally very complete. The patient has had increasing difficulty of micturition for two or three years, for the last few weeks has passed water in a fine stream, for the last week in a difficult dribble, now he cannot pass any. You will find a very distended bladder. *Per rectum* you can feel a soft swelling, which bimanually is found to fluctuate.

*Treatment.*—First I wish to learn where the stricture is. It is usually at the junction of the membranous and bulbous portions of the urethra. For this purpose I take a No. 6 or No. 7 soft catheter. What I intend is, if possible, to pass an instrument and empty the bladder; failing this, to fall back on some operative procedure.

First get ready some soft rubber and some silver catheters. The difficulty of passing a soft instrument is to guide it. Putting the penis slightly on the stretch is often advantageous. Having, then, let us say, localised the stricture with a No. 7 rubber, try the smaller sizes until you find one which enters. If you fail, fall back on your metal instruments, and knowing that the stricture is tight begin with No. 2, and go on to No. 1, or possibly No.  $\frac{1}{2}$ .

In using a metal catheter you must have a definite plan. Consider the urethra as having a "roof," a "floor," a right and a left "side," and examine each in turn. Depress the handle and explore carefully the roof. Next try the right side, then the left, and lastly raise the handle and feel along the floor. Note that false passages nearly always open on the "floor."

There comes a time when you wonder if the point is in a false passage or not. The points to guide you are these:

a. Observe whether the instrument is at right angles to the long axis of the body.

β. Observe if it is rotated at all on its own axis.

γ. Try gently to withdraw it. If it is caught it is probably engaged in the urethra at the stricture.

δ. Pass the finger into the rectum and feel the point.

I recommend you the next time you have to pass a catheter in a normal urethra to find out what it feels like from the rectum. There should be one eighth to one fourth of an inch of tissue between the finger and the point. In the case of false passage the partition is very much thinner, and the point will feel as if about to pierce into the rectum.

By using instruments intelligently in this way, you can in most cases get one past the obstruction. If you fail, then you must have recourse to operation; you have the choice of aspiration, puncture, and perineal section.

I cannot lay down laws to guide your choice. It depends mainly upon circumstances. For instance, if you are called to see the patient in his cottage at night, where there is no light but that of a candle and no assistance, temporary relief by aspiration is all that should be done. At your next visit you may puncture and leave the catheter *in situ* for a time. This gives the urethra rest, and may relax the stricture.

On the other hand, in a hospital with good light, good assistance, etc., I think it is better to do perineal section in the first instance.

External urethrotomy is easy in a good light, extremely difficult in a bad light. Even in hospital practice, in the case of a patient admitted during the night, it may be well simply to aspirate, leaving perineal section till later.

I pass over the details of the operation itself.

d. *Retention in advanced age* is nearly always caused by the prostate, and this occurs in two ways:

a. The middle lobe is enlarged and projects into the urethra, and the bladder, when distended, presses it down like a ball valve.

β. One lateral lobe is enlarged, the urethra becomes curved laterally, and again the pressure of a full bladder produces a ball-valve action.

Enlargement of both lateral lobes hardly ever causes retention.

Enlargement of the prostate, according to Sir Henry Thompson, never occurs under fifty-four years of age. I think we may allow a margin to this limit, and say that it is

practically never seen under fifty years. How does retention occur in elderly men with enlarged prostate? It occurs slowly. The patient for some reason, such as lack of opportunity, has passed no water for a long time, the bladder is distended, pressure is exerted on the enlarged lobe, he gets retention, and sends for the doctor. As a rule there is no difficulty in passing a fair-sized, say No. 8, rubber. If you fail with this, try a stiffer instrument. There is no better catheter to use than the French kind made of gum elastic spread on silk.

I keep a catheter specially made of double webbing except at the point. This can easily be made in an emergency by passing a No. 2 an appropriate distance into a No. 7. Sometimes the *coude* variety is useful. Lastly, try a fair-sized, say No. 9, silver. This will probably pass easily until it reaches the neck of the bladder. Here it encounters firm resistance. In that case it is a valuable piece of manipulation to withdraw the catheter gently a quarter of an inch and depress the handle firmly between the patient's legs. The point slips up past the obstruction. The cause of this difficulty is a cul-de-sac formed by the projection forwards of an enlarged middle lobe.

In some rare cases all these means of relief fail; you may try Brodie's "over-curved catheter." The method of using this is to take out the stilette, straighten the catheter, pass it at once into the urethra, and as it automatically curls up, to try to push it onwards into the bladder. Almost as good a plan is to pass in a French catheter with stilette as far as it will go, and then partially withdraw the stilette. The effect of this is to cause the point of the catheter to curl forwards, and so pass the obstruction. So much for the general treatment of acute retention of urine.

Before I dismiss the subject I wish to consider what happens when urine is extravasated.

When there is a stricture, it is not the bladder but the urethra which ruptures—generally at a pouch of mucous membrane which has formed just behind the stricture. The patient is straining to pass his water when he suddenly feels a sharp cutting pain in the perineum. For the time he may feel relieved, as the tension of his bladder is lessened, but very soon he has disagreeable burning pain in the perineum; in two or three hours the perineum swells up, and later the scrotum, penis, and side of the pubes. At this stage it looks like erysipelas of the scrotum, which is swollen, red, and oedematous.

In twenty-four hours the skin of the part is black and sloughing, *i.e.* the urine causes gangrenous cellulitis, and the patient is in a generally septic condition. Treatment must be by incision and drainage.

It is an interesting fact, that while in nine out of ten cases of extravasation of urine inflammation, etc., occur, in the tenth case no such thing happens. These latter cases are nearly all traumatic. The explanation is simple. As a sequence of stricture, the urine nearly always becomes

ammoniacal and septic, whereas the urine of a healthy person is generally aseptic.

One word about catheters. You cannot be too careful of them. Silver catheters are of course easily kept clean. The difficulty is with the soft kinds. Keep these each in separate compartments in a box, otherwise they may adhere, so that, when separated, a rough line is produced. Do not buy too many of them at once. Simple flexible catheters keep for no length of time; they get stiff and crack easily. But whatever else you do, keep them all perfectly clean.

### The Summer Concert.

**T**HE Summer Concert, which was held on July 7th, was in every way successful. The Great Hall was even more crowded than in former years. Lit up by numerous fairy lights and Chinese lanterns the Square looked delightfully cool and inviting, and the Musical Committee tactfully allowed a long interval between the first and second parts of the concert; and many of those who, after the usual fierce scramble for ices, lingered in the Square listening to the distant strains of "Iolanthe," cordially echoed the sentiments of the fair visitor who remarked that "really hospitals were not such horrible places after all." Even summer concerts, however, have their drawbacks, and the continual dripping of warm wax from the lamps was decidedly annoying to most people. A very wise man wrote that "ointment and perfume rejoice the heart." That may be so, but they certainly do not improve dress clothes.

The musical part of the entertainment was remarkable for the galaxy of new talent displayed, three new soloists and a fresh conductor, both for chorus and orchestra, making their appearance, and worthily maintaining the high standard set by their predecessors.

The programme opened with Herold's "Overture to Zampa," which was well played by the orchestra. Mr. T. B. Davies then followed with "Ask nothing more of me, Sweet," by Marzials. It was his first appearance, and one may express the hope that it will not be his last.

Dr. Womack followed with a violoncello solo, an Adagio by Bargiel, and once more delighted his audience by his execution. Sister Luke, who followed with Haydn's "My mother bids me bind my hair," received a well-deserved encore. Two delightful piano solos by Mr. Baldwin were much appreciated, and made us wonder why we had not heard him before.

A summer concert would be incomplete without Dr. Samuel West, and the four short songs, three in German and one in English, which he gave delighted every one, and were warmly applauded.

The chorus brought the first half of the concert to a close with a part-song, "Hushaby, Baby," by Rowton, which was quite one of the prettiest we have heard at these concerts for some time, and reflected great credit on Mr. Nixon's successor. It is many years since the chorus were encored, and evidently, though their numbers are smaller than in former years, their quality has by no means deteriorated.

The second part opened with a selection from "The Pirates of Penzance," and showed us that, though we are the poorer by Mr. Nixon, we are the richer by Mr. Forster.

Mr. Bell was heard to advantage in "O dry those tears" (Teresa del Riego), with violoncello accompaniment by Mr. Hallows.

This was followed by a second part-song, "Good night," by Pinsuti, which was well rendered.

After an admirable violin solo by Mr. A. Hamilton, Nurse March sang "The lark now leaves his watery nest," by Pellissier, and was not allowed to sit down again till she had given "Violets" as an encore.

The last item, the Junior Staff chorus "Here's a health unto his Majesty," as usual, was enjoyed by everybody, and brought an unusually good concert to a fitting conclusion.

### The Eighth Decennial Club.

**T**HE seventh annual dinner of this Club took place on July 11th at the Café Royal, and was fairly well attended. Dr. H. Morley Fletcher presided, and proposed the toasts of "The King" and "The Club." In a most eloquent speech Dr. Fletcher described the foundation of decennial clubs by Abernethy, and referred to the various famous Bart's men who have belonged to the many decennial clubs. He also pointed out that for the first time in its history the Eighth Decennial (or Contemporary) Club numbered among its members one of the senior staff of the Hospital—to wit, Mr. Waring. The toast of "The Chairman" was ably proposed by Dr. Steevens, and was drunk with much enthusiasm. In a characteristic speech Mr. Bailey proposed the toast of "The Secretaries," Mr. Waring and Dr. Drysdale, who briefly responded.

### Notes.

SIR DYCE DUCKWORTH is to give the Opening Address of the Session 1902-3, on the 1st of October, at The Owens College of the Victoria University, Manchester.

\* \* \*

WE venture to congratulate the Medical School on a most successful Prize Day. The presence of the Lord Mayor emphasised the intimate relations between the Hospital and the City, and furnished another illustration of the high regard of the City for its oldest Hospital. Our many guests spent an extremely pleasant afternoon, which was transformed by "tea in the Square" from a purely academic celebration into a delightful social function, and the proceedings were in every way worthy of the reputation of the Hospital.

\* \* \*

At the recent Intermediate London M.B. Examination nine out of ten candidates from Bart's were successful, and two of them, F. B. Ambler and J. C. Meade, obtained Honours.

\* \* \*

WE beg to offer our apologies and congratulations to Col. Poynder, whose name we omitted from the list of Coronation honours to Bart's men. Lieut.-Col. J. L. Poynder, I.M.S., was awarded the Kaiser-i-Hind Gold Medal for "public services in India,"—a very high distinction.

\* \* \*

FOR the first time in our history we have won the Inter-hospital Shooting Cup at Bisley.

### The Annual Prize Day.

**T**HE annual distribution of prizes took place on July 18th, and after a lapse of some years was once more held in the Great Hall. A very large number of visitors and students were present, and the Hall was crowded when the Treasurer rose to open the proceedings.

Sir Trevor Lawrence thought that the Medical School should be congratulated on reverting to the old custom of having a public prize-giving. He pointed out that in so doing they were coming into line with almost all large educational centres, including the other medical schools. Sir Trevor then called upon Dr. Calvert to read the report of the progress of the School during the past year.

Dr. Calvert proceeded to read the following report:

MR. TREASURER, MY LORD MAYOR, LADIES AND GENTLEMEN,—The number of students who entered during the year 1901-2 was 140. In the previous year the number was 142. The total number of students working at the Hospital was 519. In the number of full entries we still maintain the lead amongst the Metropolitan Schools of Medicine.

During the past year several changes have taken place in the Hospital staff. Mr. Willett has been appointed Consulting Surgeon, Mr. Cripps has become full Surgeon, and Mr. Waring Assistant Surgeon.

Mr. D'Arcy Power has taken over the Throat Department from Mr. Bowly, Dr. Drysdale has succeeded Dr. Garrod as Medical Registrar, and Mr. Dailey has succeeded Mr. Waring as Surgical Registrar. Dr. Riviere has been elected Casualty Physician.

In the Medical School Dr. West is now Joint Lecturer on Medicine, Mr. Bowly Joint Lecturer on Surgery, and Mr. Waring Joint Lecturer on Anatomy.

Dr. Drysdale has become Demonstrator of Morbid Anatomy, Dr. Williamson Demonstrator of Practical Midwifery, and Mr. Bailey Demonstrator of Practical Surgery.

In the Pathological Department, the work of which is constantly increasing, important additions to the staff have been found necessary. Dr. Garrod has been appointed Demonstrator of Chemical Pathology, Mr. Gask has been appointed Demonstrator of Pathology, Dr. Rainbridge and Mr. Rose have been appointed Junior Demonstrators of Pathology.

In the Department of Practical Anatomy Mr. Bailey and Mr. Mundy have resigned their appointments. Mr. Harmer has been elected Demonstrator, and Mr. C. E. West succeeds Mr. Douglas as a Junior Demonstrator.

Mr. Beckton and Mr. Gauvain have been elected Assistant Demonstrators of Biology. Mr. R. Brownerton has succeeded Dr. Scholberg as the Treasurer's Research Student.

Among the distinctions won by St. Bartholomew's men during the past year, the first place must be given to our Senior Physician, Sir Wm. Church, who, in March last, was elected for the fourth time President of the Royal College of Physicians, and more recently the King has added still further to Sir William's weight of honours by giving him the *K.C.B.* One of our Consulting Surgeons, too, Sir Thomas Smith, whose name has recently been so much before the public in connection with the King's illness, in March of last year was appointed Hon. Sergeant-Surgeon to the King, and in the following July he received the *K.C.V.O.*

Dr. Gee has been appointed Hon. Physician to the Prince of Wales.

Mr. Alfred Cooper and Dr. Job Collins—both of them old students of this Hospital—have received the honour of knighthood.

Dr. Ronald Ross, whose researches in malaria are so well known, has received the *C.B.*

At the Royal College of Surgeons—Mr. Marsh has been elected the Bradshaw Lecturer, Mr. Eccles has given the Hunterian Lectures, and Dr. C. P. White has given the Erasmus Wilson Lectures.

In the City of London itself, my Lord Mayor, I may point out that we have recently done very well:—Dr. Collingridge has been appointed Medical Officer of Health, Dr. Waldo Coroner, and Dr. Williams has succeeded Dr. Collingridge as Medical Officer of Health to the Port of London.

And to this list of distinctions, sir, which could easily be extended, I have much pleasure in adding the name of one of our students—Mr. Hogarth, formerly of Christ Church, Oxford—who, like so many of our students, volunteered for active service in South Africa, and won there the medal for distinguished conduct in the field.

And in examinations we have fully maintained our reputation. At the University of London.—Twenty-three men have taken the degree of Bachelor of Medicine; Mr. C. J. Thomas obtained the scholarship and gold medal in medicine and a gold medal in obstetric medicine; Mr. A. E. Thomas obtained a gold medal in forensic medicine and second class in medicine; Mr. E. E. Young obtained first-class honours in obstetric medicine.

At the intermediate M.B. examination, Mr. E. E. Maples obtained a gold medal in anatomy, first-class honours in materia medica, and honours in organic chemistry; Mr. K. S. Wise obtained honours in physiology and in organic chemistry.

Five men have obtained the degree of Bachelor of Surgery, Mr. Ridout obtaining honours.

Six men have taken the degree of Doctor of Medicine.

At the University of Cambridge.—Nine men have taken the degree of Doctor of Medicine, Dr. Langdon Brown obtaining the Horton-Smith prize.

Nineteen men have taken the first part and thirteen men have taken the second part of the final examination for the degree of Bachelor of Medicine.

At the University of Oxford.—Four men have taken the degree of Bachelor of Medicine.

At the Royal College of Surgeons.—Twelve men have taken the final examination for the Fellowship.

At an examination for the *Indian Medical Service* Mr. A. E. J. Lister obtained the first place, and Mr. Lister was again placed first on passing out of Netley.

At the examination held last May for the *Naval Medical Service*, Mr. C. M. Morris obtained the first place.

Turning to the athletic side of the School, we may be said to have done fairly well. We still possess the Inter-hospital Athletic Shield, and we have won this year the inter-hospital Cups for Shooting and Hare and Hounds.

In conclusion, sir, the medical officers and lecturers wish to thank the Treasurer and Governors of the Hospital for the interest they take in the welfare of the School—an interest necessary to the School, and necessary also to the great Hospital to which it is attached, seeing that the work of both is so closely associated that whatever affects the one must equally affect the other.

Mr. Waring read the list of prize winners, which was as follows:

- EXAMINATIONS, 1901-2.
- Lawrence Scholarship and Gold Medal.—R. C. Elmslie.
  - Brackenbury Medical Scholarship.—A. E. Thomas.
  - Prax. Acc.—W. W. Jewdine, E. G. Pringle.
  - Brackenbury Surgical Scholarship.—F. P. Connor.
  - Matthews Duncan Medal and Prize.—A. R. Nelligan.
  - Senior Scholarship in Anatomy, Physiology, and Chemistry.—J. G. Atkinson.
  - Senior Entrance Scholarships in Science.—J. M. Hamill, R. F. Moore.
  - Junior Entrance Scholarship in Science.—H. E. Quick.
  - Preliminary Scientific Exhibition.—D. W. Hume, A. M. Jukes.
  - Jeffreson Exhibition.—A. Kernahan, E. de Verteuil.
  - Shuter Scholarship.—J. K. Willis.
  - Kirkes Scholarship and Gold Medal.—E. G. Pringle.
  - Bentley Prize.—Not awarded.
  - Hickens Prize.—K. S. Wise.
  - Wix Prize.—Not awarded.
  - Harvey Prize.—F. B. Ambler.
  - Sir George Burrows Prize.—E. G. Pringle.
  - Skyner Prize.—E. G. Pringle.

- |  |   |
|--|---|
| Practical Anatomy (Junior).                            | Practical Anatomy (Senior).             |
| Treasurer's Prize.—P. L. Giuseppi.                     | Foster Prize.—F. B. Ambler.             |
| 2. A. M. Jukes.  | 2. C. B. D. Butcher (Lecturer's Prize). |
| 3. S. H. Rendall.                                      | 3. E. H. Shaw.                          |
| 4. J. E. H. Roberts.                                   | 4. M. B. Reichwald.                     |
| 5. H. R. Prentice.                                     | 5. B. E. Moss.                          |
| 6. C. A. Stidston.                                     | 6. W. G. Ball.                          |
| 7. A. Abrahams.  | 7. J. E. Pratt.                         |
| 8. G. W. Lloyd.  |   |
| Junior Scholarships in Anatomy and Biology (1902).     |   |
| 1. P. L. Giuseppi.                                     | 2. H. E. Quick.                         |
| Junior Scholarships in Chemistry and Histology (1901). |   |
| 1. F. B. Ambler.                                       | 2. R. H. Bott.                          |

Sir Trevor Lawrence then introduced the Lord Mayor in a few graceful words.

After distributing the prizes the Lord Mayor spoke as follows:—Mr. Chairman, Ladies and Gentlemen,—I feel it a very great honour to take such a prominent part in to-day's proceedings, one which usually is fulfilled by a distinguished physician or surgeon.

There are many things of which the Corporation may well be proud, but none is more worthy of our pride than St. Bartholomew's Hospital. The Hospital ever since the year 1544 has been intimately associated with the Corporation, and though I have the privilege of being associated with several city hospitals, I must confess that I am drawn most closely to the oldest of them, within whose walls I stand to-day.

We live, Mr. Chairman, in a period of progress, and no

hospital can hope to do its work efficiently nowadays unless its medical school is thoroughly up to date. In our London hospitals the importance of the medical school and the nursing home has at last begun to be more fully recognised, and I rejoice that during my year of office I have been associated with the Hospitals Fund. It affords me great pleasure to offer my congratulations not only to the numerous prizemen, but to you, Mr. Chairman, who have the honour to preside over this great institution; and I hope this Hospital may long continue and extend the work which it has carried on so nobly in the past.

Sir William Church then rose to propose a very cordial vote of thanks to the Lord Mayor for his kindness in coming to deliver the prizes, in spite of the fact that this was a peculiarly busy year for the Lord Mayor. The Lord Mayor had touched upon the close relation between the Corporation of the City of London and the Hospital.

Although Henry VIII was considered the second founder of the Hospital, yet the credit was really due to Sir Richard Gresham and the Corporation of London, and the Great Hall was chiefly the result of the bounty of the City of London. Sir William asked for a very hearty vote of thanks to the Lord Mayor. (Loud applause.)

The vote of thanks was seconded by Mr. Howard Marsh, who expressed the indebtedness of the School to the Lord Mayor, who was one of the busiest men in England, and whose motive in coming was therefore a very strong one.

The motion was put by Sir Trevor Lawrence, and was carried amidst great enthusiasm.

In reply, the Lord Mayor remarked that the afternoon's proceedings had given him very great pleasure; he yielded to none in his good wishes for the success of the Hospital; and he hoped that such great institutions would always be supported by voluntary effort, and never thrown upon the rates.

Mr. Langton proposed a warm vote of thanks to the Treasurer, to whom the Hospital is so much indebted. The Treasurer was an old student of St. Bartholomew's Hospital, and son of Sir William Lawrence, who was one of the greatest surgeons who have ever lived. Every one knew how admirably the Treasurer fulfilled his duties, and how much time and attention he gave to the affairs of the Hospital. The Treasurer had at heart the best interests of the School, and was carefully considering the many problems to be solved by the School in the near future.

Dr. Gee heartily seconded Mr. Langton's proposal, which was put to the meeting by the Lord Mayor, and carried with loud applause.

Sir Trevor Lawrence, in his reply, thanked Mr. Langton for his remarks, referred to the honour which he felt in holding the office of Treasurer, and alluded to the honour felt by the Hospital in having as Patron the King, and as President the Prince of Wales.

The proceedings then terminated, and every one adjourned to the Square, which, crowded with visitors and students, presented a very animated spectacle, tea and strawberries furnishing an agreeable conclusion to a most delightful and successful function.

### Amalgamated Clubs.

#### THE UNITED HOSPITALS ATHLETIC CLUB.

THE thirty-sixth annual meeting of this club was held on June 25th, and was better attended than it has been for some years. This may have been owing to the probability of a keen struggle between St. Bart.'s and Guy's for the shield. As it was, Bart.'s won it quite easily, the surprise events being the 100 yards and 220 yards, which were won by W. H. Orton. The other winners from Bart.'s were H. E. Graham, who again won the half and one mile, D. M. Stone the weight, and J. G. Gibb the three miles. G. M. Levick was unlucky enough to hurt his ankle at our own sports, so that although he gallantly turned out to throw the hammer for us, it was not surprising that he did not win, although he got a second, which counts three points. Stone also tied for the second place in the high jump, P. Gosse being second in the one mile and the three miles. A new feature at this year's sports was the inter-hospital tug-of-war, which brought together again many of the Rugby forwards.

Unfortunately the judges refused to allow some of the heaviest men in our team to pull, on the ground that they were out of their year, so that the team was largely recruited from men who had come down to be spectators and not performers. Our first pull was with St. George's, whom we pulled over twice; but we, in our turn, were defeated by St. Thomas's after a most gallant struggle. The team was made up of the following:—Messrs. Carroll, Chaff, Douglas, Wilson, Hamilton, Gould, Marshall, and Scott. London eventually won the Cup, which was presented by the now defunct United Hospitals Cycling Association.

The result of the day's sports was—  
St. Bart.'s 1st, with 72 points—6 firsts, 4 seconds.  
Guy's 2nd " 36 " 3 " 2 "  
London 3rd " 16 " 1 first, 2 "

The officials were—  
President.—C. W. Mansell-Moulin, F.R.C.S.  
Captain.—P. Gosse (St. Bart.'s).  
Hon. Sec.—L. D. Bailey (St. George's).  
Judges.—S. K. Holman, A. F. Voelcker, H. M. Fletcher, G. R. Turner, and J. H. Reay.  
Referee.—C. Herbert, Esq.  
Clerks of the Course.—Messrs. J. H. Drysdale, M.D.; J. G. Turner, F.R.C.S.; I. Lane, F.R.C.S.; and H. S. Desprez, M.D.  
Timekeeper.—P. Furnival, Esq., F.R.C.S.  
Starter.—E. H. Pelling, Esq.

#### PREVIOUS CHAMPION HOSPITALS.

|                        |                        |
|------------------------|------------------------|
| 1867—Guy's             | 1885—St. Bartholomew's |
| 1868—St. George's      | 1866—St. Bartholomew's |
| 1869—King's            | 1867—St. Bartholomew's |
| 1870—King's            | 1868—St. Bartholomew's |
| 1871—Guy's             | 1869—St. Bartholomew's |
| 1872—Guy's             | 1870—St. Bartholomew's |
| 1873—St. Bartholomew's | 1871—St. Bartholomew's |
| 1874—King's            | 1872—Guy's             |
| 1875—St. George's      | 1873—Guy's             |
| 1876—St. George's      | 1874—St. Bartholomew's |
| 1877—Guy's             | 1875—Guy's             |
| 1878—Guy's             | 1876—St. Mary's        |
| 1879—St. Thomas's      | 1877—St. Mary's        |
| 1880—St. Thomas's      | 1878—St. Mary's        |
| 1881—St. Thomas's      | 1879—St. Bartholomew's |
| 1882—St. Thomas's      | 1880—St. Mary's        |
| 1883—St. Thomas's      | 1881—St. Bartholomew's |
| 1884—London            | 1882—St. Mary's        |
|                        | 1883—St. Bartholomew's |

The following is a detailed list of the events:

- 100 Yards Challenge Cup.  
1st. W. H. Orton (St. Bart.'s).  
2nd. W. T. Gibson (London).  
3rd. T. Smith (St. George's).  
Won by inches only. Time (against the wind)—10½ sec.
- Half-mile Challenge Cup.  
1st. H. E. Graham (St. Bart.'s, holder).  
2nd. L. E. Wigiam (St. Thomas's).  
Won by five yards after a great race. Time—2 min. 3½ sec.
- Putting the Shot.  
1st. D. M. Stone (St. Bart.'s, holder), 36 ft. 7 in.  
2nd. J. L. Rankin (Guy's), 35 ft. 1 in.
- High Jump.  
1st. J. E. Lascelles (St. Mary's, holder), 5 ft. 10 in.  
2nd. { D. M. Stone, } tied with 5 ft. 4½ in.  
      { H. Sears, }  
Lascelles' jump constituted a record for this event.
- 220 yards Challenge Cup.  
1st. W. H. Orton (St. Bart.'s).  
2nd. T. C. Smith (St. George's).  
3rd. E. Morgan (Guy's).  
Won by five yards; two between second and third. Time—24½ sec.
- One mile Challenge Cup.  
1st. H. E. Graham (St. Bart.'s, holder).  
2nd. P. Gosse (St. Bart.'s).  
3rd. E. L. Pilbean (Guy's).  
Gosse made the running till the bell, when Graham took the lead and won easily. Time—4 min. 30½ sec.
- Throwing the Hammer.  
1st. J. E. Rankine (Guy's).  
2nd. G. M. Levick (St. Bart.'s).  
3rd. E. E. Graham (St. Bart.'s).  
Distance 100 ft. 3 in.
- Quarter-mile Challenge Cup.  
1st. R. W. Allen (Guy's).  
2nd. H. C. Devas (St. Thomas's).  
3rd. H. F. Collier (St. George's).  
Won by four yards, inches separating the next two. Time—53½ sec.
- Long Jump.  
1st. E. Morgan (Guy's, holder), 20 ft. 6 in.  
2nd. W. J. Gibson (London).
- 120 yards Hurdles.  
1st. W. J. Gibson (London, holder).  
2nd. E. M. Harrison (Guy's).  
Won by three yards. Time—17½ sec.
- Three mile Challenge Cup.  
1st. J. G. Gibb (St. Bart.'s, holder).  
2nd. P. Gosse (St. Bart.'s).  
3rd. A. G. Simmons (St. Thomas's).  
Gibb led all the way, winning easily in 15 min. 57 sec.

## Reviews.

DISEASES OF THE ORGANS OF RESPIRATION. By SAMUEL WEST, M.D., F.R.C.P., Senior Physician to the Royal Free Hospital; Assistant Physician to St. Bartholomew's Hospital.

Dr. West describes his work as a "Treatise on the Aetiology, Pathology, Diagnosis, Prognosis, and Treatment of Diseases of the Lungs and Air-passages." It is obvious that such a treatise must of necessity be bulky if it is to be in any sense of the word complete, for it has to cover an immense amount of ground.

Let us say at once that Dr. West has succeeded in producing an admirable and exhaustive book, in which the many and various affections of the lungs and air-passages are elaborately treated from the clinical and pathological points of view. Dr. West's great experience in such diseases enables him to illustrate many of his points in diagnosis and treatment from cases that have come under his own observation—a fact that adds immensely to the interest and usefulness of the work, and gives to many of the opinions expressed the weight of personal experience.

Dr. West does not hesitate to express dogmatic opinions—a fact which necessarily lays him open to attack from those who differ from him; but the value of the work is much increased thereby, for the most valuable addition to medical literature at the present time is the free expression of the opinions that a close and accurate observer has come to after much clinical practice.

The pathological and bacteriological sections are largely composed of extracts from recent works, and, on the whole, they give a fairly complete *résumé* of the various subjects treated.

To come to details, the sections in the first volume that are especially good are those dealing with bronchitis, emphysema, and the pneumonias, though we do not consider that Dr. West has made out a convincing case for the existence of capillary bronchitis as a clinical and pathological entity apart from broncho-pneumonia. As regards the aetiology of what Dr. West calls "ordinary, genuine, true, large-lunged emphysema," we are pleased to see that he insists on the inadequacy of the various mechanical explanations to account for the condition without some structural change occurring first. He would have strengthened his case if he had quoted some recent statistics that point very strongly to an hereditary factor as present in a large proportion of the cases.

In the second volume the longest section is that dealing with phthisis. We regret that Dr. West should have retained this word for all cases of pulmonary tuberculosis, for it conveys a certain clinical picture which it is the object of modern treatment to prevent rather than to cure, and we consider that Dr. West's somewhat pessimistic views of the ultimate history of cured tubercle would be modified by the consideration of the numerous cases who have been able to devote a year to their recovery, and when the diagnosis has been made in the earliest stages and before the classical symptoms of "phthisis" have occurred.

The section dealing with the various climates that have been recommended for tuberculous patients contains a great deal of information that cannot fail to be of use to those who have to give advice on this difficult subject. At the same time we wish that Dr. West had gone more fully into the subject of sanatorium treatment; some authoritative

statement on the results and prospects of this system of therapeutics is much needed at the present time.

Pleurisy in its various forms is treated fully and in an interesting manner; the same is true of the section dealing with pneumothorax. Dr. West makes a very strong case in favour of radical operative treatment of pyopneumothorax, and the cases he quotes in support of his practice seem to us to be conclusive. The clinical account of asthma is excellent, and there is a short review of the various theories in vogue as to its causation. Dr. West sums up in favour of spasm of the bronchial muscles and diaphragm "associated in many cases with more or less vaso-motor disturbance in the bronchi."

The whole work is fully illustrated with many admirable microscopic and post-mortem figures, most of which appear for the first time. This adds considerably to the value of the book, which being, as it is, the result of a patient accumulation of facts, and the outcome of a large experience, will prove to be a useful addition to medical literature.

IMPRESSIONS OF A DOCTOR IN KHAKI. By FRANCIS E. FREMANTLE, M.A., M.B., B.Ch.Oxon., M.R.C.P., D.P.H. (London: John Murray. Price 10s. 6d.)

Few books on the war have interested us more. We are impressed alike with a fascinating narrative, vividly written, with criticisms frankly expressed, and with the value of the book afforded by its insight into the minute details and inner workings of the medical services; an insight which can only be obtained from the unfettered civilian who has seen, marked, and inwardly digested.

Dr. Fremantle went out from Guy's as one of the pioneer civil surgeons on the "Rosslyn Castle," which carried the first detachment of the 1st Army Corps.

The book is written in diary form, and furnishes impressions jotted down when still fresh and vivid; this greatly adds to its value. The freedom and independence of these impressions is quite refreshing. Dr. Fremantle's experience embraced life in a base hospital, in a hospital ship, in a field hospital, in sick convoys, in the trek, and in the field of battle.

The author was at Wynberg during the heavy fighting under Methuen at a time when practically all the wounded were sent to the base, and when there were many deficiencies and much to criticise. If the structures are severe they are none the less convincing. Here is an extract from Wynberg referring to the hospital orderlies:—"I went into one of my huts on Sunday, and found that my head nurse, so to speak, was confined to cells for being drunk on the previous night; and the only remaining orderly said that that was nothing, as he had had eleven days not long ago, and lost his corporal's stripes after fourteen years' service. 'It ain't no game, this job it ain't,' he continued. 'I'm going to chuck it, sir, when I gets' omie; try some other trade. Eightpence a day! Lor' blimey! And the orderlies curse the patients for not helping them, and the patients curse the orderlies for making them do all the work. What can you expect under such conditions? . . . The whole system is bad, and is primarily due not to the exigencies of war, but to the exigencies of a slowly grown, iron-bound, almost mathematised system, clogged with trivialities, and hampered at every turn by an excess of officials, official returns, and all the paraphernalia of red tape.' This was in the days when nurses were clamouring to be sent out, and were not sent; orderlies, like 'unmounted men,' were preferred.

We get considerable insight into the life and character of Tommy Atkins, and many a good anecdote. Here we have a fine apology for war:—"After all, an army represents pretty well the scum of the earth at its very best, and it is because it gives the scum its chance of getting to its very best and becoming no longer scum that the army is, perhaps, the greatest philanthropic institution in the nation."

The following extract gives an excellent account of field-hospital work following the battle of Donkopp, now known as the battle of Johannesburg:

"The field hospital had been erected. The sergeant and corporal cooks had made an ant heap into a fireplace, and were preparing hot milk, tea, and bovril over a roaring fire made of barbed-wire fence-posts. By 5.30 the first batch of wounded had arrived, and were lying in a row, wrapped up in their blankets, the worst cases on stretchers, the rest on the ground outside the tents. The sergeant-major walked to and fro with hot drinks and rum. The two chaplains of the brigade went round talking to the men, distributing cigarettes, keeping the "nominal roll," carrying lights for the medical officer, tending the dying, and cheering everybody in turn. The only medical officer available, having never before seen a field hospital at work after action, struggled with the arrangements in general, and every now and again was able to dress a wound or superintend an R.A.M.C. orderly in treating a simple case. One tent was kept as a surgery. The rest were filled as they were erected with patients carried or helped out from the surgery. The surgery tent, an ordinary bell-tent, twelve feet across, was supplied with two panniers, which stood on the right of the door, to support one stretcher at a time, and so enable the worst cases to be attended to without more discomfort than was necessary. On the left of the doorway were the antiseptic and fracture boxes, with an orderly to distribute their contents. Beyond them on the left side of the tent, and again at the further end, two other orderlies were able to treat slight cases sitting on the ground. But the work of the medical officer in charge, in supervising the slight cases, trying himself to dress the severe cases, and being constantly called away from the surgery tent, was difficult and vexatious in the extreme. 'Where shall this tent be pitched, sir?' and he had to go and explore the ground in the neighbourhood.

"'I ain't been looked at yet, sir,' remarked two or three of the Gordons, as he nearly tripped over them in the dusk. 'I aven't got no blanket, sir,' complained a fourth poor chap, looking very cold in his kilt. 'There won't be enough bovril to go round, sir,' said the cook. 'The General is here, sir,' reported the corporal. 'May we have our stretcher, sir?' asked four Gordon stretcher-bearers, who had carried a 'fractured thigh' two miles, and would now have to transfer him to the ground. 'Twelve more wounded, sir,' said the staff-sergeant, coming up with some of the ambulance waggon. 'The officers' tent has got four cases in it already, sir; where shall Captain — go to?' 'That corporal, sir, is dying; will you come and see him?' 'Mr. —, sir, is ready for you to dress him; he has been waiting rather a long time.' Poor M— of the Gordons was brought in, shot through the neck, lying peacefully on a stretcher. He had already passed to his rest. F— of the Cornwalls, a universal favourite, lay unconscious in the corner of a crowded tent, and followed him before midnight. Fortunately, as matters were reaching a climax, Providence arranged that three Australian doctors, Major M. C—, and Lieutenants R— and H—, should miss their way; and they, with Surgeon-Captain R— of the mounted C.I.V., his veterinary colleague, and his orderly, came and offered their services. All turned to with a will. The consulting surgeon from Sydney stood on one side of the tent and dressed cases. The C.I.V. trio stooped on the other side and dressed their cases.

"The other Australians kept count of every case on arrival, fed the surgery tent, and themselves dressed many cases in turn, just as they were lying out on the ground, while the officer in charge was free to put his hands in his pockets and answer questions. It was pitch-dark, and there were but three lanterns and a few naked flickering candles. It was horribly cold, and the troops had been without rations, except of meat, all day, and had no prospect of any for the next. The supply of milk and bovril in the hospital was limited; the supply of spare blankets still more so. However, help came from various quarters. The General and his staff sent their private blankets, and lent others which once belonged to Boers. The supply officer raked in some extra supplies from somewhere. The N.C.O.s and men worked like slaves. The adjutant of the Gordons, and twenty-five of his men, despite the fatigues of the day, brought down from their camp, two miles away, the kits of the wounded Highlanders, and were up till nearly midnight distributing them. Above all, the surgical work progressed slowly but steadily."

One of the most readable chapters in the book is one in which the writer describes a visit to a Boer commando, Theron's scouts. Having set out with his servant to find some wounded men of Loelke's Horse, he falls in with the commando, and spends the night with them. The commandant was a splendid liar and a tremendous hero.

In his conclusion, which Dr. Fremantle divides into three parts, written at different periods, he draws attention to some of the most obvious faults both in the system and the constitution of the R.A.M.C. Further, he points out—what has been from the first obvious to the medical profession—that the Hospitals Commission was only allowed to see and hear what was thought proper by the senior officers of the respective hospitals. In the second part he sketches out the problems which, in his opinion, have to be faced in any reforming scheme, and outlines a scheme of his own for an entirely civilian service. In the third part, however, after he has served as secretary to Mr. Brodrick's committee, he admits that "opinion is not yet ripe for such a revolution," and accepts with enthusiasm the recommendations of the committee. How far he is justified may be judged from the present competition for thirty vacancies in the R.A.M.C., more than seventy candidates having presented themselves.

In conclusion, we venture to congratulate Dr. Fremantle on the energy and industry which have produced this book, delightfully refreshing in its style, and extremely interesting both to the laity and the medical man; and if it serves in future times of trouble to bring the civilian into closer touch and greater harmony with his professional brethren in the service it will indeed have accomplished a great end.

The book is most attractively bound, and the illustrations from photographs and pen-and-ink sketches excellently reproduced.

### Junior Staff Appointments.

#### HOUSE SURGEONS.

|                    |               |   |
|--------------------|---------------|---|
| <i>Mr. Langton</i> | October, 1902 | E. L. Farncombe, B.A. (Oxon.), M.R.C.S., L.R.C.P.   |
| "                  | April, 1903   | H. V. Wenham.   |
| <i>Mr. Marsh</i>   | October, 1902 | E. C. Mackay, M.R.C.S., L.R.C.P.  |
| "                  | April, 1903   | V. G. Ward, M.B.(Lond.), M.R.C.S., L.R.C.P.   |
| <i>Mr. Butlin</i>  | October, 1902 | E. E. Young, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P.   |
| "                  | April, 1903   | R. C. Elmslie, M.R.C.S., L.R.C.P.   |
| <i>Mr. Walsham</i> | October, 1902 | J. F. Alexander, M.A., B.C.(Cantab.), M.R.C.S., L.R.C.P.  |
| "                  | April, 1903   | A. M. Amsler, M.R.C.S., L.R.C.P.  |
| <i>Mr. Cripps</i>  | October, 1902 | F. P. Connor, M.R.C.S., L.R.C.P.  |
| "                  | April, 1903   | H. Love, M.R.C.S., L.R.C.P.   |
| INTERNS            | October, 1902 | E. H. Hunt, M.A., M.B., B.Ch.(Oxon), M.R.C.S., L.R.C.P., C. W. von Bergen, M.B., B.S.(Durham), M.R.C.S., L.R.C.P. |
| EXTERNS            | "             | "   |
| "                  | January, 1903 | J. C. Sale, M.R.C.S., L.R.C.P.  |

#### OPHTHALMIC HOUSE

SURGEON October, 1902 J. Corbin, M.R.C.S., L.R.C.P.

### Calendar.

|                   |                                     |
|-------------------|-------------------------------------|
| Aug. 12.—On duty. | Dr. Hensley and Mr. Walsham.        |
| " 15.—On duty.    | Sir Lauder Brunton and Mr. Cripps.  |
| " 19.—On duty.    | Sir William Church and Mr. Langton. |
| " 22.—On duty.    | Dr. Gee and Mr. Marsh.              |
| " 26.—On duty.    | Sir Dyce Duckworth and Mr. Butlin.  |
| " 29.—On duty.    | Dr. Hensley and Mr. Walsham.        |
| Sept. 2.—On duty. | Sir Lauder Brunton and Mr. Cripps.  |
| " 5.—On duty.     | Sir William Church and Mr. Langton. |
| " 9.—On duty.     | Dr. Gee and Mr. Marsh.              |
| " 12.—On duty.    | Sir Dyce Duckworth and Mr. Butlin.  |
| " 16.—On duty.    | Dr. Hensley and Mr. Walsham.        |
| " 19.—On duty.    | Sir Lauder Brunton and Mr. Cripps.  |

### Examinations.

#### CONJOINT BOARD.

*Anatomy and Physiology.*—C. H. Fernie, A. C. Wroughton, E. H. Shaw, R. C. P. McDonagh, W. G. Loughborough, J. S. Williamson, W. H. Harvey, J. G. Gibb, R. V. Favel, R. C. P. Berryman, G. I. Morse, G. J. Eady, J. R. R. Trist, F. Gooding.

*Examination for Diploma of D.P.H.*—A. R. J. Douglas, F.R.C.S.; H. Mundy, F.R.C.S.

#### UNIVERSITY OF LONDON.

##### Intermediate Examination in Medicine.

*Entire Examination.—First Division.*—R. H. Bott, C. H. Fielding.

*Second Division.*—W. G. Ball, W. H. Barnett, C. B. D. Butcher, B. E. Moss, J. E. Pratt.

*Physiology only.*—J. G. F. Hosken, S. W. Milner.

*Honours List.*—F. B. Ambler, Third Class Honours in Physiology and Histology; J. C. Meade, Third Class Honours in Anatomy.

### Appointments.

DRUITT, A. E., M.R.C.S., L.R.C.P., D.P.H.(Cantab.), appointed under Church Missionary Society to West Africa Mission in Hausaland.

MAYNARD, Major F. F., M.B., F.R.C.S.Eng., I.M.S., appointed to act as Ophthalmic Surgeon and Professor of Ophthalmic Surgery in the Medical College, Calcutta.

MUNDY, H., F.R.C.S., appointed Surgeon to the ss. "Ingeli."

### New Addresses.

JONES, H. LEWIS, 143, Harley Street, W.  
WARDE, A. B., Northumberland Lodge, Bloemfontein, Orange River Colony.

### Birth.

MASTERMAN.—On July 2nd, at Jerusalem, the wife of E. W. Guiney Masterman, F.R.C.S., D.P.H.Cantab., of a daughter.

### Death.

CORFIELD.—On July 14th, at Gothic House, Upper Tooting, Phyllis Marjorie, only child of Carruthers Corfield, M.R.C.S.(Eng.), L.B.C.P. and L.S.A.(Lond.), aged eighteen months.

# St. Bartholomew's Hospital



## JOURNAL.

VOL. IX.—No. 11.]

AUGUST, 1902.

[PRICE SIXPENCE.]

### NOTICE.

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

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

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

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

### St. Bartholomew's Hospital Journal,

AUGUST, 1902.

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

### Affections of the Nasal and Air Passages in Congenital and Tertiary Syphilis.

A Clinical Lecture delivered at St. Bartholomew's Hospital.

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

(For the report of this lecture we are indebted to the EDITOR OF THE CLINICAL JOURNAL.)



YOU will remember, gentlemen, that at my last lecture I was speaking to you about primary and secondary syphilis of the nasal and air passages in general. I want now to turn to the affections

of these regions in congenital syphilis, and in tertiary syphilis.

You know that congenital syphilis differs in many ways from acquired syphilis. It manifests itself in some cases very early in life, but in other cases it is not evidenced until after the lapse of months or years. In the case of syphilis of the nasal passages the disease manifests itself more early in life than in any other place almost. You know that the common name for this condition is "the snuffles." If you were to examine the nasal membrane in a child who has what is called the snuffles, you would find there was a considerable occlusion of the nares by the accumulation of crusts, and if you remove those crusts you find, in many cases, nothing more than a general catarrhal swelling of the mucous membrane, with no ulceration or destruction of it whatever. But if you examined a little deeper you would often find in the submucous tissue that there was a gummatous deposit, and a thickening of the periosteum. In a great many cases there is nothing more than this general thickening. But in a small proportion of patients, again, in this condition there supervenes ulceration; so that, even in infantile life, in a few months there may be caries, and sometimes even extensive necrosis. But you must remember that these conditions are rare, and that the usual manifestations are those which I mentioned at first—a seeming catarrh, a swelling of the mucous membrane, and the formation of crusts. Usually there is some thickening, but seldom more than that. Occasionally there is open ulceration and caries, and even extensive necrosis in the early months of life.

In a great many cases of congenital syphilis there is no evidence of nasal syphilis in infantile life; and even when there is evidence, a child who is treated often recovers, so that afterwards the only thing which remains to show for the disease is that the nose assumes a curious shape, the end being lumpy, tilted up, and swollen, and altogether out of proportion to the size of the nose as judged by the nasal bones and the lateral masses formed by the superior



maxillary bones. The consequence is that the nose in many children, without being extensively destroyed, or deformed, is of a characteristic shape, with a slightly depressed bridge, and rather a "blob" at its end. In other cases there is left a real impairment of growth of the bone, so that the bridge of the nose may never properly be developed at all, and the child may grow up with a sunken nose, though there has not been definite external evidence of disease as shown by destruction of bone. It does not, therefore, necessarily follow that because a child has no evident perforation of the septum of the nose and no necrosis his nose will not be ultimately of an altered shape. It may be of an altered shape though neither of these conditions has obtained. In other cases again, unfortunately, as I have mentioned to you, there are extensive caries and necrosis, and the whole shape of the nose is permanently altered, so that the patient may be said practically to have very little nose at all, as far as prominence on the face is concerned.

Later in life, when the time for infantile syphilis has passed by, there may be a condition such as I show you in this drawing. This is the face of a child of eight which presents the condition known as "syphilitic lupus," or a lupoid syphilide. You know that in describing syphilitic eruptions terms are employed which indicate more simple eruptions. For instance, we talk of a syphilitic psoriasis, which is not psoriasis at all; what is meant is merely that it is a syphilitic eruption which has the appearance of psoriasis. We talk of syphilitic acne, and that again is a syphilitic eruption which bears a resemblance to acne. In the same way we talk of syphilitic lupus, which has nothing to do with lupus; it is syphilis having the appearance of lupus. This condition, which may be called syphilitic lupus, or a lupoid syphilide, or tertiary syphilitic ulceration of the nose, is a disease which may supervene at any time after the period of the second dentition. It is not very common, but it is sufficiently so to be well recognised, and therefore it is a condition which you have to differentiate from typical tubercular lupus. It differs from it chiefly in the rapidity with which it extends, and the amount of destruction of tissue which is involved, as well as in the way in which it passes far beyond the ordinary limits of lupus if it is allowed to go untreated. You will see in this next picture still further evidence of the destruction which may result from the extension of the disease. This is the face of a child of nine whose teeth present the characteristic notches which are supposed to be due to syphilis. Evidently the child had congenital syphilis. In this child's nose is seen, at a later stage, what was seen in the first picture, an extensive laceration of the skin, a wide opening of the whole of the cavities of the nose, and the destruction of a great part of the ala on the left side. That illustrates a much more extensive destruction in depth of tissue than you get with lupus until the lupus has

been going on for years, and usually not then unless it has extended over a very large surface of the face. This, then, is evidence of nasal syphilis at a stage of life later than infancy. At the same time that this happens, and rarely before, there may be ulceration inside the nose, and there may be ulceration of the pharynx. The larynx, fortunately, is rarely affected in congenital syphilis, although I shall tell you presently that in tertiary syphilis it is. But the tongue is affected in congenital syphilis in a good many cases. Here is a good picture of a child, a boy aged seven, who had been under treatment one and a half years, and here you get the typical conditions of tertiary syphilis of the tongue. So you see there may be not only affections of the nose in children, but there may be affections of the pharynx with ulceration, and affections of the tongue of the same nature as those with which you are familiar in cases of acquired syphilis in the tertiary period. As far as these patients are concerned you may say in general terms that the diagnosis is tolerably simple. There is not much else that looks like an ulcerative syphilide of the nose; there is nothing which closely resembles this condition of the tongue, and therefore, without wasting too much time upon the matter, as it is a subject which one has hardly time to discuss now, it is enough to say that the diagnosis is easy, and that the treatment to be adopted is that for syphilis in general, not only by means of iodide of potassium, but also by mercury. Both of these are useful, and if administered in reasonable doses, and continued for a sufficient time, the results in these cases of syphilis of children, as apart from the cases of infancy, are thoroughly satisfactory. I need hardly remind you that the general treatment of syphilis in infants is very unsatisfactory. A large number of such patients are sure to die very young whatever you do for them. The evidence which you may detect of the disease in the nose is not the only evidence which will guide you in the diagnosis, but it will enable you to realise that probably the child has syphilitic disease going on elsewhere in its body. You will be able to see that its viscera are very likely unsound, and that, apart from the condition of its nose, it is likely to die. Moreover the trouble in the nose causes some interference with the vitality of the child, and often makes it very difficult for it to suck its food. Thus the chance of recovery of a sick child is very materially prejudiced, not so much from the amount of destruction of tissue, as on account of the difficulty which it has in taking its nourishment.

We will now leave hereditary syphilis, though there are many more things which might be said about it, and turn to tertiary syphilis. And here, again, we begin with the nose. Tertiary syphilis of the nose may attack either the external surface of the nose or the inside of that organ. Let us say a few words about the external surface first, and dismiss the subject. A person with acquired syphilis may

have such a condition of the nose as I pointed out to you as occurring in childhood,—that is to say, a so-called ulcerative syphilide or syphilitic lupus. This, then, is a condition which may occur both in congenital and in acquired syphilis, and you may expect to find patients with tertiary syphilis who have destruction of the ala of the nose, or of a considerable portion of its tip.

Next with regard to the inside of the nose. Here, of course, you have to do with conditions which are very much more serious, and this chiefly because they are so latent, and therefore liable to be overlooked. If you examine the inside of the nose in cases of tertiary syphilis, at the beginning of some syphilitic affection of the inside of the nares, you may find, either on the outer side of the nostril, on the turbinate bodies, or on the septum (the last being the more common), a swelling. No ulceration precedes this as a rule. That swelling is due to a gummatous deposit in the periosteum, and sometimes in the substance of the turbinate bodies. All that the patient complains of is some difficulty in breathing through the nose. The swelling is soft, and if the condition is on the outer side of the nose you are liable to say that it is hypertrophic rhinitis, and indeed it looks like it. But if you examine further you will find there is a much more substantial swelling; it is not the oedema which you associate with enlargement of the turbinate bodies. This swelling is different from that; it is much more thick and substantial, is often not limited to the turbinate body, and does not disappear when you put cocaine into the nose. So you have something which looks like hypertrophic rhinitis, and which may be mistaken for it. At that stage, if you recognise the disease and treat it, you can get your patient well without trouble occurring inside the nose beyond the temporary blocking and consequent difficulty in breathing. The whole of this swelling may be entirely removed by the administration of iodide of potassium and mercury, and the patient may completely recover without having a sore place inside the nose at all. You are less likely to make the mistake of not recognising this early condition when it affects the septum, because swellings of the septum are not very common apart from syphilis. They occur in tubercle, but generally the patients we are speaking of are older than patients who have tubercular swellings of the septum. Then there is new growth, but the cases are not like that. In cases of syphilitic disease of the septum there is generally a thickening and evident swelling of one side. Often, however, both sides of the septum are involved, so that you may have enlargement of the septum as a whole. If you recognise this condition you can often prevent the patient from having anything more the matter with his nose, because at this stage the condition is amenable to treatment. If you wait, or if the patient does not see you soon enough, what happens? What happens on the outer side, in the condition which resembles hypertrophic rhinitis?

What happens in the septum where there is not yet any ulceration? These swellings will ultimately break down, they will ulcerate, and they will leave an open place which discharges purulent and blood-stained material, which is the debris of the tissues which have been destroyed. How much tissue has been destroyed varies immensely in different cases. In one case when the gumma bursts and discharges its contents there is found to be an ulcer, at the bottom of which the bone may not be evidently exposed, or the bone is perhaps exposed over only a very small area, and that ulcer heals up. Or it may be that there is an ulcer, at the bottom of which carious bone is extensively exposed, and this will take a long time to heal. These conditions may extend, the ulceration may progress, more bone may become carious, and ultimately the whole inside of the nose may become widely and extensively ulcerated, with perforation of the septum and necrosis of other bones. At any rate, the state of the patient after a time is that a great deal of the nose is destroyed from within. Whilst these changes are taking place, in not a few cases there is no necessary alteration in the external shape of the nose, even although there may be extensive destruction of the septum. You will be able to see patients in the throat department in whom there is a large hole in the septum of the nose, and yet the bridge has not fallen in. I want you to remember that, because it seems to be the opinion of many people that as soon as the septum of the nose is destroyed the nose falls in. But the nose does not fall in simply because of that. The nose is supported laterally by the nasal bones and the superior maxillary bones, and these do not necessarily fall in. These make the bridge. The nose does not depend merely on the support which it receives from the septum. Therefore in many of these cases you can see destruction of bone, and yet, though there is a complete breaking open of the cavities of the nose, so that they form one large cavity, there is not necessarily any material deformity. In other cases, unfortunately, there is much material deformity, and such large portions of the nose may be destroyed that either the bridge of the nose may sink in and leave the fleshy part of the nose projecting as a shapeless mass, or ulceration may extend to the tip of the nose, and all the soft parts of the organ may be destroyed. In some cases both of these conditions go together,—that is to say, a destruction of the soft parts and of the bony framework of the nose.

With regard to the differential diagnosis, when it is a case of ulceration there is as a rule very little difficulty in diagnosing the condition; but you have to keep in mind that there is a form of ulceration of the septum of the nose which is not due to syphilis; that is called "atrophic ulcer" of the septum of the nose. It occurs almost always in women, and generally in women over forty years of age. It has no definitely recognised cause. Tubercle also may perforate the nose, but that almost always occurs in quite

young subjects. Perforation of the septum of the nose by syphilis is the most common. Atrophic ulceration of the nose, let me say at once, is a very slowly extending form of ulceration, which may very likely take a year or two to perforate the septum. It occurs immediately behind the tip of the nose, and as it occurs in that place it usually perforates the cartilage and not the bone. Ultimately it gradually cicatrises at its edges, leaving, however, a permanent hole through the septum of the nose. That is a curious condition, the pathology of which we do not understand; but you may say definitely it is so unlike the course of syphilis that you are not at all likely to mistake the one for the other.

As to symptoms, I have already told you that at the beginning the only thing which the patient will complain of, before there is ulceration, is some obstruction to the passage of air through the nose. You can easily understand that afterwards, when there is ulceration, the patient complains of discharge from the nose, and it is to be noted that in many cases the discharge is characteristically blood-stained. If you find a discharge from the nose which is practically always blood-stained the case is most likely to be one of tertiary syphilitic ulceration. If, however, the patient be a child and there is a blood-stained discharge from the nose, remember that the commonest cause for that is undoubtedly the presence of a foreign body in the nose; and I need hardly say this is something altogether different from what we are considering. We are speaking about tertiary syphilis now, in which the patients are adults; and if there be a profuse blood-stained discharge from the nose, that is almost always an indication of tertiary syphilis. Other discharges from the nose are seldom regularly blood-stained. Later on the patient may complain of loss of the sense of smell, which is due to the destruction of the mucous membrane and of the terminal filaments of the olfactory nerve. Later on still the patient may have *ozæna*, of which, however, he will not complain so much as will his friends. *Ozæna* is a characteristic fetid odour which may occur from other causes than syphilis, but it is one of the great troubles of tertiary syphilis, when ulceration has extended and destroyed much of the bone and is associated with caries or necrosis.

What you will be able to do for your patient will greatly depend upon the state in which you see him. In all these cases the ordinary antisyphilitic remedies should be employed, and always remember to employ mercury as well as iodide of potassium. I am no advocate of giving iodide of potassium and withholding the mercury. You have also to carry out measures for local cleanliness, such as the washing out of the nose with salt and water and afterwards the introduction of an antiseptic powder. In the throat department we have been using loretin and borax. The first of these is practically iodoform under another name and in another form. It has about the same proportion of

iodine, which it liberates in contact with living tissues, and thus acts as a disinfectant; we use it instead of iodol, because it is cheaper and because it is insufflated much more easily. After having used other preparations we have come to the conclusion that on the whole loretin is better than most things. I always use it with borax, because borax liquefies mucus and promotes a more watery discharge from the nose, and seems to prevent to some extent the formation of the thick crusts and scabs. I am not particular as to the exact form of antiseptic which you may use; the essential thing is that you should wash the nose out to get rid of the crusts and scabs, and afterwards that the patient should use some antiseptic powder to blow into the nose. Most of these cases yield to treatment, but a few of them do not.

And now let me point out one of the results of syphilitic ulceration of the nose when the ulceration has ceased. Cicatrization ensues. In the case which is illustrated in the picture I show you cicatrization has ensued to an extent which is very rare; nearly the whole of the nares is completely occluded. There is an absolute stoppage of the nostrils by scar tissue, so that the patient has no breathing-room at all. This is a complication which you have to bear in mind, but it does not often happen. When there is complete occlusion of the nares as a result of ulceration of a syphilitic nature the cases are most difficult to treat. The treatment, indeed, is almost sufficient to occupy a lecture by itself. It is very difficult to restore a passage or channel in any part of the body which has been closed by a cicatrix, and you have, in such patients, to perform some plastic operation.

Let us now pass to the other end of the nasal passages, namely, the pharynx. There is not so much to be said about the pharynx as about the nose in tertiary syphilis; but the back of the pharynx may be ulcerated, and so may the roof of the mouth and the soft palate. Let me remind you that the roof of the mouth is the floor of the nose; what is the ceiling of one story is the floor of another. The result is that ulcerations inside the nose may result in perforation of the palate; and you may feel, before there is perforation, the same swelling which I have mentioned as occurring inside the nose before ulceration commences there.

If you are examining a patient with syphilis, and if you find, after having satisfied yourself of the evidence of syphilis inside the nose, that there is a bulging on the upper part of the hard palate, you may be sure that if you do not get that patient quickly under the influence of treatment there will be perforation inside the mouth. At a later stage the palate may be ulcerated, and so may the pillars of the fauces and the pharynx. These ulcerations you may see either at the time that they are recent and open, or you may see them later, when the process of cicatrization is going on. The picture which I have shown

you of occlusion of the anterior nares represents the similar condition which may occur after ulceration in the pharynx. A little time back a patient came here quite unable to breathe through the nose. The examination of the anterior nares showed nothing, but on opening the mouth you could see that the palate was drawn upwards, and was adherent to the pharynx, that the pillars of the fauces were dragged upon, and that there was only a small hole left through which one could pass a fine catheter into the naso-pharynx. The whole of the rest of this space was shut off by an extensive scar, the result of tertiary syphilitic ulceration of this region, which had destroyed the uvula and the pillars of the fauces.

And now, in conclusion, a few words about tertiary syphilitic ulceration a little lower down, namely, in the larynx.

With regard to the larynx there is not so much to be said, but what is to be said is of very great importance. In many cases a patient who has tertiary syphilis has a hoarse, harsh voice. If you examine him you will find either swelling or ulceration to account for it. The swelling may be an ordinary gummatous swelling, entirely analogous to that which I described as taking place in the septum of the nose or the turbinate bones; and you may find on one side of the larynx a lump which, we will say, is above the vocal cord, for the ventricular band is a very common place for this condition, and so is the ary-epiglottic fold. As that swelling increases it infiltrates the muscles, and although the cord itself is free and may appear normal the movements of the cord may be hampered, and the patient as a result talks with difficulty. If you see the same patient later on you may notice that the swelling has disappeared and an ulcer has come in its place—the gumma has broken down. Here, in exactly the same way as in the nose, there may be superficial ulceration or deep destruction of the muscles in the larynx, of the ligaments, or of the crico-arytenoid joint; and as a consequence there may be a permanent alteration in the movements of the cord owing to the destruction of the muscles, and to the formation of fibrous tissue, and perhaps to ankylosis of the crico-arytenoid joint. Then, in exactly the same way as gummatous infiltration in the nose extends to the periosteum, so it may extend to the perichondrium and the cartilages of the larynx, although fortunately this is more rare. It may then give rise to perichondritis, with effusion underneath the perichondrium, entirely analogous to periostitis, so that sometimes one side of the larynx may be blocked by a large swelling which completely occludes that side of the larynx, and quite hides all the normal tissues. All that you can see in such a case is a large deep-seated swelling lifting up everything, and making the whole of the anatomy of the larynx so completely altered that you can hardly recognise it.

Let us now go a step further. Ulceration may result in

destruction of cartilage. We have got as far as perichondritis, and the ulceration may go on to ulceration of the cartilage. Of all cartilages which are likely to be destroyed the chief is the epiglottis, which is destroyed more often than is any other in cases of tertiary syphilis. Here is a picture which shows very wide-spread infiltration and ulceration inside the larynx; and here is another, from a man who was forty years of age, in whom there has been very extensive destruction and ulceration of the essential parts of the larynx, including some parts of the vocal cords. I have already said that hoarseness is the characteristic condition early in these cases; and the other thing to be noticed is that this condition of ulceration and swelling in the larynx in syphilis is almost painless. It thus differs materially from many, though not from all cases of tubercle, for many cases of tubercular laryngitis are very painful. Syphilitic laryngitis hardly ever causes pain, even if it is very advanced. Later on, not only may the voice be materially altered as the parts are infiltrated, the muscles destroyed, and the edges of the cord ulcerated, but on account of the amount of swelling there is sometimes considerable dyspnoea, and if treatment is not applied sufficiently quickly you may have to do a tracheotomy. You may find that a patient who has not had dyspnoea will on a certain day, within a few hours of your seeing him, develop severe dyspnoea. The explanation is that in a case where there has been already an open ulcer of the larynx the patient may, by exposure to cold or wet, have an ordinary catarrh; and where there is already much swelling of the larynx, the swelling which supervenes from the catarrh is sufficient to turn the balance and make it difficult for him to get a sufficient quantity of air down into the lungs at all. Later on, as ulceration ceases and cicatrization ensues, the larynx may be contracted in the process, and so there may be stenosis. The result may be that after the ulceration has ceased the dyspnoea may be much worse than it was during the active process of ulceration. It will be serious in proportion to the amount of tissue which has been destroyed and to the fixity of the parts which are left; so there is no hard and fast rule about these cases. Fortunately a large majority of the patients who have syphilitic ulceration of the larynx recover without any permanent dyspnoea, though with altered voice and permanent hoarseness, conditions due to the damage which has been done to the vocal cords, and to their fixity, which is irrecoverable. But most of them have not any permanent dyspnoea, though some of them may have some shortness of breath on exertion now and again. You may, however, meet with cicatrization, analogous to that which I showed you in the case of the nose, which may result in a gradual drawing-in of the orifice of the glottis, so that dyspnoea may be serious, and this dyspnoea you may have to treat by the use of a permanent tracheotomy tube. The dyspnoea which is the result of the swelling occurring whilst the syphilitic pro-

cesses are in progress you may have to treat by the employment of tracheotomy, but in the majority of such cases, where the dyspnoea is due to the inflammatory swelling, the use of a tube will only be temporary.

You will see, then, that in general terms syphilis, as it affects the nose, or the pharynx, or the larynx, begins in a large number of cases when it is in the tertiary period in a swelling. If you recognise it when there is only swelling, you have recognised it in time to prevent very much damage in a large number of cases. In the second stage this swelling is succeeded by ulceration, with destruction of tissue to a very varying extent. Thirdly, there ensues cicatrization, and that may result either in the natural healing of the ulcerated parts, leaving no other damage, or it may result in stenosis, so that there may be narrowing of the nares, or even occlusion and stenosis of the larynx, causing more or less serious dyspnoea.

### Notes of a Holiday in and Impressions of Spain.

By HENRY RUNDLE, F.R.C.S.

**M**OST people who travel at all have visited France, Belgium, and Switzerland, but Spain is a little off the usual track of European travel, and it attracts relatively a mere sprinkling of English visitors. This is due to many causes. It is less convenient of access than these countries. The train service is bad; one fast train only per day, and that usually run at night, is not enticing as a means of locomotion. These fast trains seem to stop at all the stations, and the ordinary trains stop between the stations as well. The hotels are not up to date; the culinary art, to put it mildly, is unsatisfactory in all but the larger towns, and many of the comforts which an Englishman is accustomed to are absent. Whatever drawbacks there may be, Spain is a fascinating country, and deserves a foremost place for holiday travel, being rich both in historical associations and romance, and also in treasures of art and architecture. I hope that these reminiscences of a recent holiday spent there will be interesting, especially to those who intend to be present at the International Congress of Medicine to be held in Madrid in April, 1903.

Cheerless and discouraging were the circumstances under which we started upon our journey southwards on February 1st, 1902. The Channel crossing was abominable. A gale which surpassed anything experienced for ten years at least made it highly dangerous to attempt to enter the harbour of Calais. The steamer therefore went on to the sister port of Boulogne, which has the advantage of being sheltered by Cape Grisnez, and there we landed. Most of

the passengers looked the very incarnation of sea-sickness. We reached Paris shortly before midnight, and a very good dinner quickly soothed our squeamish stomachs.

The next day we started from the Gare d'Orsay. This station is one of the finest, and certainly the cleanest and quietest for its size and importance, in Europe. There is no smoke. The train is drawn by an electric engine for some little distance out of Paris, and by a similar engine both passengers and luggage are lowered to the station.

Leaving at 12.15, we travelled across France through the valley of the Loire, a lovely country studded with old châteaux, reminding one of "the Dukeries" in our own country, and passing Tours, Poitiers, Bordeaux, and Biarritz to Irun, the frontier town, where the luggage was examined, and we and our luggage were transferred into a Spanish train. Here we first met with the Guardia Civil, a noteworthy feature of Spanish travel. The Civil Guard is a fine corps of nearly 20,000 men. It is the most trustworthy body in Spain for the defence of law and order, and is under the control of the War Minister. Two men belonging to this corps travel in every train. In case of any difficulty it is best to apply to them for help.

About half an hour after leaving the frontier we passed through San Sebastian, the summer resort of the Court, and then entered the gorges of the Pyrenees, with magnificent mountain scenery of the wildest kind. After traversing barren and treeless plains we reached Burgos. It was piercingly cold here; the streets were covered deep in snow. On arriving at the hotel we were glad to warm ourselves over the glowing embers of a brazier, for there were no fireplaces in our rooms.

Burgos is the home of the Cid, the national hero of Spain. He was born and spent a part of his life here, and is buried in a convent a few miles from the town. The cathedral is the finest Gothic church in Spain after those of Seville and Toledo. The Chapel of the Constable, with its richly carved tombs of the family of that name, is very fine. Close to the west end of the cathedral is San Nicholas, a church well worth seeing for its beautiful high altar, carved in stone from floor to roof. We drove to the Carthusian convent of Miraflores. A monk who took us round asked if we were Americans, and seemed relieved on being told that we were English. Evidently Cuba and the events of 1898 were still in his thoughts. We also went to the nunnery of las Huelgas, a refuge for women of noble families condemned to a life of seclusion, and to the Hospital del Rey. This building, founded in 1225 and restored in 1862, is ill-adapted for a hospital. The beds are placed in small alcoves projecting from a long cheerless corridor, with small windows at the top.

It was a night's journey from Burgos to the Escorial, a great stone building telling of greatness and death, and comprising in itself a convent, a church, a palace, and the Royal Mausoleum of Spain. This is built in a barren waste

with a range of hills behind, reminding one of Dartmoor. It is one of the gloomiest places conceivable. Gautier, in his *Voyage en Espagne*, suggests that a man, after seeing it, can always console himself, whatever the trouble of his life may be, by thinking that he might be at the Escorial, and is not. Philip II ordered the Escorial to be built as his own tomb, and had it planned in the form of a gridiron, in honour of St. Lawrence, because he had invoked his aid during the battle of St. Quentin, and was successful in routing the army of France. The church is magnificent, and ranks as one of the great Renaissance churches of Europe. Beneath the high altar is a chamber reserved for the burial of kings and the mothers of kings, and connected by a passage is the burial-place of the rest of the royal family. The most interesting room in the palace is the little inner room or cell in which Philip II died, from which, through an opening into the chapel, he could see the celebration of mass while too ill to leave his bed.

In the afternoon we left for Madrid, a distance of eighteen miles. Our first impressions of the capital were not promising, for the weather was raw, wet, and disagreeable. The surroundings of the city are not attractive. It was made a royal residence by Charles V in 1524, on account of its bracing air (it is 2130 feet above the sea), which he thought would keep him free from gout. We found it very cold. Let those with weak lungs avoid Madrid in the winter. The men wrapped themselves up in long cloaks drawn quite over their mouths. There is a Spanish saying that "the wind in Madrid cannot blow out a candle, but it is quite enough to kill a man." We were told that in summer it is very hot. These extremes of temperature, among other causes, give Madrid the unenviable distinction of being the most unhealthy capital in Europe. In 1901 the deaths numbered 17,242, and of these 4064 were of children under four years old. This gives a rate of about 33 per 1000. Two great evils in Madrid are food adulteration, which is virtually unchecked, and overcrowding. The 528,000 inhabitants are herded in 17,000 houses, which gives an average of 31 persons per house.

There are many small hospitals in Madrid, and four large ones, viz. the General Hospital, San Carlo, San Juan de Dios, and de la Princesa. We visited the last, which is the most modern. It was built in 1852 by Queen Isabel II to commemorate the birth of the Princess of Asturias, and was restored and enlarged by King Alfonso XII in 1880. It contains sixteen wards, with sixteen beds in each, and is built in three stories around a central space. The top story is for the accommodation of nurses and staff. The floors are of marble, and there is a dado of tiles on the walls; but the sanitary arrangements are defective, the lavatories, etc., being placed immediately inside the entrance to the wards. This was the best hospital we saw in Spain, and surgery seemed to be in a much more advanced state here than elsewhere in the Peninsula.

Madrid is less distinctly Spanish than any other city we visited, and has much the same appearance as other European capitals. The Puerta del Sol, the largest *plaza* and the favourite lounge in the city, and the Prado, or Rotten Row, have a gay and lively aspect. In the latter there was a show of carriages and horses as good as man could desire. But the two chief sights are the Royal Armoury, which contains the most perfect collection of mediæval armour in the world, and the Picture Gallery, which is worth a journey to Madrid to see. Velasquez, the unrivalled portrait painter, can be seen here as in no other gallery. He displayed his great genius in painting the plain-looking *Infantas* in the ridiculous costume of the period, with their curious surroundings of dwarfs and ferocious-looking dogs. They seem as if they were about to walk out of their frames. We could, with little difficulty, believe the story that a couple of these pictures, placed upon easels in Velasquez's studio, made onlookers fancy that the real persons were actually there. In this gallery are many of the most lovely works of Murillo, the painter of holy people and angels and beautiful children. Here is his famous picture "El Tiñoso," or St. Elizabeth of Hungary tending the sick poor, in which he expresses at once both the active human and the devoutly religious conception of life. We knew but little of Goya until we saw his pictures here. He was the painter of peasants and the barbarisms of the bull-fight, where he was evidently at home. The gallery of modern art in the Calle de Alcalá contains pictures of great interest. Madrid has but few fine buildings: the most important is the royal palace on the west side of the city. There is no cathedral, and only one fine church, San Francisco. It has the form of a large rotunda with six chapels, which are adorned with many good frescoes and pictures by modern Spanish artists. It was the Church of the Franciscan Monastery before it was turned into a parish church, and the monastery is now used as a barrack and military prison.

From Madrid we went to Seville, a journey of fourteen hours. In one of the most delightful papers of that most delightful book, *Virginibus Puerisque*, Stevenson has charmingly described the sensations of a man "ordered south," as he passes from frost and cold into sunshine and warmth. This was our experience. Hitherto we had been in winter, but in Seville the sky was clear, and the air warm and sunny like that of early summer. We were among the palms and orange trees bearing fruit, and geraniums, roses, and carnations flowering in abundance. We went at once to the cathedral, which ranks in size only after St. Peter's at Rome. It is very grand, and the pictures are magnificent. Among the finest are "The Guardian Angel" and the celebrated "St. Antony of Padua," both by Murillo. The figure of St. Antony was cut out and stolen in 1874. A big reward was offered for its recovery, with the result that it was found in America and brought back again in the

following year. We were in Seville at Carnival time, and had an opportunity of seeing a curious and an unique ritual, a dance by ten of the choir boys before the altar. They were dressed like pages in doublets of blue satin and gold, and white knee-breeches. Their graceful and dignified movements to the accompaniment of instrumental music and castanets were very striking and most reverent.

Standing high over the cathedral is the famous Giralda tower. It is the work of the Moors, and was designed by Al Geher, the Arabian, with whose productions, of another kind, schoolboys have painful acquaintance, for he is supposed to have been the inventor of algebra. We had no opportunity of seeing a bull-fight. One of our party went to a cock-fight, which seems to have been a cruel and brutal excuse for betting. There is much truth in the couplet,

"He who hath not Seville seen  
Hath not seen strange things, I ween."

Seville is not merely a place of pleasure. Merchant ships of large draught were lying in the Gua'aluquiver close to the city. The tobacco factory, employing 5000 women workers, is an immense building. In spite of dirt and evil smells it should be seen: so also should the pottery where Moorish lusted ware is made.

On leaving Seville we travelled *visá* Ronda to Algeciras, a Spanish town opposite Gibraltar, where the railway ends. There is an excellent hotel here, the "Reina Cristina," under English management. Here we stayed the night, and early the next morning crossed the bay to Gibraltar, a passage of half an hour. At the gate at the end of the quay the sentry interrogated us as to our nationality: we passed on, proud to find ourselves upon British territory. We spent two days on the Rock, a place dear to every Englishman as a record of past valour. Having obtained the necessary permit, we visited the long, cool, rock-hewn galleries, from the portals in which we had lovely glimpses of the sea, and Spanish hill-tops, and the coast of Africa, which is fourteen miles away. This great limestone rock, sitting so square and seemingly solid on the sea, is honey-combed with these spaces. It is the especial character of the rock material that it will stand, when hollowed out, without any support. The new docks, three in number, constructed at a cost of £5,000,000, are nearly finished. The long principal street was a lively sight, with a motley crowd of many nationalities. So, too, was the market for meat and vegetables, with stalls held by Spaniards on one side, and by Moors on the other. We were disappointed in not catching sight of any of the Barbary apes, the only wild monkeys to be seen in Europe.

On our way back we stayed a night at Ronda, which is grandly situated, and was familiar to us from the excellent description in E. W. Mason's novel *Miranda of the Balcony*. From Ronda to Bobadilla is a run of a little over an hour.

This is an important junction. We lunched there and changed carriages for Granada. The railway ride is very pretty, and passes through the estate of Soto de Roma, which was given by the Spanish Government to the Duke of Wellington. We stayed at the Washington Irving Hotel, which is close to the Alhambra, the most famous show place in Spain. It is always open to the public, and a guide who only repeats what one reads in guide-books is quite unnecessary. The exterior of the Alhambra is bare and plain, but there is nothing more lovely in Moorish art than the interior, with its spacious courts and fretted ceilings, and filigree walls covered with a tracery as delicate as frost-work. Near the Alhambra is the Generalife, the summer palace of the Moorish kings. It is not so large or magnificent as the Alhambra, but the palace gardens, with old cypresses and oranges and myrtles, are still as they existed in the days of the Moorish kings 600 years ago.

Up the hill above the hotel a glorious view is to be had. There are times when nature appeals to us more strongly than does cathedral, palace, or picture. Such an instance was a sunset which we saw from this point. The bold ragged spurs of the Sierra Nevada, covered with snow, stood out grandly against the sky. In the foreground was a lovely landscape, with woods and dwellings set far apart. As the sun sank into a bed of cloud, and then behind the peaks, a faint golden light crept over the snow-clad mountains, producing on those who had eyes to see a mental impression which will always be remembered. It was a Sunday evening, no sound was to be heard, a deep calm pervaded the land on which we stood wrapt in admiration.

The cathedral, which is in the town, is well worth a visit. It contains the magnificent tombs of Ferdinand and his wife Isabella, the great queen who sent Columbus to find the New World. We drove to the Gipsy quarter, a straggling village composed of holes cut out in the side of a hill. These gipsies are not wanderers as in England; they have settled in some of the most prosperous cities of Spain, and make a living by stealing, telling fortunes, and dancing.

Although the distance from Seville to Cordova is only seventy-five miles, the journey took nearly eight hours, owing to changes and waiting. This town, which during the government of the Moors was the capital, and had a million inhabitants, is now poor and half deserted. Its great treasure is the vast and wonderful mosque: the outside has a heavy appearance, but the interior is a most beautiful example of Moorish architecture. The low roof is supported by a forest of columns, nearly a thousand in number, surmounted by horseshoe arches, on which are exquisite carvings. Some of the columns in the centre have been removed, and a Christian church erected. The most interesting part of the building is a small chapel, the Mihrab, where the Koran used to be kept. It is roofed like a shell with a block of white marble, and decorated

with mosaics of glass and gold. On the spot where the Koran rested the marble floor is worn into a circular hollow by the faithful Mussulmen, who used to approach it crawling on their hands and knees.

Leaving Cordova at 10 p.m., a long and tiring journey through the night brought us to Toledo the next morning at 11.30. Seen from a distance the appearance of this city, which was once the capital of the whole of Spain, is most imposing. It is surrounded on three sides by the Tagus, and like Rome it stands on seven hills. The cathedral is very grand, and is the See of the Archbishop of Spain. Street says that this cathedral "equals it if it does not surpass all other churches in Christendom in the beauty and scale of its plan." The carving of the stalls and the stained glass in the windows are superb. On the walls of the church of St. John of the Kings are hung heavy chains, removed from the limbs of Christian prisoners, who were released when the Moors were expelled. Close by are lovely Gothic cloisters, which have been recently restored. Sword-blades, daggers, and knives, for which Toledo has long been famous, are still made there, as perfect as ever. The old Toledo blades were so elastic that they could be rolled up like a watch-spring. Formerly the Jews were very numerous and important in Toledo: two old synagogues which contain fine Moorish work still remain.

In the evening we went on to Madrid, and found the people in a state of consternation on account of riots that were taking place in Barcelona. We had arranged to go there, but when it was announced that men were being shot in the streets, and that the disturbances were so serious as to warrant the reserves being called out and martial law proclaimed, we changed our plans and went to Biarritz, a delightful place for a rest after three weeks' hard work sightseeing; then to Bordeaux, a prosperous commercial city with as fine a water front as any city in Europe, thence Paris, and finally home.

Looking back upon this visit one fact stands out distinctly, viz. that Spain is in a lamentably backward state. Two amusing incidents were recorded lately in a Spanish newspaper, which could only have happened in such an unprogressive country. The students of Madrid and other universities held meetings, and agreed to present a petition to the authorities that, in honour of the King's coming of age, they should be given their degrees without the formality of a previous examination. The students were not unanimous in this modest demand. Some of them expressed a preference for examination, but the "slack" ones carried the day. In the same paper is an account of a disturbance in the women's ward at the Hospital of San Juan de Dios, occasioned by the punishment of three patients who refused to say their prayers. It is stated that the ringleaders were sent to prison for a fortnight, but that after undergoing this penance they would be allowed to return to the hospital to complete their cure.

It is strange that Spain was more prosperous under the Moors than she has been under Christian rulers, and that since the Moors were driven out, the nation has almost continuously retrograded. Some four years ago the most prominent English statesman, in a speech delivered at about the time of the destruction of the Spanish fleet in the Pacific, spoke of Spain as a "dying" nation. It is certainly hard to realise that this shrunken Power was England's predecessor as mistress of the seas. Still Spain is far from being a worn-out country. There is no land in many respects more highly favoured: she has mineral wealth, a rich soil with an immense variety of products, grand harbours and broad navigable rivers, and is capable of great development.

During the past seventeen years the position of the Queen Regent has been a difficult one. Summed up in the fewest words, it may be said that under her rule there have been peace, political consolidation, and material development at home; while abroad the loss of the last vestige of Spain's once splendid colonial empire, and with it much of its national pride, may be a blessing in disguise. The country has been relieved from a great drain upon its money and its men, and the hands of its rulers are more free to cope with works of reform at home.

Alfonso XIII, born a king six months after his father's death, succeeded to supreme power on his sixteenth birthday, May 17th, 1902. The task before him of combating the growing forces of republicanism and socialism is not an easy one.

### Smithfield Letters.—11.

Collected by JOHN STREET ROAD.

**D**EAR BOY,—It is now many posts since you received any letter from me. My health, though not fundamentally bad, yet, for want of proper attention of late, called for some repairs. I shall drink water for a month and avoid the comforts of social life. I have been much troubled of late by a dropsy in my feet, and I want you to be my oracle now that you are so far advanced in your studies. It has occurred to me that there is in your hospital a physician who has some skill in this disorder, though his name I am not at this time able to recall. My memory, which, as you will have observed from my letters to you, is in many respects marvellous, can never provide me with anything but quotations; hence I must appeal to you to act in its stead.

Your last letter gave me a very satisfactory account of your manner of employing your time at Mackenzie's; but I am not willing that you should go on your journeyings through the lower quarters of the city without a *valet*, and one that speaks Yiddish will be best fitted for the work you

have in hand. And while you occupy your days in acquiring that technical dexterity without which success can never be yours (here I must remind you of that quotation, "*Ubi dolor ibi digitus*," which is the motto of the famous ointment H—m—c—a, for my quotations will out!), yet you should by no means neglect to occupy your evenings with the pleasures of the town. There is hardly any place or any company where you may not gain knowledge if you please.

Whatever I myself see or hear, my first consideration is whether it can in any way be useful to you. As a proof of this, I went accidentally into a print shop the other day, where, among many others, I found one print from a famous Italian picture, *Il Studio del Physico*, or *The School of Medicine*. An old man, supposed to be a professor, points to his scholars, who are variously employed in medicine, surgery, and the art of midwifery. With regard to medicine he wrote, "*Tanto che basti*," that is, *as much as is sufficient*; with regard to surgery, "*Tanto che basti*" again; and with regard to the study of midwifery there is written, "*Non mai a bastanza*"—*there can never be enough*. I understood this to mean that you may cultivate enough medicine and surgery to enable you to pass your examinations, but it is the third branch which will make your practice a lucrative one. Yet, as I examined the picture more closely, I found depicted in the clouds at the top of the piece three midwives (approved by Act of Parliament), with just this sentence written over them: "*Senza di noi ogni fatica è vana*," and I cannot find a meaning to this, for even my memory fails me at this line, which is not included in my *Dictionary of Quotations*. I would be obliged if you could obtain for me a rendering of the words from one of your tutors.

At one of your dinners I remember to have heard Dr. C— express himself fluently in foreign tongues; it may chance that even this is no stranger to him.

Since I last wrote to you I am informed that a famous building in your neighbourhood is being pulled down; I refer of course to the Newgate prison; and I must confess I cannot conceive where you and your fellows will now spend your leisure time, but I pray you inform me whether there is not perhaps some more recent asylum set apart for the disciples of Æsculapius; the votaries of Bacchus I am told are appropriately housed in Vine Street in their hour of need.

Now I must not conclude without asking you whether you suppose this to be the first time a housebreaker has been in the Newgate gaol? my memory is again treacherous on the point. I shall be content with an answer in three weeks or so: the friend who propounded the question to me is, I hear, not likely to recover. Adieu.

### Bart's in Calcutta.

(From our own CORRESPONDENT.)

**I**N the "long ago," when, at the Annual Footer Dinner, one used to join in the vociferous applause which invariably greeted the toast of "The Old Bart's Men," and when one heard the "Old Bart's Man" who replied enlarge—as he always did, whoever he was—on the toughness of the "link that joined Old Bart's Man to Old Bart's Man in the most distant parts of the world," one used to accept it all as a part of the Bartholomewan creed. Yet few of us were prepared to find how true it all is.

There is in India a small multitude of Bart's men, and one meets them in the most out-of-the-way and unexpected places, and everywhere the traditions of the Old School are maintained with the greatest loyalty. In my own experience I can recall a number of occasions when my newness to the country and juniority in the Service was tempered by my good fortune in meeting an Old Bart's Man, until then an absolute stranger, who, as soon as he found I was from Old Bart's, took me up and gave me every possible help and assistance, often at considerable inconvenience to himself. Sometimes it took the form of supplying some article of camp kit that inexperience had forgotten to provide; at others it was a kindly coaching up in the intricacies of the Service, and the best way to set about getting what one wanted; and in every case it was a friend in a strange country, and a friend who talked affectionately of "the square," and spoke of the staff by their Christian names.

Calcutta at present has a good share of Bart's men—the "Bart's ring" it has been called by others!—some of whom have done many years there; and nowhere is there a group of Old Bart's Men who take a greater pride in or speak more affectionately of the old place.

A few weeks ago at a farewell dinner given to O'Kinealy and his wife—who are going home on leave—by Bird, there were among the company no less than five Bart's men: C. P. Lukis, Physician to the Medical College and Lecturer on Materia Medica; F. O'Kinealy, Civil Surgeon of Howrah; R. Bird, Civil Surgeon of the 24 Pergunnahs; B. C. Oldham, 1st Resident Surgeon; and H. Meakin, 2nd Resident Surgeon at the Presidency General Hospital.

Many were the reminiscences of Bart's, and even a rattling fire of story after story failed to exhaust the supply, though carried on to a late hour. Old friends in the shape of Bart's stories, that had slipped into the byways of one's memory, were dragged out, and they in turn dragged out others. Sometimes it was a mimicry of a mannerism of some revered member of the staff that brought a howl of laughter, sometimes an incident at consultations or in the out-patient room or surgery, or a story of the "rooms" or Lecture Theatre. Often it was a reference to some con-

temporary,—and I should like to be able to say how many names were mentioned!—but it always began with "Do you remember?" And what *didn't* we remember, sitting under the punkahs in Bird's verandah?

Since then Oldham has gone to Patna as civil surgeon, and H. T. Walton has come in his place as first resident surgeon to the Presidency General Hospital, while F. P. Maynard has come in as Professor of Ophthalmic Surgery at the Medical College. F. V. O. Beit passed through a short time ago on his way to Burmah, and there are several other Bart's men near enough to come in occasionally.

So the old place is well represented here, and we hope to get in a goodly number for the Old Bart's Dinner, which has now become an annual institution during the cold weather in Calcutta.

### The Noble Art of Skrimshanking.

By G. E. CATHCART, M.R.C.S., L.R.C.P.

**I** SHOULD be very sorry if this heading were to give anyone the false impression that skrimshanking is, or has ever been, in any way a common vice in the army of occupation. It is not likely to do so. Yet amongst an army of 200,000 odd, recruited "from all the ends of the earth," some black sheep are unavoidable; nor can you count these same sheep so very black, making due allowance for *badly* "fed-up" men, over a year perhaps on a blockhouse line, or after two years' almost continuous trekking.

It is with one of the more adroit of these gentlemen and his "ailment" that I shall now attempt to deal.

*The sleeping sickness.*—This I take to be a rare disease (in no way to be confounded with its namesake of the Upper Congo, or true African lethargy). Its pathology is quite unknown, and the signs and symptoms vary widely with the tastes and histrionic abilities of the patient. My only case was as follows:—I was then on blockhouse duty on a line manned by His Majesty's —th Regiment of Foot. A blockhouse about two miles off telephoned up that one of their men was seriously ill. I arrived. One's arrival lacks dignity, as to enter a blockhouse necessitates, first, a stroll through the mazes of a barbed-wire entanglement, which catches one portion after another of the outlying regions of one's anatomy, eliciting wild and wicked words, together with fragments of one's riding breeches. Then follows a crawl after the manner of the beasts that perish through a species of square tunnel 3 ft. by 3. During this stage of arrival one is apt to be forcibly reminded of one's "latter end"—an excellent moral tonic according to moralists—by striking it sharply against the top and outer edge of the tunnel, and "jamming" ignominiously.

I found the patient in the dorsal decubitus. He complained of "pains all over" and inability to eat. His temperature was slightly raised, 99° 8' F. if my memory serves, but his tongue was clean; the rest of the physical examination revealed nothing, classing him conveniently as "not yet diagnosed" (the N.Y.D. of the R.A.M.C.). My treatment was purgative and antipyretic, and leaving him a tin of milk, and striking him off duty, I departed as rapidly as the above mentioned fortifications would allow.

I had that afternoon to take over a small Field Hospital about nine miles away, during the absence of the medical officer in charge.

I was relieved about midday of the following day and returned to my camp, only to hear that the worthy I had visited on the previous day was vastly and horribly worse, could not speak, and had been quite unable to take nourishment of any kind, which, put more boldly, meant I suppose that he did not fancy tinned milk (I don't myself).

Greatly worried, I telephoned to the Field Hospital for a tonga, and saw my unfortunate patient again.

At this point of my tale I regret its original title, wishing I had substituted one more worthy, such as "The conscious simulation of morbid conditions carried to the level of one of the Fine Arts." "*Sed litera scripta manet*." He was still recumbent, and I did not like his looks at all. His eyes were half closed and dull, and he was somewhat cold as to the hands and feet. His brow was clammy; also at the mention of brandy he gave no sign. His teeth chattered idly against the glass, and I had to drench him as a pony is drenched. He spoke no word, but moaned feebly. Yet (strange and conflicting fact!) his pulse was hardly in accordance with the above-mentioned signs. It was a full pulse, somewhat rapid, and regular as an eight-day clock. His temperature was now 98°. Making him as comfortable as a tonga will permit, and making a note (unfortunately a mental one) that, though the poor gentleman was doubtless ill, he was hardly as near death as he would have me believe, I sent him up to the Field Hospital.

(In relating this I am fully aware that, following the example of many of my seniors and betters, I am "giving myself away upon paper.")

The further details of his case unfortunately only reached me later, indirectly. I would have given much to see them. On his arrival at the Field Hospital the medical officer in charge was puzzled as I had been, but taking his pluck into both hands he made a diagnosis of "auto-intoxication," and sent him on to No. 3 General Hospital, Kroomstad.

The orderly medical officer there, seeing a man apparently on the verge of dissolution, sent at once for the officer in charge of the ward (a grizzled R.A.M.C. major), who summed up the case rapidly, and called for a long pin. At the second application of this "specific" the

patient languidly opened his eyes; at the third he sat up in bed suddenly, and informed the major with surprising vigour who he considered his (the major's) mother to have been, adding a corollary to the effect that he (the major) was "an ensanguined person of no social importance." He said other things too, which cannot be set down here —. His further progress to recovery was rapid and uninterrupted.

A case like this makes people tired, and saps the milk of human kindness. *Experientia docet!*

### A Case of Cirrhosis of the Liver with Symptoms resembling Uræmia; Recovery for over a Year.

By JOSEPH A. ARKWRIGHT, M.D. Cantab.

**I**N the May number of this JOURNAL a Clinical Lecture by Dr. Gee was published, in which a case of "Hepatic Uræmia" was described. The following case is, I think, of the same nature.

The patient (S. W—) was a publican and farmer, a tall, heavy, stout man, 50 years of age, who for some years had had an enlarged liver. He was in the habit of drinking a considerable and indefinite amount of beer and spirits, but not of getting drunk. He led a fairly active and industrious life. He told me that his brother also had an enlarged liver.

During the latter half of March, 1899, he complained of being drowsy and feeling tired, but he did not sleep soundly at night, in spite of occasional doses of bromidia. He frequently felt heavy and unable to work; his skin and conjunctivæ were slightly jaundiced, the face of a dark purplish-brown colour due to jaundice in addition to the purplish capillary congestion.

At the beginning of April he was suffering from dyspnoea, œdema of the legs, tremor of the hands, and severe pains in the arms and legs, but he did not stay in bed. The edge of the liver was hard, and was felt at the level of the umbilicus; the bowels were open, two or three loose motions being passed daily. The urine was scanty, dark-coloured, and a thick cloud of albumen appeared on boiling and adding dilute acetic acid.

The diet for the last two or three weeks had consisted almost entirely of milk food, but he also took some spirits, though less than usual.

On April 6th he was worse, and had been unable to get out of bed. Attacks of stupor, from which he could not be thoroughly roused, had occurred frequently during the last few days, and on this day the lethargy and stupor were continuous but variable, and were sometimes so great that he could scarcely be roused to speak: any movement

required a great effort. The pulse was 100, full and strong; the apex-beat of the heart was felt in the fifth space, just outside the nipple line.

Dyspnoea was constant but variable in degree; sometimes it became worse, suddenly causing him to sit up in bed. Muscular twitching, jerkings of the limbs, and hicough were frequent. The knee-jerks were very sluggish, and could scarcely be obtained at all.

The patient appeared to be gradually becoming unconscious, and sinking into a coma resembling that of uræmia.

On the evening of April 6th, in spite of the apparently free action of the bowels, a drachm of sulphate of magnesium and half a drachm of carbonate of magnesium were given, and repeated every two hours, and a sixth of a grain of nitrate of pilocarpine was given hypodermically. Alcohol was completely withheld.

On April 7th the patient's condition had improved; the bowels had been open six or seven times, large watery motions having been passed. He had slept for four or five hours; this was the first real sound sleep which he had had for a month.

On April 8th he had less pain in the limbs; there was general improvement, the knee-jerks were active; the sulphate and carbonate of magnesium were continued. The patient steadily improved from this date; the bowels were open freely four or five times a day.

On April 22nd there was scarcely any jaundice; no attacks of stupor occurred, and he had good sleep at night; the pulse remained about 100 in rate. The urine was now passed freely, between three and four pints in twenty-four hours, with a specific gravity of 1014, and showing only a very faint trace of albumen on boiling and adding dilute acetic acid. The liver had receded about one and a half inches.

The patient was able to get up and walk about the room. One drachm of sulphate of magnesium was at this time taken thrice daily, and the bowels were in this way kept open four or five times a day.

By May 6th further great improvement had taken place. He could walk upstairs without dyspnoea, and had no pains in the limbs. The urine was plentiful; the pulse 100; no alcohol, and only a vegetable diet, with milk, butter, and cheese, had been taken. The patient continued to abstain from alcohol and meat for eight or ten months.

In the summer of 1900 he did some work—haymaking—and drank beer and spirits and ate meat again. These articles of diet he gradually took more of, and he became less active and more heavy and torpid mentally.

About August, 1900, he contracted pneumonia, and died on the third or fourth day.

This case of cirrhosis with enlargement of the liver in a stout man shows the utility of promoting very free elimination, especially by the bowels, when symptoms occur of

stupor, twitching, etc., resembling uræmia, and due to combined defective action of the liver and kidneys. The symptoms came on gradually and increased in spite of there being two or three loose actions of the bowels daily, and in spite of meat being removed from the diet and the alcohol being considerably lessened, but very free and continued purgation by the use of the salts of magnesium produced rapid and continued improvement, which lasted for over a year. A partial relapse was due apparently to a return to the former diet.

### Notes on the Use of Ethyl Chloride as a General Anæsthetic.

By H. F. PARKER, M.D. (Cantab.).

**S**OME six months ago there was published in the ST. BART'S JOURNAL a short account of the use of ethyl chloride as a general anæsthetic, together with a summary of the personal results obtained in some 140 administrations that were carried out at the Wolverhampton and Staffordshire General Hospital.

Not having a copy of the paper at hand at the present time I cannot refer to it in precise terms; but the conclusions that were there drawn as to the utility, convenience, and comparative safety of the drug have been fully maintained by a more extended personal experience, and also by the opportunity afforded of seeing it administered frequently by others.

Altogether at the above-mentioned hospital upwards of 500 administrations have been now performed with but a small percentage of failures, and without the occurrence of any dangerous symptoms except in a single case, which shall be mentioned later.

I may remind readers that, when using a Breuer's mask the ethyl chloride (or kélène) is sprayed on to a piece of gauze contained in a metal globe, through which the air passes before it is breathed by the patient; whilst by means of a double set of valves the expired air is made to escape by a different route.

The main features of the anæsthesia are—

1. Its quick induction, viz. a half to two minutes.
2. The rapid recovery of the patient in from a half to two minutes, even after operations lasting for an hour or more.
3. The pleasant character of the anæsthesia, the absence of embarrassing sequelæ, and the remarkably slight effect that is produced on either respiration or pulse.
4. Its somewhat light character, rendering it an unsuitable anæsthetic for use when abolition of the reflexes and complete immobility are essential.

In cases where nitrous oxide gas would ordinarily be used ethyl chloride is usually as good or even better, and it is readily given as an antecedent to ether. In the latter case the following arrangement is used. Into the top of a Clover's inhaler is inserted a Barth's two-way valve apparatus, and to this again is attached the metal globe of a Breuer's mask. Ethyl chloride alone is at first administered, and then, as consciousness is becoming lost, the ether chamber is gradually rotated until, at the end of some two minutes, it is desirable to replace the valve apparatus by the ether bag.

Ethyl chloride can be used with great advantage for most operations in children (including radical cure of hernia, amputations, etc.), and for most minor and many major operations in adults, more especially in women. It would seem to be the anæsthetic *par excellence* in the operations for "adenoids" and "empyema," since the laryngeal reflex is practically never lost, also in cases of collapse (*e.g.* from serious abdominal disease), where the depressing effect of chloroform itself counts for something against the patient's recovery.

Moreover, although vomiting not infrequently occurs, it is almost always slight, and is never lasting in character.

It should be a most useful and convenient anæsthetic for general practitioners and for dentists. I have not had an opportunity of trying it in midwifery practice, in which it should probably be of considerable service, since the patient can easily hold the mask over her face, and very little anæsthetic is needed to diminish sensibility. At the same time it may be as well to remember that delusions are not uncommonly caused by this anæsthetic, and have, in at least two cases recorded in the literature, led to the making of unfounded charges against the administrator.

In one of the above 500 cases serious cardiac depression occurred, but that under circumstances that might readily have been prevented. The ethyl chloride was being administered by an experienced anæsthetist by the usual method to a somewhat anæmic woman for the extraction of three molar teeth. The patient, to whom the same anæsthetic had been successfully administered on a previous occasion, was seated in an upright position in a chair, and had, as a matter of fact, only a short time before finished her tea. At the end of about two minutes, by which time 5 c.c. had been given, the patient showed signs of syncope, viz. pallor, widely dilated and fixed pupils, and cessation of respiration. Inversion and artificial respiration were at once performed, and she "came round" rapidly in a manner that would probably not have been the case from chloroform, so rapid is the elimination of ethyl chloride from the system. This escape from a fatal accident was a cause for congratulation, and at the same time a lesson that ordinary precautions must not be neglected, and that the upright position is not one that it is well to adopt even for the extraction of teeth.

### A Case of Ruptured Femoral Artery and Vein.

By E. H. HUNT, R.M., R.Ch.



B., æt. 41, carman, was brought up on the evening of July 12th by the police; they could say nothing about him except that he had been found in the street, and it was said that a hay-cart had knocked him down.

He was unconscious, collapsed, pale, cold, sweating, and pulseless; respirations very shallow. A rapid examination revealed no injuries to the head, arms, chest, or abdomen, and patient made slight movements of both legs. He was at once removed to the Surgery Ward, without any diagnosis having been made. He was given Liq. Strych. Hydrochlor.  $\text{m}$  hypodermically, and Oij saline, temp. 107°, was infused into the left basilic vein. After Oij his pulse was comparatively good at the wrist, and he began to talk incoherently and struggle. A more thorough examination again showed no injuries to the arms, head, chest, abdomen, or back. A large hæmatoma was found in the right calf, and the left thigh was greatly swollen from the knee upwards. There were marks of bruising in front of the left thigh, just above the knee, and the circumference of the thigh was two inches more than on the right side. Neither the anterior nor the posterior tibial arteries could be felt pulsating in either foot. The radial pulse was also by now again very feeble. The legs were wrapped in wool and placed with the knees semi flexed.

The patient remained all night very collapsed, but about 6 a.m. became conscious. It then came out that he had been sitting on the shaft of a hay-cart, when a fire-engine startled the horses. He was thrown into the road, and one or both wheels passed over his legs.

At 10 a.m. on the 13th the circulation in the left foot was obviously very slight, and the veins were distended; there was no sensation below the knee. By the evening all circulation had ceased in the foot, and the veins were empty. A diagnosis of ruptured femoral artery and vein, which had been previously made, was now rendered almost certain.

On the 16th blebs had appeared on the outer side of the left leg below the knee, but patient had recovered some sensation on the inner side of the calf. The temperature had risen to 101°.

On the 17th, after consultation in the ward, Mr. Cripps amputated the left leg through the lower third of the thigh. On dissecting the amputated limb a complete rupture was found through both the femoral artery and vein, just at their entry into the popliteal space. The ends were separated by an inch and surrounded by blood-clot.

The patient made an uninterrupted recovery. The ideal treatment of this case, namely, immediate ligation of the torn vessels, was impracticable, firstly owing to the impossibility of immediate diagnosis, and secondly, owing to the grave general condition of the patient. Also, even in the amputated limb, it was a matter of some difficulty to find the torn ends of the vessels among the blood-clot and bruised tissues. Mere ligation of the femoral artery above the rupture would not have been of much avail; in fact, it is possible that the rupture of the vein was the chief agency in the causation of the gangrene.

I have Mr. Harrison Cripps's kind permission to publish this case.

### Notes.

DR. R. HENSLÖWE WELLINGTON, of the Middle Temple, has been appointed Deputy Coroner to the City of Westminster and the South-western Division of London.

DR. CLIVE RIVIERE has been appointed Assistant Physician to the East London Hospital for Children.

DR. F. A. BAINBRIDGE has been appointed a Research Scholar to the British Medical Association.

THREE Bart.'s men headed the list in the recent examination for the Indian Medical Service. They were A. T. Pridham, F. P. Mackie, and F. P. Connor, and we offer them our heartiest congratulations.

WE rejoice that the witty writer of the Smithfield letters is continuing his correspondence. The present epistle furnishes abundant evidence that the author's energy has not been seriously diminished, nor his natural force abated by the distressing affliction to which he alludes in his letter.

WE have to record the death of H. T. Parker, M.D., an old Bart.'s man, who for some years had been Medical Officer and Inspector of Egyptian Prisons. He was invalided home with enteric fever, and died on the ship at Southampton.

By the death on July 30th of Mr. James Thomas Ware, F.R.C.S., in his eighty-sixth year, the Hospital loses one of its oldest members. Mr. Ware, who was the grandson of Mr. James Ware, F.R.S., an oculist of eminence and one of the founders of the Medical Society of London, entered the Hospital in 1835; as the custom then was, as an "articled student" to Mr. Vincent, then surgeon to the Hospital. In process of time he became house surgeon in Colston and Queen (now Lawrence) Wards. In the time of which we are speaking—more than sixty years ago—there were no house physicians and only three house surgeons, and Ware and his colleagues, Bostock and Ormerod, occupied rooms over the Henry VIII gate, while at the Hospital Mr. Ware took an active part in founding the Metropolitan Convalescent Institution, now so well known for its important and beneficial work at Walton, Broadstairs, and Highgate. One of his fellow-students, Theodore Monro, being struck by the necessity of country air for a poor girl in one of the wards, whose leg had been amputated, and who was about to be discharged, though in a state of great weakness, consulted Mr. Ware and a few other fellow-students, and after conferring with their friends they determined to establish a home for convalescents in the country. The result was that they founded what is now known as the Metropolitan Convalescent Institution. At this time there was no such thing as a convalescent home. This institution was the first—the pioneer—of the large number of these useful and

beneficent homes which are now spread all over the country. For many years Mr. Ware took an active part in the management of this charity as a member of the committee, especially as one of its surgeons, and when he was unable to assist in this work he became one of its vice-presidents. When still a young man his health failed for a time, and as a consequence he relinquished the medical profession, though his knowledge of it was of great use to him in after life, especially in reference to his work as chairman of the Board of Guardians of Farnham. On retiring from the profession Mr. Ware settled on his family property at Tilford, near Farnham, where he fulfilled, until laid aside by ill-health in later life, with ever-ready kindness and consideration for others, the various duties that fall to the lot of a country squire.

THE following were successful at the recent examinations for entrance to the Royal Army Medical Corps:—Mr. A. H. Hayes (sixth); Mr. R. Storrs (tenth); Mr. F. A. H. Clarke (twelfth); Mr. R. L. V. Foster (fourteenth).

A COMPOSITE picture of famous Bart.'s men and of the Hospital itself has recently been issued to the subscribers by a well-known Cheltenham firm, and has given rise to much dissatisfaction. It was stated that the picture would be printed on India paper; that, however, is not the case. It was further stated that the picture would be signed by Hanhart, whereas it is signed by Hager. Moreover the picture itself contains two very serious errors; the Church of St. Bartholomew the Great is described as St. Bartholomew the Less; and the Roundabout in Smithfield Place is designated the "Square." When one adds that in its general appearance the picture closely resembles a tradesman's Christmas almanack, the annoyance of the subscribers can well be understood.

IT is rumoured that some of the most distinguished members of the Nursing Staff have lately devoted themselves to bacteriology in the Pathological Laboratory. It has been stated that under their benign influence the anthrax bacillus lost all his virulence, and became as innocuous as a sarcina; that the typhoid bacillus stretched out his flagella, and allowed them to be stained with ease; and that the carbol-fuchsin positively blushed with delight. Such facts speak for themselves, and we need say no more. Doubtless the streptococcus is even now gnashing his teeth with helpless rage, as he reflects on his inability to work his wicked will.

But seriously there can be no doubt that the Nursing

Staff is to be congratulated on going to the fountain-head, and gaining a *practical* knowledge both of the organisms of suppuration, and of the most efficient means of destroying them.

### Amalgamated Clubs.

#### RIFLE CLUB.

The competition for the Inter Hospital Cup took place at Risley ranges on July 17th. The competition consists of ten shots at 500 yards by teams of six from each hospital, the total aggregate being 300 points.

Bart.'s and St. Thomas's tied with 226 points each, but according to N.R.A. rules in respect to ties the team with fewest "outers" in the score is considered to have done the best shoot; accordingly, as we had only six outers to St. Thomas's twelve, we were judged the winning team. The Cup therefore comes into our possession for the ensuing year for the first time in its history, and long may it remain.

The somewhat poor score may be accounted for by the variable wind and bad light. Read with 43 was top scorer.

The following represented the Hospital:

|                     |           |    |
|---------------------|-----------|----|
| A. C. Brown (capt.) | . . . . . | 37 |
| W. R. Read          | . . . . . | 43 |
| J. Morris           | . . . . . | 35 |
| P. A. Dingle        | . . . . . | 39 |
| S. H. Andrews       | . . . . . | 38 |
| W. W. Jeurwine      | . . . . . | 34 |

226

### Correspondence.

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

DEAR SIR,—Might I draw the attention of medical students to a point which will help them in general practice, especially if that happens to be amongst the educated classes? It is one which I regret not to have paid more attention to when working at the bedside, *viz.* prognosis.

This is the first question asked by the uneducated and educated alike after, and sometimes before, one's physical examination of the sufferer; diagnosis with the "lower" classes not being so difficult, providing one is sufficiently concise in language and unwilling to revise a diagnosis before them.

The first question asked by anxious relatives is, "What is it, doctor?" Then, "Is it serious?" and "Will he recover?" Other questions of a probing nature rapidly follow, requiring great tact and diplomacy, especially if a man is not quite sure of his ground.

We all know perfectly well that to arrive at a trustworthy prophecy a correct diagnosis must be made, but even if this is made it is often extremely difficult to forecast events, and ward clinicians should make a point of asking themselves the following questions, which will really be of inestimable value in after life:

- (1) Is this patient going to die?
- (2) How will he die—suddenly or not? painlessly or not?
- (3) If he recovers, will it be a complete convalescence?

Another point worthy of remembrance is to be able to warn the relatives of certain complications incident to the particular disease. For a man desirous of "kudos" this is not the least remarkable point.

I speak from a few years' short but impressive experience.

I am, sir,

Yours truly,

J. W. MALIM.

## Review.

PRACTICAL MEDICAL ELECTRICITY. By DAWSON TURNER, M.D., F.R.C.P.Ed. Third Edition, 7s. 6d. (Ballière, Tindall, and Cox.)

The issue of a third edition of Dr. Dawson Turner's book on Medical Electricity sufficiently indicates the estimation in which it is held. The author within comparatively short limits covers the whole field not merely of static, galvanic, and faradic electricity, but also of the newer applications of electric rays, the Röntgen and Finsen, in the treatment of disease. The book may be regarded as divided into two portions. In so far as it is a practical guide to the equipment and methods to be employed in an electrical department of a hospital it is admirable, concise, lucid, and comprehensive; but when we turn to those pages that deal with therapeutics we must confess to a feeling of disappointment. There is no critical survey of the position at present occupied by this branch of medical treatment, and there appears to us to be a want of balance and restraint in many of the statements made. Perhaps, however, the disappointing character of this section is inherent in the subject; the beneficial uses of electricity as a therapeutic agent are, as the author observes, a matter of empirical and not of scientific knowledge, and the exaggerated claims which have been made in this respect have given rise to much scepticism.

The book is well illustrated and well printed. There is a bad misprint at p. 283; and, if a mere Southron may be permitted to hint at a classical error, "neuritis" is not a permissible plural form of "neuritis" (*vide* pp. 213, 215).

## Calendar.

- Sept. 9.—On duty. Dr. Gee and Mr. Marsh.  
 " 12.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 " 16.—On duty. Dr. Hensley and Mr. Walsham.  
 " 19.—On duty. Sir Lauder Brunton and Mr. Cripps.  
 " 22.—Examination for Entrance Science Scholarships and  
 Jefferson Exhibition begins.  
 " 23.—On duty. Sir William Church and Mr. Langton.  
 " 26.—On duty. Dr. Gee and Mr. Marsh.  
 " 30.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 Oct. 1.—Annual Dinner of Old Students.  
 Beginning of Winter Session.  
 " 3.—On duty. Dr. Hensley and Mr. Walsham.

## Examinations.

## CONJOINT BOARD.

The following have completed the Examinations for the Diplomas of M.R.C.S. and F.R.C.P.:—R. H. Sankey, H. E. Stanger-Leathes, F. W. Cheese, L. Orton, H. W. Atkinson, C. H. Gregory, G. G. Ellett, F. H. Elliot, N. A. W. Conolly, N. Macfadyen, G. S. Ewen, E. L. Martin, G. W. Micklethwait, C. C. Robinson, H. Love, E. G. Pringle, A. A. Meaden, D. H. Evans, E. O. Hughes.

## Appointments.

CONOLLY, N. A. W., M.R.C.S., L.R.C.P., appointed Anaesthetist and Junior House Surgeon to the Royal Infirmary, Bristol.

DOUGLAS, A. R. J., F.R.C.S., appointed Plague Officer by the Indian Government.

HOOLE, J., M.R.C.S., L.S.A., appointed Medical Officer and Public Vaccinator for the Hartington District of the Ashbourne Union.

ORTON, G. H., M.B., B.C.(Cantab.), appointed Medical Officer to the Casualty Department at the East London Hospital for Children.

ROBINSON, C. C., M.R.C.S., L.R.C.P., appointed House Physician at Bethlem Royal Hospital.

SCRAN, J. J. S., M.R.C.S., L.R.C.P., appointed House Surgeon to the Huntingdon County Hospital.

SMITH, W. C. B., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Hospital, Portsmouth.

STANGER-LEATHES, H. E., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Royal Infirmary, Bristol.

## New Addresses.

GALSWORTHY, L., 6, Brunswick Place, Regent's Park, W.

GRAHAM, C. H., Wellington, New South Wales.

HOOLE, J., Parwick, near Ashbourne, Derbyshire.

PRATT, ELDEN, Henfield, Sussex.

WATSON, C. G., 44, Welbeck Street, W.

## Births.

CRACE-CALVERT.—On July 25th, at Vale of Clwyd Sanatorium, Llanbedr Hall, Ruthin, North Wales, the wife of George A. Crace-Calvert, M.R. (London), M.R.C.S., of a daughter.

CRAWFORD.—On June 20th, at the Spring, Pembury, Kent, the wife of Cyril Crawford, of a daughter.

KNIGHT.—August 3rd, at Rotherham, the wife of H. Ernest Knight, M.D. London, of a son.

## Marriages.

HORDER—DOGGETT.—On September 3rd, at the Parish Church, Newnham, Herts, by the Rev. G. Todd, Vicar, and the Rev. J. T. Inskip, Vicar of Leyton, Essex, Thomas Jeeves Horder, M.D. (London), M.R.C.P., 141, Harley Street, W., youngest son of the late Albert Horder, Wincombe, Swindon, to Geraldine Rose, only daughter of Arthur Doggett, Esq., of Newnham Manor, Baldock, Herts.

WARD—FINCH.—On August 14th, at the Cathedral, Cape Town, by the Rev. Arthur Brooke, Arthur Blackwood Ward, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P. London, of Northumberland Lodge, Bloemfontein, Orange River Colony, to Angela Susan Dorothea, second daughter of the late Henry C. Finch, Esquire, J.P., of Redheath, Watford, in the county of Herts, and of Mrs. Charles Maynard Hallewell, of Vale House, Monkton Combe, Bath.

## Death.

WARE.—On July 30th, James Thomas Ware, F.R.C.S., eldest son of the late Martin Ware, Esq., of Tilford, Surrey, and Russell Square, W.C., aged 85.

## St. Bartholomew's Hospital



## JOURNAL.

VOL. IX.—No. 12.]

SEPTEMBER, 1902.

[PRICE SIXPENCE.]

## NOTICE.

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

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

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

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

## St. Bartholomew's Hospital Journal,

SEPTEMBER, 1902.

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

## On the Use of Sulphate of Hyoscyamin in Paralysis Agitans.

By W. P. HERRINGHAM, M.D.

THE shaking palsy is generally reckoned an incurable though not a fatal disease. I wish to incite others to the trial of a drug which in three cases appears to have had a decided effect for good.

I used it first on an old lady whom I saw in consultation many years ago. She was lying in bed shaking so violently that the bed shook with her. I suggested sulphate of hyoscyamin. I heard two years later from her doctor

that after a little difficulty he had been able to give it regularly, and that the tremor had practically ceased.

A few years ago I saw a case with Mr. Chune Fletcher, of the Charterhouse. The patient was an old man who had some tremor, but whose principal trouble was spasm of the muscles of the neck which bowed his head upon his chest, and practically deprived him of the power of reading, which was his great delight. He was bedridden and helpless. I thought he had paralysis agitans, and told Mr. Fletcher of the previous case. He used the drug perseveringly, and, I believe, had no doubt about its effect. He told me that the old man so far recovered that he was able to go out and about, and resume his ordinary quiet life, and that he swore by the drug.

Three months ago an old man of sixty-five came to me at the Hospital with a very severe form of the disease, which had come on unusually rapidly. It was a quite typical case with immobile features, quavering voice, bent body, and shaking limbs. The shaking was very severe. It entirely prevented him from work, and made him extremely miserable. I took him into the ward and put him on the drug. I do not think anyone who saw him had any doubt about his great and rapid improvement. In a month he was almost relieved of the tremor, and felt, he declared, a completely different man. I noticed, however, that the face and the position of the trunk when standing had not altered.

Now all these three cases have been in bed and regularly attended. I have used the same drug in a few out-patients without any benefit. Yet the improvement can hardly be from rest alone, as two of them were bedridden before they began the treatment.

I hope gentlemen who have such cases under them, which they can look after satisfactorily, will give the drug a trial and let us know the results.

The dose to begin with had better be not more than  $\frac{1}{100}$  of a grain thrice a day. After a week increase it to  $\frac{1}{100}$ , and then to  $\frac{1}{50}$  and  $\frac{1}{25}$  of a grain. It may produce certain ill-effects, headache, dizziness, and such like.



If it does, lessen the dose. It can be increased again later. I have always given it in solution, but some chemists make tablets of it.

Judging from my own experience, I should say it is not likely to succeed unless a patient is able to be properly fed and cared for; and as the drug may cause unpleasant symptoms, he should be seen every two or three days at least.

### A Batch of Mistakes, etc. V.\*

By a G. P.

**B**LONGER than a twelvemonth has passed since I ventured to record from the pages of my "black" book. I return now to these pastures, having the desire to improve myself by confession, and to help, haply, some gentle reader over similar and ever-present pitfalls. Most mistakes, when once made, need never be repeated.

The following misfortunes will fall roughly under seven main groups:

1. Mistakes due to insufficient examination, which is subdivisible into—

(1) Absolute insufficiency of examination.  
(2) Relative (not noticing what is present).

2. Mere carelessness.

3. A want of recognition of the meaning of a phenomenon.

4. Bad management.

5. Insufficient hypothesis.

6. Bias.

7. Human frailty (a personal equation).

For the purpose in hand, a mistake may be defined as "any evil result which may accrue to patient or doctor within the terms of honour." I add the last phrase because no honourable doctor would call it a real fault of his to have lost a patient for refusing to act according to some delusional or criminal wish on the part of the patient.

The following are examples of the above headings.

R. S.—, *æt.* 24, a big man, fell heavily on his left hip. Half an hour afterwards there were extreme eversion, much bruising over the great trochanter, inability to flex the hip, but no shortening by the usual measurement, and no crepitus. During the necessary lying in bed he had retention of urine and irregular pyrexia, associated with thrombosis of the left internal saphena vein. Three months afterwards there was a definite shortening of three quarters of an inch on the injured side. Although there was not much swelling of the thigh at the time of the first measuring

there was probably sufficient to bulge the tape. Consequently a primary diagnosis of contused hip had to be altered to "impacted fracture." The bad general condition after the injury was a sample of what might be expected in an elderly man with similar damage. The mistake falls under 1 (2).

I. E.—, *æt.* 47, suffered from excruciating "supra-orbital neuralgia," which yielded to no ordinary remedies (unless Potass. Iodid. be so called). In other respects she seemed healthy. Her son had a dull right cornea and suspicious teeth. I stretched the supra-orbital nerve with but transient benefit. Some months after this I re-investigated the nose, and found evidence of a recently perforated septum, which certainly indicated iodide. Before this drug had been long tried she blew out of her nose from the affected side, at various times, long strands of coagulated offensive mucus, the first passage of which at once relieved the neuralgia. Later on she developed a typical soft node over the frontal sinus of same side, and through the hole thus formed I was able to syringe into the nasal cavity. Here I insufficiently examined for causes of pressure, and did not "think of" a specific cause (1 [1] and 5).

J. McC.—, *æt.* 50, an ex-guardian, had mitral regurgitation of long duration, with easily induced dyspnoea and Cheyne-Stokes breathing, which during the last six weeks had caused an alarm of his death (during a "pause"). He was an active man, and loved to roam about his master's park, and accompanied him to the moors. He died away from home. I had no business to let him travel; a heart case with Cheyne-Stokes breathing, from my experience, is fairly sure to die within three months of its obvious onset, however well the patient may be in other respects (which is unlikely). His family were by no means pleased with my hesitating advice, but the poor chap pleaded hard for a happy last month, and I yielded (? 3 and 4).

E. B.—, *æt.* 9, a little red-haired girl, who had gone through a mild untreated attack of scarlet fever, whose mother was ignorant, alcoholic, and suffering from a menopause associated with heart discomfort. I was asked to see the child because of some small purpuric spots and præcordial pain. The next day a hurried message came that the legs and arms were as "black as ink." I regret to say insufficient notice was taken of the story, and I only arrived in time to find the child moribund, with huge subcutaneous hemorrhages. I have seen now three such cases of malignant purpura after scarlet fever, which all died. The condition is doubtlessly septic (3 and 6).

S. K.—, *æt.* 35, complained very often of a congested and uncomfortable throat, which I used to travel some miles to "paint." She was also rather neurotic, and had intermenstrual pain as well as dysmenorrhœa. A gynaecologist who saw her diagnosed Graves' disease, but an eminent surgeon of St. Bartholomew's removed an ordinary goitre from her neck. Living in a goitiferous region, I have

often noticed throat symptoms, such as hawking, globus, "congestion," sore throats, etc., with nothing wrong *per pharynx* (they are relieved by *Pig. Glyc.* and *Tannic ē Ir. Iodi* to the tonsils). I did not notice or look for the goitre in this case, and so deserved to lose my patient's confidence (as I did) (1 [1] and 5).

R. C.—, a domestic, who for some years had been liable to chlorosis and dyspepsia, after tooth extraction fainted. Menses ceased, and old symptoms recurred. Three months after this there was so much flatulent distension of abdomen that her mistress "accused" her. At this time amenorrhœa from shock, chlorosis, and dyspepsia would quite account for her symptoms. Four months after the cessation of menses the breasts seemed active, but I could not obtain an abdominal examination. In another month the fetal heart was audible. Meanwhile her employers said I could say if I would, and called in the "opposition." I notice none of the text-books will pledge themselves to the statement that mammary changes even in the first pregnancy are diagnostic, and it is well known the breasts become active in some lower animals long before conception. In these cases it is hard to decide how to act loyally both to patient and employers, especially when the employer also "employs" us. If the latter are reasonable, and will wait till the fetal heart ought to be audible, the proper course is to tell the former if *she* does not tell her mistress *you* must. It does not do to merely get her to give "notice," for the mistress might subsequently, with some justification, blame you for keeping her in the dark, especially when the time comes for a character. On the other hand, if the employers be unreasonable, one can only say, "I can't tell yet;" and should they say, "You can if you will," the only course seems either to remain negative or to get the patient to confess to the doctor. One may sometimes say, "If you were married I should say so-and-so," and brave the storm which may ensue; and if a denial, act accordingly. In trying to get such a confession I probably increased the annoyance, and lost my patient in this case. But, as a matter of fact, patients rarely change their doctors by reason, but by feeling. There is usually something displeasing. When the wolf means to eat that lamb he finds plenty of excuses. This case is an example of 4. Its narration may probably help some one.

E. M.—, *æt.* 14, was reprimanded by her music-mistress, and not allowed to play hockey. I was called in the night to see her, and found her with acute chorea and slight hæmatemesis. After shaking my head the chorea vanished in four days, but she was unaccountably pallid and weak. There was no history of rheumatism or previous chorea. During the next week I was more than once told that the urine was very dark, but having examined it on the second day and found nothing amiss I did not further examine till told of its scantiness. The case was now evidently acute nephritis, which finally cleared up after a somewhat chronic

course. This was another lesson to heed what lay observers notice, which one is apt not to do when the observation appears inconsequential. I am not familiar with the association of chorea and Bright's disease; there was no suggestion of œmia. Verily that music-mistress had an uncomfortable time of it (example of 6, bias in favour of chorea and only chorea).

R. H.—, *æt.* 29, had for some years been suffering from wrist-drop and colic due to lead-poisoning (drinking-water contaminated by lead outflow pipes). He having been previously treated for rheumatism and anæmia, I came along, pointed out the nature of the case to his doctor, and ordered Potass. Iodid., without taking sufficient care about an aperient with it. He had also interstitial nephritis, another cause which would prevent the due elimination of set-free lead. Whatever the cause, the man had convulsions very quickly afterwards, and nearly complete paralysis of his legs for two months. He is now (one year) nearly well, and I am glad to say he and his family (who also suffered from plumbism) are great friends of mine. I knew of the risk of Potass. Iodid. in this way, so must call the mistake an example of 2, and inasmuch as I was much overworked and was bad with migraine it falls also under 7.

A. S.—, *æt.* 48, the mother of a large family, two of whom had died from tuberculous meningitis, and two were always ailing, whose life had been full of ups and downs, had suffered much from unaccountable vomiting, migraine, epistaxis, membranous colitis, and was generally neurotic, suddenly became almost blind. I, with several better men than myself, labelled her neurasthenic, but for some reason had omitted to examine the urine (which every family doctor should do), till an examination of the fundus oculi when the blindness came made this almost superfluous. Instead of being looked upon as a somewhat troublesome neurotic, she ought to have been carefully treated for interstitial nephritis with chronic uræmia. Her vision is now improving (example of 1, 2, 3, and 6). An examination of the urine will explain many cases of otherwise unaccountable headache, anæmia, and neuralgia, especially in young people. I think the prognosis of life with the appearance of albuminuric retinitis must be much better in private than in hospital practice, judging by my experience.

J. S.—, *æt.* 50, consulted me for a pain at the tip of his left shoulder and an easily induced dyspnoea. In answer to a leading question he said the pain would occasionally shoot to his left elbow. Nine months ago he had slight right hemiplegia, and six months ago his brother had died suddenly (? apoplexy) at the same age as he was. His arteries were hard, the cyclids a little baggy, the heart's apex in the nipple line and beating irregularly, urine sp. gr. 1.005, and no albumen—a sort of case one frequently comes across and labels arterial degeneration (sclerosis), and thinks of closing coronary arteries. He promised to be very careful and do all I told him, and soon found the

\* Contributions to this JOURNAL by the same author will be found in Vol. V, p. 187; Vol. VII, pp. 150 and 103; Vol. VIII, pp. 89 and 118.

value of amyl nitrite, and particularly requested me not to upset his invalid wife. Fourteen days after our interview he read the lessons in church, carved for his family, and whilst doing so died within ten minutes. It seemed to me too rapid a death for cerebral hæmorrhage, so I signed angina pectoris. I was perhaps not unjustly blamed by his family for not informing them of his possible danger. But he had promised to be very careful. I explained to him as much as I could; his wife was already a great invalid, and could stand no worry, and I believe one would be so rarely right in prognosing sudden death that there would be great risk of producing needless depression and anxiety. The country G.P. must not be an alarmist or pessimist. It is decidedly difficult to steer in such cases. This was a notable example how misfortunes may come in battalions—an invalid wife, the brother's death, a death from diphtheria of a favourite grandchild, a daughter recently operated upon for tuberculous elbow, and now his death, all within a year (example of 4 probably).

R. V. L.—, æt. 9, a fragile-looking little girl who six weeks ago had come in quite good health from Malta. She had lived there, in Valetta, in the best part, for over a year, and had never had Malta fever. She now became weak and languid, suffering from the usual accompaniments of pyrexia. The diagnosis rested chiefly between enteric and Malta fever, but for either the serum reaction was negative, nor did a subsequent examination give the test. After an illness of three weeks, taking the while small doses of quinine, she got well, and my consultant diagnosed febricula, and rather hesitatingly I agreed, and in three months' time allowed her to rejoin her parents at Malta. One year afterwards almost exactly the same history, but she is now sadly emaciated and suffers from periodical arthritis and the other signs of Malta fever, the blood still giving the positive reaction. The mistake of letting her return is obvious, and also, as I was often told in my student days, of not backing my own opinion; yet seeing that she had lived there in good health, and that nearly eight weeks elapsed between the onset and leaving Malta and the negative reaction, I thought I had possibly been overbiased (example of 7 and 26 [bias against being biased]). Apparently in this case as long as she was in Malta she was immune, but her last dose succeeded in "taking." It reminds us in these days of rapid transit to be on the look-out for non-indigenous disorders. I may mention sodium sulphocarbolate added to her quinine usually relieves her arthritis. An antitoxine is badly needed.

S. D.—, æt. 25, suffered many things, even at a Bath hospital, for "rheumatism and sciatica," with no result of good, but rather became worse. I had frequently examined him for pressure sciatica, but till the day of a consultation never noticed quite a large iliac abscess, and that flexion of the hip with leg extended did not aggravate his pain

(a useful diagnostic point between ordinary and pressure sciatica). We found also a distinctly tender fifth lumbar vertebra. I draw a veil over this case. The mistake did not come from not thinking of, but simply from not noticing, and falls under 1 (2) and 7, under which last heading so many of our mistakes fall. Perhaps it would be best to say *reasonable* human frailty; carelessness (*e.g.*) is hardly reasonable.

I fear some of these mistakes will be considered to have been avoidable, or of too trivial a nature for record. Yet I venture to think their clinical features are not devoid of interest to a would-be or actual general practitioner. I conclude my effort by making a few remarks of an aphoristic nature, some of which have rather attractive Latinity.

He who does not know, and who knows not that he knows not, is asleep; wake him (after an old proverb).

Doctor, if it had not been for thee my child would yet have lived! (from an Abernethian Address by Sir W. J. Collins).

This is a sad thought, and one which should be ever present with us.

It is a great mistake to be annoyed with and impatient with a sufferer. *Res est supra miser.* The worst of it is a vicious circle is established. You get cross with yourself for being cross, and become crosser, and vent it on the sufferer; and then, alas—!

It is wise to remember there is some romance in medicine, it is not all a matter of auscultation and percussion. I feel sure love affairs have much to do with some cases of chlorosis, and impede recovery. *Nullis amor medicabilis herbis.*

We are also far too negligent of sexual matters with young people. As men (gentlemen) of the world, we could often help much more than we do.

Never object to a consultation, but see that a better man than yourself is called in—if possible! If you are a consultant, don't be too sure the family doctor must be an imbecile.

*Semper et mutabile femina!* But trust no one overmuch.

There are some cases one never "gets on" with, the first uncomfortable impression of the doctor is never quite erased. This applies especially as regards women, who judge by the heart, not by the head, very often. Therefore study manners, deportment, and appearance. The gentleman has perfect ease. "Be thou familiar, but by no means vulgar."

Be slow in thinking, because you are not successful, that the patient doesn't believe in you. It is perhaps a greater mistake to be over-sensitive than obtuse in these matters. Keep confidence in yourself, and you will probably, within reason, deserve it. It is good to remember that some people are absolutely delighted that their case baffles you.

It is scarcely ever wise to say there is "nothing wrong." Say rather, "I can detect nothing just now;" but don't say, except to a lawyer, "there may be."

Whilst we are paid for our services—and we certainly make no pretence usually that we do not expect payment—I think we can hardly expect to flourish in the society in which our education entitles us; and in most cases our pedigrees are not illustrious. The lawyer probably holds a somewhat higher position; he is not a man of pills and physic, and, I think, dispensing their own drugs is against those who do so. In this connection, however, there is no doubt that many patients think much more of drugs dispensed in the doctor's surgery. Yet when one reflects on the important secrets entrusted to us, we can certainly claim a right to equality with the highest ranks. I like the quotation that "the debt of the body can be paid in money, the mind not." Yet I think we have no right to expect gratitude.

It is remarkable how much nearer worth the expenditure is her new gown in a woman's mind than our best reasoned medical advice.

We must keep our own dignity and self-esteem (if we truly think it deserved). We are usually taken at our own valuation.

There is no doubt that the constant necessity to be kind, courteous, charitable, self-controlled, and clean really makes us obtain these qualities.

Only a good man can be a good doctor (Nothnagel).

An old physician used to make the following prayer daily:—"O God, open Thou Thine eyes, and behold the poverty of our art."

Be not too sure what is cause and what effect. A recent writer has suggested port wine drinking is due to gout, and Dr. West pertinently suggests plumbism is quite likely to result from interstitial nephritis.

In the early days of practice, kindness to and zeal on behalf of the poor help us to the seats of the mighty. *Per ardua ad astra.* But I would strongly advise anyone who is not a lover of poverty, one whose education makes him shudder when his nerves are jarred by the intellectual disparity, to be very careful. He will eventually kick down the ladder behind him; such conduct is not rare, and is an opprobrium to us. It suffices to do one's medical duties.

Matthew Baillie used to say, "I never, in any single instance, applied directly or indirectly to be physician to a family or individual; and I never tried, directly or indirectly, to lessen the confidence of a family or individual in the medical practitioner they were accustomed to employ."

This is, I fear, in some respects a counsel of perfection, but it is worth attempting.

Do not enter too much into medical details of the case, the patient will get into a horrid stew, and you will be sent for in the middle of the night to account for the papilla circumvallata! An intelligent patient is apt to realise very

sadly how inexact is our knowledge and how fallacious our art.

Be optimistic, the worst does not always happen; and remember, as Ballantyne observes, heredity hands down good things as well as bad.

If Mr. Editor thinks fit I will, on a subsequent occasion, tell the readers of this JOURNAL more on these subjects, but I must let off one more spark. In the recent life of Sir James Paget will be found "He always looked as if he knew he was representing the medical profession." This is indeed a sentence on which a sermon could be preached. I would also call attention to some beautiful lines of Browning's:

"One who never turned his back, but marched breast forwards;  
Never doubted clouds would break;  
Never dreamed, though right was worsted,  
Wrong would triumph.  
Heid we rise to fall, are baffled to fight better,  
Sleep to wake."

### A Point in the Theory of Emphysema.

By SHEFFIELD NEAVE.



R. GEE'S book, *Medical Lectures and Aphorisms*, has brought up to date the question as to whether acute emphysema be due to expiration or inspiration; but in respect of subsequent developments it has always appeared to me that in this controversy some confusion of ideas has arisen between the causes of acute emphysema and the theory of its after effects on the shape of the chest, together with the other permanent changes caused.

It is stated that the expiratory muscles are weaker than the inspiratory, and it is argued that the former are overcome by the latter; but even given these premises, do they really explain the retained inspiratory position of the chest in confirmed emphysema? The two forces are not simultaneously antagonistic, and it is not shown that the expiratory muscles could not bring the chest to the normal position of expiration if the period of their function and nerve stimulation were sufficient. Surely to say that nothing but the inspiratory muscles could bring the chest to its barrel-like inspiratory position, and that the expiratory muscles are not sufficiently powerful to make it return to the normal expiratory position, does not advance knowledge much. The real question is not whether they have sufficient power, but why they do not do so; and I think I can offer an explanation. There is nothing in the abstract to show that these muscles are weaker than those of inspiration, and we can only estimate the respective value of them either absolutely or relatively by the results of their action under the same degree of nervous stimulus,

so that to come to a conclusion we should have to show that the co-ordination of the respiratory centres was dealing this out in fair proportion. Indeed, the researches of the physiologist actually show that the pressure in the trachea is greater on expiration than on inspiration, and it has been argued that the relative strength of the two groups of force can be measured from this.

It must be remembered in confirmed emphysema that during the quiescent state of bronchitis we often are not dealing with blocked bronchioles, etc., and that the lungs are free from any obstruction to the passage of air, the mechanism merely having to accommodate itself to those vesicles which have been stretched and are inelastic. Following Dr. Gee's example where he chooses the emphysema of croup instead of that of bronchitis, I propose to deal with this state of chronic emphysema without bronchitis as being its simplest form.

After emphysema is established, the chest assumes the position of extraordinary inspiration, the ribs as a whole are drawn upwards and fixed by the muscles of inspiration in that position,—respiration in the most marked cases being only carried on by the diaphragm and the abdominal muscles alternately, which act much in the same way as a piston from below.

Thus, instead of—

|                            |              |
|----------------------------|--------------|
| Complemental air . . . . . | 100 cub. in. |
| Tidal air . . . . .        | 20 "         |
| Reserve air . . . . .      | 100 "        |
| Residual air . . . . .     | 100 "        |

we have—

|                        |                      |
|------------------------|----------------------|
| Tidal air . . . . .    | 20 cub. in. or less. |
| Residual air . . . . . | 300 "                |

It is probable that the tidal air represents the requirements of those alveoli that are still normal or partially retain their elasticity. Hence the amount is smaller than in the normal condition.

Under the microscope the lung substance between the alveoli has been much diminished, and it is difficult in many places to distinguish between the pavement epithelium and the surrounding tissues. The encircling capillaries have disappeared, and the alveoli in places have actually broken through into each other. From this we may infer that their elasticity is diminished in parts of the lung or quite lost, so that some of the air vesicles tend to collapse like an inelastic bladder, instead of an elastic india-rubber air balloon. On the other hand, if respiration is to continue some elasticity must remain, and some parts remain normal. We thus have a number of air vesicles that have been so stretched that they cannot actively contract on expiration (and here be it noted how Dr. Gee points out that in normal quiet respiration it is this power of elastic contraction which is nearly solely responsible for expiration). In the same way these damaged vesicles give no elastic opposition to the inrush of air on inspiration, as

normally they should. Thus as they present less resistance on inspiration they must be first filled, and to make use of the functional vesicles with their elastic resistance the non-functional vesicles must be kept distended by keeping the chest more in the inspiratory position, and respiration must be conducted at a higher degree of inflation of the whole chest.

Normally the rhythm of respiration is regulated by the reflex action of the vagus on the respiratory centre—distension of the alveoli calling the expiratory muscles into action, and *vice versa*. Now those portions of the alveoli that are damaged have their nerve-endings destroyed, and can give no such calls on the nervous centre.


Imagine for the sake of argument an emphysematous chest with no obstruction to the air-passages at the moment, and in a position of complete expiration (which it never really assumes). At the commencement of inspiration the damaged vesicles will be first filled, owing to the absence of elastic resistance; they will also require more air than normal, owing to their hyper-distension. This in reality is the position of such a chest at the end of expiration.

Imagine then such a chest in reality at the end of expiration. The functional portions are empty, and call on the centre for the inspiratory muscles to act; while the non-functional portions with their damaged nerve-endings remain filled. The latter, having been unable to expel their contents by elasticity, are deprived of the action of the expiratory muscles by the call of the functional portions (already empty) on the centre to stop their action and commence inspiration.

To sum up, the chest permanently assumes its well-known form, owing to the necessity of keeping the injured vesicles filled with air; and this position is due to the altered innervation and consequent altered action of the respiratory muscles without reference to the comparative strength of the two groups.

### Chronic Ulcers of the Leg.

By E. H. HUNT.

 HAVE chosen the subject of chronic ulcers of the leg for my paper to-night for the reason that they are so very common, and are therefore of extreme importance for study. Probably no other one surgical complaint causes so much inconvenience and worry.

They are chiefly found in London among hospital out-patients, or in infirmaries, and in the country among club patients. This leads us straight to perhaps the chief reason why these chronic ulcers are so unpopular with the medical profession, for there is very seldom a fee to be made out of them, and the medical attendant in exchange perhaps for a lot of time and trouble gets in return only a

minimum of gratitude, fame, and money. But if they are unpopular with the medical profession, they are still more unpopular with the poor people who own them. They have formed such an important element in the lives of some people as to deserve mention on their tombstones, *e. g.*—

"She had two sore legs and a baddish cough;  
But her legs it was as carried her off."

And again,

Here lies the body of Susan Peg,  
Who had no issue but one in her leg;  
And what made the old lady appear so cunning,  
While one leg kept still, the other kept running.

I feel sure that these chronic ulcers deserve much more attention than they usually get, and that if any one will carefully study those he sees in the surgery he will be well repaid.

The causes of these ulcers may, I think, fairly be divided into two classes; (1) the causes which start the ulcers, and (2) the causes which prevent them healing.

(1) Of these, injuries are by far the most important. Almost every ulcer begins as an injury. It may be very slight, as *e. g.* an abrasion in a patch of "varicose eczema," and yet be the commencement of an ulcer which persists throughout life; or it may be severe, as in the case of a girl who stepped into some boiling marmalade, and who for years afterwards had an ulcer which reached from the top of her boot to the top of the calf, and was one of the largest I have ever seen. Here this initial severe injury was really the only factor in the case, for the girl was otherwise healthy. In some cases the injury may be repeated, and not only cause but keep up an ulcer. Some eighteen months ago I saw scores of such ulcers, some of them of huge size. One measured roughly thirteen inches by four feet, and was caused by the constant rubbing of a saddle on the back of a mule. Apart from injury I know of but one other cause of an ulcer on the leg, and that is the sloughing of the skin over a breaking-down gumma.

(2) The causes which prevent healing are more varied.

i. The injury may have been very severe, and have caused a huge ulcer; or it may be repeated, not only as in the gross example of the poor mule, but also in our ordinary out-patient, in the form of constant movements and rubbings, or even little knocks and bruises.

ii. Tertiary syphilis.

iii. Sepsis.—This is invariable in out-patients before treatment, and alone will prevent some ulcers from healing for years.

iv. Bad circulation.—This is far more important even than sepsis, for septic ulcers heal well in other parts of the body. The causes of bad circulation are many, and must be carefully distinguished.

(a) Varicose veins, leading to venous stagnation, and

constituting the chief factor in a large majority of all cases. These varicose veins are found mostly in women, and are the result of a long series of pregnancies, the veins and the ulcers getting worse with each succeeding child. It thus comes about that the larger the ulcer the more work the poor woman has to do, and the more difficult is it for her to lie up. These ulcers present a characteristic appearance, the most important feature of which is the rich purple colour of the edge; that is, it is purple when seen in the surgery after the patient has been standing or sitting for some hours; but raise the foot up for a few minutes, and the purple colour is replaced by a healthy pink. This change of colour is most striking, and of the greatest diagnostic value. The ulcers so frequently seen at the lower end of the cervix uteri in "prolapsed" are also largely due to venous congestion, and are in many ways comparable to the "varicose ulcers" of the leg.

(b) Another cause of venous congestion is the habit of wearing garters or straps, above or below the knee, and it is with the greatest difficulty that patients can be persuaded to give them up.

(c) Then, again, there was lately in Casualty Ward a very large congestive ulcer of the leg due to an old "white leg," the only possible treatment being amputation.

(d) One meets occasionally with most interesting ulcers, due to defective arterial circulation.

There was a patient in Casualty in January, 1899, under Mr. Willett, who had symmetrical ulcers on the front of both shins, and symmetrical gangrene of the posterior edges of her pinnae. She had no heart disease and no varicose veins; also the ulcers were by no means typical "congestive ulcers," being, even when she stood, of a good colour. A diagnosis was made of "Raynaud's disease," and with this most people concurred.

Then, again, there was a man coming up to the surgery during many months with chronic ulcer of the left shin.

His left foot and leg were very cold, and obviously he had some serious circulatory trouble. On examination it was found that he had had a popliteal aneurism cured by ligature of the femoral artery some four years back. This ulcer had commenced as a small injury, and had never healed. It had naturally got much worse, when he had worn a Martin's bandage presented to him by a friend. This case illustrates perhaps more forcibly than any other I can quote the necessity for careful diagnosis.

(e) *Anæmia*. One of the commonest features of "chlorosis" is of course "swelling of the feet." The feet are not only œdematous, but also cold. They are even colder as a rule than those of patients with varicose veins. Traumatic ulcers of the ankle in anæmic patients, therefore, take a long time to heal. I saw two such sitting side by side in the female duty room last winter, and both did well on iron, etc.

(f) Heart disease, etc.

This factor (bad circulation) is, as I have said, of the greatest importance, but needs careful diagnosis; and the one single feature which is common to all is "cold feet."

v. We then come to general diseases, such as gout, nephritis, diabetes, etc. It would be well to examine rather more frequently the urine of surgical out-patients.

vi. *Malignancy* is a rare condition to find in a chronic ulcer, but in any doubtful case the diagnosis can be cleared up by the microscope. There are several excellent specimens in the museum, but I have only seen one case in the surgery.

Now it must be carefully borne in mind that the conditions which have been grouped together as "causes which prevent healing" occur in different combinations, e.g. injury combined with sepsis, varicose veins, and bad health; or, again, gummata combined with sepsis and atheroma, and so forth.

There is no use at all in treating any one of these conditions by itself. It may be that an ulcer which was syphilitic to begin with is now kept up entirely by sepsis and venous stagnation. The original gumma may have no more to do with the present ulcer than had the initial kick to do with the deep sloughing ulcer in the old "white leg."

The importance of an accurate and full diagnosis of every ulcer lies of course chiefly in the fact that it affords such excellent indications for treatment, and it is with this object that I have laid such stress upon what I have called "causes which prevent healing."

In every ulcer one has to do four things:

- i. Protect from further injury.
- ii. Rest the part. Even in a perfectly healthy person an ulcer which once forms behind the heel or over the Achilles tendon may take months to skin over. Mr. Harrison Cripps uses for these an anterior moulded splint, which keeps the part at rest, and the results are surprising.
- iii. *Procure asepsis* by fomentations, dry dressings, baths, etc.; of these, Sanitas fomentations are particularly effective.

iv. *Keep aseptic* as by dry dressings, red lotion, Friar's balsam, and by Unna's plaster, Leslie's strapping, tinfoil, etc. With these last three only harm will come if the ulcer be not already "aseptic." With a really aseptic ulcer on any part of the body, epithelium forms at an incredible rate under tinfoil, but only so long as asepsis continues. Another point to bear in mind is that an ulcer which will do well under such a treatment as this is also one in which skin grafts are likely to take, and by skin grafting one may save much time.

Bearing these four indications always in mind, one has in addition to treat the various special conditions which any one ulcer presents.

*E. g.*, i. *Syphilis*.—One interesting point about a gummata ulcer is that, when it heals, the scar is perfectly white. That is to say, the scar is white if the gumma was the sole

factor in the causation of the ulcer; but if sepsis and bad circulation have kept that ulcer from healing for months the scar will be pigmented, the pigmentation being due to the sepsis and bad circulation, and not to the gumma. The same leg may show white scars of healed gummata ulcers above the knee, and pigmented scars below the knee, among varicose veins.

ii. General diseases, gout, diabetes, nephritis, etc.

iii. And lastly, bad circulation according to its cause.

For the great group of ulcers caused by venous stagnation from varicose veins, the important thing is for the patient to lie up. Next to this, but a long way behind it, comes the application of such things as bandages, elastic stockings, elastic bandages, crêpe elastic bandages, and "Unna's plasters." Ordinary bandages, except perhaps a well-applied "dosset," are almost useless. Elastic stockings are bad because they stretch in just the places where they ought not to. Martin's elastic bandages last well, but are uncomfortable in hot weather. Crêpe elastic is, I believe, very nice to wear, but is more expensive in the end than Martin's. With all these things, and especially with "Unna's plasters," the best result is only obtained when they are applied after the leg has been raised up for a long time. The ideal time for putting them on is just before rising in the morning.

For surgery out-patients, who have been sitting and standing for a few hours, the leg must be raised on a stool for as long as possible, at any rate until the purple colour has quite gone. I have often seen Unna's plasters being put on in the surgery with the foot on the floor, the ulcer being blue in colour and septic. Under these conditions an "Unna" may do much harm. An "Unna" properly used is a most valuable thing.

It is in many cases necessary to continue their use long after the ulcer has healed,—as, for instance, when there is much "eczema." Another point to remember is to place a piece of cyanide gauze over the ulcer itself before putting on the gauze bandage if there is much discharge.

Next, bear in mind always the pernicious habit of wearing garters.

Other causes of bad circulation must be appropriately treated.

Finally, let me again urge you to look upon a chronic ulcer with interest, approach it with feelings of suppressed excitement; examine it and diagnose exactly why it came, and why it stays. Do not pass it by and dismiss it with the remark, "Oh, another varicose ulcer;" but rather say thusly: "This is an ulcer of the most extraordinary interest. It began as a small scratch in the middle of a patch of varicose eczema, and it will not heal now, partly because it is dirty, and partly because the lady has varicose veins, and wears garters. The colour of the edge is blue when the foot is down, and red when it is raised. The ulcer is spreading here, for the edge is undermined; but healing there, for

the edge shelves, and epithelium can be seen growing. This piece of slough smells much more than that bit, and so forth." You then, perhaps, treat this ulcer in the surgery for months, but it will not heal, for you cannot make its owner keep it clean, and she will not lie up. Finally, perhaps, you admit the case: it is cleared up thoroughly now, and then you skin-graft it. You are gratified when your grafts "take," and the ulcer heals all over in a day or two. She is discharged and goes out. Two months later you enter the surgery and see your friend waiting. She tells you she has come to have her fomentation changed, for the whole ulcer has broken down again. You then sadly realise that things would have turned out much the same in the end if, when you had first seen that patient, you had passed her by with the remark, "Oh, another varicose ulcer."

### An Unusual Case of Meningitis.

By H. H. WEIR, M.R.C.S., L.R.C.P.



P—, aged 1½ years, was taken ill on September 15th, 1902, and vomited for three days. He then began to "lie about" with upturned eyes, and did not know his mother. Previously he had been well, save for sickness and diarrhoea in June, 1902. On September 21st he had convulsions, and developed a squint in the right eye, and on September 22nd he was brought to the hospital and admitted, still having frequent fits.

On admission his cheeks were flushed, and he was quite unconscious. There was an internal squint of the right eye, and both pupils were widely dilated. The left disc was examined, and its edge was found to be indistinct. No tubercles were found in the choroid. The head was slightly retracted, and the fontanelle bulging. The chest and abdomen appeared natural. The knee-jerks were present, and so was Kernig's sign.

During the day he had about ten fits, between 10 a.m. and 6 p.m., after which, under the influence of potassium bromide, they ceased. They affected chiefly the face, all the muscles of which twitched. The arms were partially flexed and rigid.

There were no more fits and no more vomiting, but the child remained unconscious and required nasal feeding. Ophthalmoscopic examination revealed nothing further.

On September 30th he seemed rather worse, and on October 1st was very twisted, lying with his head over his right shoulder, and his arms across his chest towards the left. His fists were firmly closed, and his wrists flexed. In the evening he suddenly, with a jerk, went into a position of considerable opisthotonos. He continued quite rigid, but the amount of opisthotonos varied a good deal from

time to time. For some days it was not very marked, but later the occiput and buttocks were usually about six inches apart, and on one occasion they were almost in contact. His temperature was irregular, rising at times to 100.4° F.

On October 8th an attempt was made to perform lumbar puncture, but no fluid was obtained. On October 10th, however, another attempt obtained about 5x of clear watery fluid. During the operation the child became much less rigid, and the anterior fontanelle became quite flaccid; but later on the rigidity returned in part, though the opisthotonos was not as marked as before. In the night of October 20th there was a considerable nasal discharge, and on October 21st the child died.

The Pathological Laboratory reported the fluid extracted by lumbar puncture as being sterile.

Post mortem there was found advanced and extensive tuberculous meningitis at the base of the brain. The convolutions were flattened, and the ventricles very distended with fluid. Scattered tubercles were found on the pia in the thoracic region of the cord, and in most of the organs of the body. The primary focus appeared to be a caseous bronchial gland.

The points of interest are the extreme opisthotonos and the prolonged duration, five weeks, in a case of tuberculous meningitis.

I have Dr. Tooth's kind permission to publish this case.

### Smithfield Letters.—III.

Collected by JOHN STREET ROAD.



DEAR BOY,—This letter will, I hope, find you settled to your serious studies and your necessary exercises at St. Bartholomew's after the relaxations and dissipation of the summer vacation; and although you know I regard the latter as the more solid part of your education, yet I would not have you wholly neglect the former.

I am grateful to you for sending to me, with so little delay, the name of one of your doctors, for which I asked you in my last letter; and I am pleased to inform you that so skillful was he in his ministrations that I am now completely cured of that dropsy which at one time seemed to threaten not only my comfort, but even my most harmless pleasures. I am full of regret that I may not publish to the world his name and achievements, but I am warned that your profession views such an exhibition of gratitude as little short of a heinous crime. I cannot fathom the motives, but I bow to the observances. I am pleased that you consider him to be a man marked out by the popular opinion in the hospital as likely at no short date to be promoted to be one of your assistant physicians; but surely,

dear lad, he must be over-young and untried for so responsible a position, for I must confess that I should not consider him to be within even measurable distance of his sixtieth year; to my untutored eye he seemed to be almost in the prime of his life. Still I would be the last to complain, for his knowledge of my complaint, if of no others, is undoubted, and he deserves well of humanity in that he has preserved me to the world.

So I would say to you, copy him—not servilely, but as some of the greatest masters of painting have copied others; mind his turn of conversation, in the several situations of his morning visits, the table, and the evening amusements, particularly these last.

I was but recently in your Hospital square, and though I did not see you there (for you were no doubt better occupied in the wards), I was not wholly pleased by the manners and dress of some of your fellow-students. I inquired for you of one of these,—I standing hat in hand, he, on the edge of the fountain, seated, in a white coat not of the cleanest. Judge of my surprise on being told to ask at the office for patients in the wards. Now, though I admit that my dress may not betoken me an owner of a peerage, yet at least I was as well dressed as he, and to one better versed in the accomplishments of society my conversation and general *bon ton* would have given a hint of my condition; it is a little hard to hear that I, who, as you know, am at such pains with the language I speak and write, should have been taken for a man of common clay.

Such accomplishments as mine are only acquired by use and imitation; for we are, in truth, more than half what we are by imitation. The great point is to choose good models, and to study them with care.

I would therefore have you to show some of my letters to this ill-nurtured comrade of yours if you should know him by this description, that he was wearing a somewhat dirty white coat, which I make no doubt he has not yet changed, from the pocket of which protruded a small black book and some strange tubes, such as your profession are wont to use to listen to the heart and vitals.

Let him read my letters for his own advantage and final improvement, for I feel sure that both he and I shall be safe then when next we meet.

You tell me that many of your acquaintances can find in my letters neither interest nor humour. I think I may say I have never yet been heard to laugh nor given another cause to do so, for I hold that nothing is more illiberal than rude laughter, as Martial has it, "Risu inepto nulla res ineptior;" apart from the unseemly conditions of the face to which it gives rise, consider the horrid noise it occasions. Nay, I would improve on the old saw by saying "that a gentleman should be never heard to laugh *non even scem*." Let this be your answer to those who thus complain of me.

You will but recently have had your Old Students' Dinner (to which I regret, though invited, I was not able

to come); tell me of the speakers, which is most prized? Is it not the man whose voice does not interfere with the conversation of others, and his speech does not call them from their cups by that *risu inepto* to which (aided by my dictionary) I referred above? Was it not for this that Demosthenes practised oratory by the rolling surf? Was it for the forum or the prytaneum (or whatever he called his Parliament) that he learnt to sink his voice beneath the bubbling surge? No, it was for the convivial banquet that others might *ἀπέσθαι τὸν πῦρον* without fear of interruption from his polished periods.

This, dear boy, is the object of my words and letters, that I may elevate you insensibly without interfering with your enjoyments. I wish that you had as much pleasure in following my advice as I have in giving it you. Trust to my experience, you know you may to my affection.—Adieu.

### Notes.

DR. EDKINS has been appointed full Lecturer on Physiology.

DR. HORDER has been appointed Medical Demonstrator of Pathology.

DR. LANGDON BROWN has been appointed Demonstrator of Physiology.

MR. W. D. HARMER has been appointed Assistant Surgeon to the Metropolitan Hospital.

MR. C. J. THOMAS has been appointed Junior Demonstrator of Physiology.

THE Entrance Scholarships have been awarded as follows:

Senior Science Scholarships.—1. H. J. Gauvain. 2. C. W. Hutt, W. I. Cumberledge (equal).

Junior Science Scholarship.—R. L. E. Downer, P. Hamill (equal).

Preliminary Scientific Exhibition.—G. T. Burke, J. Hadwen (equal).

Jeaffreson Exhibition.—A. L. Candler.

THE Amalgamated Clubs dinner will be held at the Café Monico, on Tuesday, November 11th, at 7.45 p.m. Mr. Bruce Clarke will take the chair, and the Committee earnestly hope that every member who can will attend in order to make the dinner a success. Tickets, price 4s., can be obtained from the secretaries of clubs, and from A. R. Neligan and D. N. Ash (Hon. Secs.).

THE Fifth Annual Company Ball of the No. 3 Company of the R.A.M.C. (Volunteers) has been fixed for November 26th. It will take place (as last year) at the Empress Rooms, Royal Palace Hotel, Kensington.

\* \* \*

WE wish to call the attention of our readers to a course of lectures which Dr. Garrod is delivering this session in connection with the pathological department. Dr. Garrod will deal with diabetes, jaundice, and similar problems of chemical pathology, and those who care to be *au fait* with modern views on these subjects should not fail to attend these lectures.

\* \* \*

DOUBTLESS many of our readers have noticed the statistics of the entry of students at the various London hospitals for the current year. It is very gratifying to find that Bart.'s still heads the list in the most important section, to wit, in the number of students entering for the full course. At the same time, a careful study of the figures furnish much food for reflection. The total entry of students at the London hospitals is not so large as it was two or three years ago. Whether this be due to the war,—which is held responsible for so much in these days,—or whether the profession is losing its charm, we cannot say. We can only endure, as best we may, the lean years which appear to be ahead of us.

\* \* \*

IT is with deep regret that we have to record the death of Mr. H. G. Read, Assistant Dental Surgeon to the Hospital.

\* \* \*

WE publish elsewhere a letter from Messrs. Benyon and Co. with reference to the composite picture of Bart.'s recently published by them. We do not know whether the explanation offered in the letter will carry conviction to the subscribers; probably most people prefer to obtain what they contract for, rather than a substitute, however excellent; and certainly every one has a right to expect that the work he pays for shall be executed without glaring inaccuracies.

### Abernethian Society.

SESSION 1902-3.

THE seasonal meeting was held in the medical theatre on Thursday, October 9th, at 8 p.m. Mr. Fairlie Clarke in the chair. Dr. Griffith delivered an address in which he pointed out the difficulties which beset the newly qualified man on starting practice. He urged the necessity for careful business habits both in relation to partners and to patients, and he recommended great caution in the purchase of practices and partnerships. The necessity of knowledge, not only of the work of the medical man, but also of the nurse, on the part of practitioners, was pointed out. *A propos* of this point Dr. Griffith regretted the

tendency among students to leave to nurses dressings and other details of work which should be done by students themselves. Point was given to his remarks throughout by examples which had come under the speaker's own notice, chiefly in connection with the work of the Medical Defence Union.

A vote of thanks to the lecturer was proposed by Mr. Paterson, and seconded by Mr. Atkinson, and carried unanimously. Dr. Griffith replied, and the meeting then adjourned.

THE second ordinary meeting was held on Thursday, October 16th, in the Abernethian room, Mr. Elmslie in the chair. The minutes of the last meeting were read and signed, and six new members admitted. As Mr. Womack was unable to read his paper, the evening was devoted to the demonstration and discussion of cases.

Mr. Stirling Hamilton showed a case of enlargement of the spleen with microscopic preparations of the blood.

The spleen filled the whole of the left side of the abdomen, and its edge could be felt to the right of the middle line. The blood-count showed 23 per cent. myelocytes, and also numerous eosinophile leucocytes. With regard to the prognosis in this case, Mr. Hamilton said that the duration of the disease was about two years, and no treatment was very satisfactory. The question of splenectomy was discussed, but operative treatment was not to be recommended.

Mr. Urwick showed a case of aortic stenosis in a boy *et. 12*. There was no renal disease, nor any arterial change, nor any history of rheumatism. Attention was directed to the great hypertrophy of the heart.

The pulse was full and forcible, and not, as in some cases of pure aortic stenosis, almost imperceptible at the wrist. Several members discussed the case, and the possibility of the condition being due to a pulmonary valve lesion was pointed out, but, quoting Dr. Gee's opinion, Mr. Urwick said the condition was probably a congenital aortic lesion.

Mr. Fairlie Clarke showed the case of a woman *et. 60*, who had a swelling in the left hypochondriac region, the nature of which was very obscure. The tumour was hard and movable, and appeared to be in connection with spleen. The patient was wasted and her general condition not improving. In addition two small hard subcutaneous nodules were pointed out, one beneath the left sternomastoid, and the other over the left iliac crest. The rarity of splenic new growths was pointed out, but no signs of malignant disease of any other viscus had been observed, and though no definite diagnosis had been made, opinion was rather in favour of splenic new growth. On account of the subcutaneous nodules operation was not to be undertaken.

Mr. Faucombe showed the case of a boy with an aneurysmal condition of the radial artery on the left side, complicated by an ulceration of the thumb. There was well-marked pulsation in the veins of the arm, and a bruit could be heard in them. The hand was cold, and circulation in it appeared defective. In the general opinion the condition was one of aneurysmal varix. Operation was discussed. Several members advocated the attempt to remedy the condition by ligation of the artery above and below or by excision.

Mr. Hubert showed a case of spastic paraplegia with a typical gait and the other classical signs. Considerable discussion took place with regard to a recent paper on the subject by Erb.

Mr. Urwick showed two cystic kidneys and a cystic liver from a woman who died with uræmic symptoms a few hours after admission.

The meeting was then adjourned.

THE third ordinary meeting was held on October 23rd, at 8 p.m., Mr. Elmslie in the chair.

Mr. Hunt read a paper on "The Ulcerations of the Leg," a full and interesting report of which appears in the JOURNAL. A lengthy and interesting discussion followed, in which Messrs. Tweedie, Elmslie, West, Jennings, and Weir joined.

The meeting then adjourned.

THE fourth ordinary meeting of the Society was held on October 30th, Mr. Elmslie in the chair. The evening was devoted to cases.

Mr. Fairlie Clarke showed for Mr. Whitaker an arthropathy of left shoulder in connection with syringomyelia. The patient, a woman, had all the signs of syringomyelia, heat and cold sense inverted, increased reflexes, spasticity, etc. The joint had undergone extensive alteration, the head of the bone being dislocated. The nervous lesion was only discovered after admission, the swelling of the joint and inability to use the arm at work being the symptoms complained of.

Mr. Hunt showed a baby three days old, delivered at the eighth month by Dr. Champneys by Caesarean section. The child, owing to the absence of liquor amnii, had been wounded by the knife in

cutting through the placenta, which was situated on the anterior uterine wall. The child was being incubated at temp. 80° to 90°. It was pointed out that premature children are cold-blooded animals, and assume the temperature of their surroundings.

Mr. Macleay showed a case of congenital dislocation of the hip-joint, in this case unilateral and in a girl. The operation for the condition had been proved unsuccessful, and was not carried out in this country. The case was treated by extension.

Dr. Hugh Walsham introduced a series of cases from the electrical department illustrating the effects of light and X-ray treatment of lupus. Before showing the cases he gave a few statistics of others which had come under his own observation.

In lupus vulgaris and erythematous an improvement was seen in 60 per cent.

Of rodent ulcer, out of eleven cases three only did badly, of which one was given up as past repair, but began to improve after the last exposure. Another was a huge rodent ulcer excavating the whole orbit, which died suddenly of hemorrhage whilst under treatment. The third was a rodent ulcer, which was afterwards excised.

As to carcinoma, all recurrent cases did badly, but the X rays relieved pain in all but one case: it was also found possible to heal up ulcerating broken down growths, but the treatment in no way prevented dissemination. He quoted a case of sarcoma of the lumbar spine, with excessive pain and a tumour the size of an orange, which after two months' treatment was quite painless and the size of a walnut only, and the patient able to walk. Keloid was considerably improved, and Paget's eczema of the nipple cured. With regard to the cure of favus, etc., and the removal of superfluous hairs, the speaker was not sanguine.

Dr. Walsham's ten cases of lupus were then shown, and one of varicose ulcer, all being improved by treatment with the ultra-violet lamp, the working of which he described.

An interesting discussion followed.

#### PROGRAMME OF THE SESSION.

| 1902.     | Author's Name.                        | Subject of Paper.  |
|-----------|---------------------------------------|--|
| July 10.— | Mr. Bruce Clarke, F.R.C.S.            | The Requirements of a Modern Hospital.                     |
| Oct. 9.—  | Dr. Griffith                          | Delivers the Sessional Address.                            |
| " 16.—    | Mr. F. Womack, M.B.                   | Ten Years of Toxicological Cases in London.                |
| " 23.—    |                                       | Discussions, Clinical and Pathological.                    |
| " 30.—    | Mr. E. H. Hunt, M.B., B.Ch.           | On Fractures.  |
| Nov. 6.—  | Mr. C. R. Lockwood, F.R.C.S.          | Medical Practice and some Modern Inventions.               |
| " 13.—    | Mr. G. E. Gask, F.R.C.S.              | Cystitis.  |
| " 20.—    |                                       | Discussions, Clinical and Pathological.                    |
| " 27.—    | Mr. A. J. Fairlie Clarke, M.B., B.C.  | Of Minor Head Injuries.                                    |
| Dec. 4.—  | Dr. W. d'Este Emery                   | The Specific Antibodies.                                   |
| " 11.—    |                                       | Discussions, Clinical and Pathological.                    |
| 1903.     |                                       |  |
| Jan. 15.— | Sir William Church, Bart., K.C.B.     | Medicine, Old and New.                                     |
| " 22.—    | Mr. J. K. Murphy, F.R.C.S.            | The Treatment of Enlargement of the Prostate.              |
| " 29.—    |                                       | Discussions, Clinical and Pathological.                    |
| Feb. 5.—  | Dr. T. J. Horder                      | Hypochondriasis.   |
| " 12.—    | Mr. R. C. Elmslie, M.R.C.S., L.R.C.P. | The Puerperal Fevers.                                      |
| " 19.—    | Mr. L. B. Rawling, F.R.C.S.           | Fractures of the Skull.                                    |
| " 26.—    | Mr. H. Williamson, M.B., B.C.         | Opens a Discussion on Treatment of Eclampsia.              |
| Mar. 5.—  | Mr. E. W. Brewerton, F.R.C.S.         | The Bacteriology of the Conjunctiva in Health and Disease. |
| " 12.—    | Mr. W. D. Harmer, F.R.C.S.            | Syphilitic Diseases of Joints.                             |
| " 19.—    |                                       | Annual General Meeting.                                    |

### Coborn Ward.

By a PATIENT.



London's far-famed Smithfield an edifice there stands,  
The pride of that great city not found in other lands,  
Where folks of all conditions—the high, low, rich, and  
poor—  
Obtain relief from suffering, and oft find speedy cure.

Accident or illness brought on by other cause  
Is treated with that promptness deerving of applause;  
For doctors, dressers, nurses, all do their very best,  
By skill and kindness blended, their patients to ease and rest.

Parker, Wiggins, Jones, and others I could mention,  
Are doctors who throughout your stay give you their best attention,  
Performing operations of various description,  
At other times they have success by medical prescription.

'Tis the Hospital St. Bartholomew that bears so great a name,  
And rightly has it been enrolled upon the scroll of fame.  
God speed that Institution, may it prosper and progress,  
Proceeding, in its noble work, some thousands still to bless.

### Obituary.

#### ALFRED COLEMAN.



MR. ALFRED COLEMAN, F.R.C.S. Eng., L.R.C.P., L.D.S., was born in December, 1828, of a Quaker family, at Wandsworth. For some years previous to his connection with St. Bartholomew's Hospital he was employed in his father's business at Lloyds. Eventually, however, he took to medicine, and qualified in 1860; in the same year he took the L.D.S. at the first examination held for that degree, and in 1863 he became a Fellow of the College of Surgeons. At the time when Mr. Coleman entered the Hospital the only resident medical officer was Mr. Wood, the apothecary; and after becoming qualified Mr. Coleman frequently assisted the apothecary as regards the dental work of the Hospital. In 1866 he was appointed Lecturer in Dental Surgery to the Hospital: up to that time no special lecture had been given on dental surgery, and the post lapsed again after Mr. Coleman's resignation. He was also Lecturer in Dental Surgery to the Dental Hospital of London, and later Examiner in that subject to the Royal College of Surgeons. In 1867 he was appointed Dental Surgeon to St. Bartholomew's Hospital; and as the work rapidly increased, assistant surgeons were soon appointed to help him.

Mr. Coleman was one of the earliest members of the Odontological Society, and later became President of the Society. Dental surgery owed much to his researches, and many of his papers appeared in the *Transactions of the Odontological Society*, the most important being those on "The Nature of Dental Caries," "Cystic Tumours,"

"Anæsthesia considered especially in Reference to Dental Surgery." Mr. Coleman was also the author of a manual on dental surgery and pathology.

In conjunction with Mr. Clover he investigated various methods of prolonging anæsthesia in dental operations; eventually he revived the present method of prolonging nitrous oxide anæsthesia by the use of a nose-piece.

In 1884 he resigned the office of Dental Surgeon, and owing to impaired health he withdrew from practice, and spent some years in New Zealand. During his stay there he took a great interest in municipal affairs, and became a member of the City Council, and Surgeon to the Defence Forces.

In 1886 he was elected a Governor of St. Bartholomew's Hospital, and on his return to England in 1890 he took up his duties as a Governor, and subsequently as one of the Almoners to the Hospital.

He died on August 26th, from apoplexy, in his seventy-fourth year.

#### FREDERICK WILLIAM GALE, M.R.C.S., L.R.C.P.

FREDERICK WILLIAM GALE, whose sudden death we have to record in this number, was educated at Sherborne, and joined St. Bart.'s in the eighties. After a year or so he went out to New Zealand, where he married. Returning to the Hospital in 1890 he resumed his medical studies, qualifying in 1895.

In 1893 a plot for resuscitating the defunct Smoking Concert Club was laid and duly hatched out, with Freddie Gale as one of its most active partisans; and it was in connection with this society that he became so well known and deservedly popular.

His songs, parodies, and original productions were inimitable, and worthy of the late Mr. Corney Grain.

Amongst his best contributions were "The St. Bartholomew's Ball," "Bolton and Dring," "A Summer's Day in the Surgery," and "The Birdseye Pill."

His talents both in song and as a pianist were such that had he chosen "entertaining" as a profession his success would have been assured, and on his departure to commence practice in New Zealand he was the recipient of a handsome gift, from those who appreciated him, at a farewell concert in St. James's Hall.

He was an ardent Freemason, and devoted a great deal of his leisure moments to the craft.

His death coming so suddenly, at the early age of thirty-four, a few weeks after his arrival in England, where he intended residing (having resigned medical work in favour of journalistic), is a terrible shock to the friends who knew and loved "jolly little Freddie Gale" so well.

He will be sadly missed, for if I mistake not it would have been his endeavour to set the Smoking Concert Club once more on its legs, to cheer up both student and staff, to blow away the cobwebs, after fathoming the mysteries of

dissecting room and lecture hall, with a "*Chœur pour rire*" in his incomparable style.

As a contemporary of his I should like to see a memorial in the St. Bart.'s Chapel to the memory of as good a friend and comrade man could wish, and will willingly give my mite towards it, so in the words of Tennyson I will leave my old friend.

"His memory long will live alone  
In all our hearts, as mournful light  
That broods above the fallen sun,  
And dwells in heaven half the night." S.

#### HERBERT SEPTIMUS WARD.

We deeply regret to record the death of Herbert Septimus Ward, who will be remembered by nearly every Bart.'s man of the last four years. His illness apparently commenced last August, when he had an attack of pain which he attributed to appendicitis. Three more similar attacks occurred between then and October, and he decided to come into Hospital, and if the diagnosis were corroborated to have his appendix removed.

Accordingly he was admitted to Pitcairn Ward on October 7th. His symptoms then did not appear to be connected with this disease, and indeed were so obscure that many different suggestions were made, and an attitude of expectancy adopted. It seemed probable, however, that his pain emanated from the right iliac bone, and provisionally peritonitis was held to be the most probable cause, but not of such a nature as to indicate operative interference.

No help was gained from skiagram, Widal test, or general examination of the blood, and since his case seemed to be more suitable for treatment in a medical ward he was transferred to Rahere on October 23rd.

Of whatever nature his illness might be he was evidently not improving, nor did the treatment of his symptoms appear to check it.

His condition became septicæmic, and antistreptococcal serum was injected, but with no result. He became worse and worse, and died unconscious on October 27th.

On further examination he was found to have had general septicæmia, which probably originated in a small patch of osteomyelitis in the right iliac bone.

Death from such a rare cause only makes his loss seem harder, and enhances the regret which his numerous friends must feel.

He entered at Bart.'s as student, having already completed his preliminary work, in September, 1898; qualified in 1900, and took his London M.B. in 1901. He was junior assistant administrator of anæsthetics from December, 1900, to February, 1902. During this period, both as student and when on the junior staff, he had a large circle of friends, and amongst other things took a very active part in the Amateur Dramatic Club, of which he was stage manager last year.

"A universal favourite and a pleasant companion, with promises of a future career opening out before him, Ward died at the early age of twenty-five, regretted by all.

"Quem di diligunt adolescens morietur."

### Amalgamated Clubs.

At a general meeting of the Amalgamated Clubs, held in the Anatomical Theatre on Thursday, October 9th, Dr. Calvert in the chair, A. R. Neligan was elected to succeed C. F. Nicholas in the duties of senior secretary, while B. N. Ash was elected junior secretary.

### THE RUGBY FOOTBALL PROSPECTS.

The opening prospects of the season are not as bright as could be desired. We have lost two of the most able forwards that our Hospital has produced in A. O'Neill, our late captain, and L. R. Tosswill, both of whom have led the pack for the past five years. Richmond was fortunate enough to obtain the services of the former, while Tosswill has returned to his old club the Marlborough Nomads. We also greatly regret the loss of H. E. Stanger-Leathes and J. Corbin, who have rendered yeoman service in past years. D. M. Stone through indisposition will be unavailable for the first part of the season. Amongst the freshmen there seems some useful material, including C. S. Lee, of Caius, Cambridge, who should prove a useful addition to the three-quarter line; also G. H. Dive (forward) and Loughborough (half). There seems no reason why a very good side should not be formed from the material available, for although there may not be so much individually, yet it all the members will make a point of turning out on every possible occasion, much may be gained by combination which would otherwise be lost. We feel sure that we shall be ably led by H. T. M. Wilson, and would join in wishing him a very successful season.

The officials of the club are—

President.—A. A. Bowly, Esq., F.R.C.S.

Vice-Presidents.—A. J. W. Wells, Esq., M.R.C.S., L.R.C.P.; H. C. Adams, Esq., M.R.C.S., L.R.C.P.; A. O'Neill, Esq.; L. R. Tosswill, Esq.

Captain 1st XV.—H. T. M. Wilson.

Vice-Captain and Hon. Sec.—E. S. Marshall.

Captain 2nd XV.—N. M. Wilson.

Assistant Hon. Sec.—F. H. W. Brewer.

Committee.—B. N. Ash, W. H. Hamilton, K. M. Miller, J. Morris, A. R. Neligan, T. O'Neill, H. B. Owen, D. M. Stone.

### ASSOCIATION FOOTBALL CLUB.

So far it is very hard to forecast anything with regard to the coming season. Of last year's team, O'Brien will be greatly missed amongst the forwards, as also will Waterfield as a hard-working half.

With regard to "freshers," there are one or two who might prove of assistance if they will play regularly.

The one great drawback to the club's success is that it never seems to be able to play its best team, so that, as in its first game this season, defeat was not due to the players, but to the four or five who scratched at the eleventh hour.

If the eleven players who are selected to play would make it their business to play in all matches, and by so doing learn a little combination, without which a "Seeger" team can never reach a very high standard, the Hospital might once more figure higher up in the Cup ties than it has done of late.

### HOCKEY CLUB.

The officers of the club are—

President.—Dr. H. Morley Fletcher.

Captain.—H. R. Hill.

Secretary.—L. L. Phillips.

Committee.—T. Fisher, W. F. I. Fowler, I. Murphy, H. Gray, W. B. Griffin.

The club opens this season with bright prospects, and hopes not only to keep the name of Bart.'s to the fore, but also to win back

the supremacy of the Inter-Hospital competition, which was lost last year to Middlesex. Hockey men will all be pleased to welcome Furber again in his old position at "back" after a year's absence from the field. The club is playing several strong teams this year, including Brondebury, St. Albans, Oxford Casuals, Southgate A, and a scratch team got together by the English International, E. H. Green. The team includes several of its old members, and started well by winning its first match against a fairly strong garrison team at Woolwich. We are sure Bart.'s men one and all will wish Captain Hill and his men the best of luck.

### THE UNITED HOSPITALS HARE AND HOUNDS.

The prospects of the coming cross-country season are very bright; in fact, a much longer list of fixtures has been arranged than any previous year. As nearly all the members of the club belong to other cross-country clubs no attempt has been made to get any fixed headquarters, although the Blackheath Harriers have kindly offered to lend their headquarters for the Inter-Hospital ten-mile challenge cup race.

Bart.'s will be running the same team as last year, including F. S. Lister, J. G. Gibb, P. Gosse, W. H. Orton, H. Barnett, G. W. Lloyd, A. C. Wilson, and P. H. Gibb.

The club is lucky in having in O. S. Norton (Guy's) an exceedingly keen and hard-working Hon. Sec., who has already done a great deal to help on the club. Mr. P. Furnivall, F.R.C.S., is President, while Dr. H. M. Fletcher represents Bart.'s among the Vice-Presidents.

P. Gosse (St. Bart.'s) is captain.

The list of fixtures for the season is—

| Date.    | Race with                   | Distance. | Place.      |
|----------|-----------------------------|-----------|-------------|
| Oct. 25. | Wellington College ...      | 5 miles   | Wellington. |
| Nov. 8.  | South London Harriers ...   | 5 "       | Croydon.    |
| Dec. 6.  | Blackheath Harriers ...     | 7 "       | Blackheath. |
| Jan. 17. | *Ranelagh Harriers ..       | 8 "       | Putney.     |
| Jan. 24. | *Thames H. & H. ...         | 8 1/2 "   | Rochampton. |
| Feb. 7.  | Cambridge Univ. H. & H. ... | 10 "      | Cambridge.  |
| Feb. 14. | Oxford Univ. H. & H. ...    | 10 "      | Oxford.     |
| Feb. 28. | *Dublin Univ. H. & H. ...   | 10 "      | Uncertain.  |
| Mar. —   | *Inter-Hospital Race        | 10 "      | "           |

Last season the U.H.H. & H. beat the Thames H. & H. and Dublin H. & H., but were beaten by the Ranelagh Harriers, but this year they hope to do better.

There will also be several handicaps of five, seven, and ten miles, which are open to any Bart.'s men.

### BOXING CLUB.

At a general meeting held in the smoking room on October 6th the following officers were elected:

Captain.—Mr. W. H. Scott.

Hon. Secs.—Mr. W. S. Edmond, Mr. J. E. H. Roberts.

Additional Committeemen.—Mr. F. S. Marshall, Mr. A. C. Wilson, Mr. E. Morris, Mr. H. Webb-Bowen.

It was proposed by Mr. Scott, seconded by Mr. Morris, that "Dr. Calvert should be asked to become President of the club."

The first practice meeting was held on Friday, October 10th, in the smoking room at 4.30 p.m. There was a very good attendance, and the boxing was very fair for the beginning of the season, Mr. Morris and Mr. C. E. Hoskyn giving a very good display.

Among those who also sparred were Messrs. Scott, Roberts, Gosse, Kemp, Edmond, Webb-Bowen, and Smith.

It is hoped that the services of Prof. J. Brock (Instructor, Belsize B.C.) may be obtained on Tuesdays.

The club meets on Tuesdays and Fridays at 4.30 in the smoking room, and all freshmen and others wishing to learn boxing are invited to attend.

### Correspondence.

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

DEAR SIR,—Our attention has been drawn to a paragraph in the August issue of your JOURNAL having reference to our picture of St. Bartholomew's Hospital. As this paragraph is likely to do us an injustice we should be glad if you will give us space for a few words of explanation.

It is true that the first few hundred circulars issued stated that the picture would be by Mr. Hanhart, and that the copies would be printed on India paper. Owing to unforeseen circumstances we had to place the commission with Mr. Hager, whose work, however, is in every way equal to Mr. Hanhart's. With regard to the India paper we have lately found that it has given a good deal of trouble to frame-makers on account of its tendency to rise from the plate-paper during damp and straining. We therefore substituted a tint which looks even better than the India, and gives no trouble in the framing. In neither case was it a question of saving expense; we paid Mr. Hager precisely the same figure that we should have paid Mr. Hanhart; and the cost of the tint was exactly the same as that of the India paper. We should like to emphasise this, as some of the subscribers assume that because the picture is not exactly as described it is *ipso facto* an inferior article.

Immediately we decided on these changes we made the necessary alterations in the prospectus, and more than two thirds of those issued contain the correct description. With reference to the picture's alleged resemblance to a Christmas almanack, it is true that, like an almanack, it contains a number of portraits and views arranged in a group, but there, we venture to think, the resemblance ceases.

We sincerely regret the inaccuracies in the nomenclature, which were due to an oversight on the part of our London photographer, and were not discovered until after the copies had been printed and dispatched to the subscribers. We now beg to say that if any of the subscribers will take the trouble to return their copies of the Memorial we will in their stead print copies with correct lettering, and will dispatch them carriage paid.

We remain, dear Sir,

Your obedient servants,

W. H. BEYNON AND CO.

CHELTEMHAM;

September 18th, 1902.

### Reviews.

THE PRACTITIONER'S GUIDE. By J. W. CARR, M.D., T. PICKERING PICK, F.R.C.S., ALBAN DORAN, F.R.C.S., and A. DUNCAN, M.D. (London: Longmans and Co.) Price not stated.

It is extremely difficult to write a review of the present volume in such a way as to avoid the reproach of bias and prejudice. Instinct would lead the critic to condemn it without a reading, a proceeding which can only occasionally be justified. The reviewer in the present case, feeling some pang of conscience, asked himself why his instinct prompted him to this unusual course. The answer was that such a book as the present volume, published with the objects avowed in the preface, is neither a text-book of the science of medicine, from which the practitioner might obtain the collective wisdom of the profession on any particular subject, nor yet is it a reasoned and balanced treatise on any special subject, such as might throw some new light on a difficult problem. By its nature it must be terse notes on medicine, surgery, and gynaecology; in other words, a "crum-book." Such books are not without their uses for the medical student about to face the gods who sit behind the tables to measure his storage capacity, but can be of little use to the practitioner who wishes to make himself acquainted with facts and methods of treatment that have possibly escaped his memory, and of still less use in an emergency.

With these considerations in his mind the reviewer turned again to the book, and industriously read through many of the articles, and felt with satisfaction that his instinct had not led him far astray. The volume is an attempt to achieve the impossible,—to put the ocean into a pint pot, in vulgar phrase. Our wise grandfathers called this sort of book a "Vade-mecum," and added often on the title-page, "a book for the pocket." This volume no one would care to place in his pocket, its bulk would betray him. At the same time let me admit frankly that if the thing is to be done at all it could hardly be better done, as Mr. Punch so often wisely observes, "if the practitioner likes this sort of thing, why, this is the sort of thing he will like."

We have thus briefly indicated our opinion of the principle which is responsible for the appearance of the volume; now let us examine the details more closely. The preface explains the reason for the

enormous preponderance assigned to gynaecological subjects. These articles are written in the author's well-known somewhat caustic strain, and embody much sound teaching. The sins of commission are trivial, those of omission slight, but for that very reason probably of great importance in the eyes of the practitioner. He will very likely find much that he does not know, or has forgotten, but those very details which he would most prize are of necessity omitted.

If this is the case in the gynaecological articles to which so large a space is given, much more is it the case with the medical and surgical sections. A disease so common and so difficult to treat as osteo-arthritis one would naturally expect to find discussed at some length. It is summarily dismissed in rather less than a page, and that page is a mere catalogue of symptoms and therapeutic means, such as is provided in many of those diaries which inundate the practitioner at Christmas. Bright's disease occupies several pages. Here we find the statement that "anatomically the contracted granular or small red kidney is practically identical with consecutive renal cirrhosis, the chronic form of surgical kidney." With the only meaning which we can attach to this sentence we find it impossible to agree. The practitioner in search of hints as to treatment is met with the illuminating and helpful remark that "if meat be given at all, it should be white and not red meat, though why the former is preferable it is perhaps not very easy to say; possibly it contains fewer extractives." The section on bacteria is ludicrously inadequate, and contains the remarkable discovery that "quarter-evil" is a human disease. Turning to typhoid fever, we are informed of Widal's serum test that "probably its absence is of greater diagnostic value than its presence." This statement appears to us almost criminal in view of the consequences which might ensue if the practitioner accepted it as true. Another piece of advice which made our blood curdle is that which urges the practitioner in cases of tetanus to trephine, and inject 2½ c.c. of anti-toxin into each cerebral hemisphere.

But enough; let us merely call attention to the fact that we have hunted vainly for any account of the method of staining sputum for tubercle bacilli; that under the heading glaucoma there is no warning against the use of atropine; that in mild cases of diphtheria the practitioner is recommended to abandon local treatment altogether, i.e. leave the manufactory of the poison alone; and lastly, that aneurism is a hideous eyresore to the educated medical man.

We wish that the authors of this book could realise the absurdness of the principles which led them to write it; but, as that pious prayer is scarcely likely to be granted, we hope they will at least amend the faults we have here mentioned, and many others we could mention.

AIDS TO PRACTICAL DISPENSING. By C. T. S. THOMPSON. Third edition. Pp. 92. (Price 2s. 6d. London: Baillière, Tindall, and Cox, 1902.)

This little manual is composed of twelve chapters, containing a brief epitome of useful information, mostly accurate and well digested, on the art of dispensing.

Although as regards size it is less ambitious than several of the standard text-books on the subject, it covers a fair range of branches, and contains practical features which should make it an elementary guide to the embryo G. P.

The inclusion of a saturation table, a very necessary feature in such a work, would be a valuable addition; information also on the solubility of alkaloids in various menstrua under the chapter on Incompatible Mixtures, would tend to explain the conditions under which, for example, aromatic spirit of ammonia and solution of strychnine, two theoretically incompatible but practically very useful drugs, may be prescribed together.

Reading through the book we notice a few misprints. Thus on page 87 "sabinde, now and then," should be "subinde;" on page 14, in the quinine prescription the quantities ʒvi and ʒvi are interchanged; and on page 44 "Bland's pills" are stated to contain carbonate of potassium. The official pill (Pil. Ferri), however, is made with carbonate of sodium. The deletion of non-official names for Pharmacopoeial preparations would do much to remove the (alas!) too apparent decay in the art of prescribing, which occasionally causes some of us much painful reflection, affecting, as it does, the welfare of the public as much as the dignity and usefulness of the medical profession.

We can recommend the book in those cases where, as the author mentions in his preface, opportunity is not available of acquiring the necessary knowledge by practical experience.

MANUAL OF SURGERY. By ROSE and CARLESS. Fifth edition. (Baillière, Tindall, and Cox.)

This new edition of the *Manual of Surgery* has appeared within twelve months of the last. The authors ascribe this to the growing need they have found to add to their work a chapter on bacteriology. They have recognised the fact that a certain knowledge of bacteriology is essential to the modern surgeon, and, very fitly, they devote their first chapter to "Surgical Bacteriology, Sepsis and Infection, Antisepsis and Asepsis." Owing to limited space they can, of course, only give a bare outline of the subject.

Their warm support of antisepsis as opposed to asepsis, in their treatment of operation wounds, renders them liable to criticism from those who differ from them. Still there is no doubt that this chapter adds to the value of the book.

Beyond the addition of this chapter there is no material alteration in the work. The book is without doubt what it claims to be, a short and concise treatise on the subject of surgery. The whole range of surgery is treated in a thoroughly practical manner.

There are many excellent skiagrams, chiefly in connection with the article on fractures. These are a great help to the study and understanding of fractures and dislocations.

The book can be thoroughly recommended to anyone preparing for an examination in surgery.

NOTES ON MEDICINE. By W. D. WOODBURN, L.D.S., etc. (London: Baillière, Tindall, and Co. Price 3s. 6d. net.)

Often the reviewer of medical works finds his task ungrateful, but his weariness is occasionally relieved and his patient toil rewarded by the discovery of a volume like the one before us. The author is too modest—he claims "no originality for these notes." We find, on the contrary, no page without its gem; new and startling statements, bright flashes of wit and humour, illuminate the book from cover to cover. The mind of the medical student wrestling with the difficulties of the physical signs of disease of the lungs must leap with joy when he reads "V. R. with bleeding character, egophony;" or "Pneumonia in Bright's disease is (bilateral) diabetes, D. T., mania, etc." We must confess that in this last sentence the jest eludes us; but a glance at the title-page reassures us, for the Scot notoriously "jokes w' difficulty," and we return to our perusal with the confident belief that the humour is there, though not apparent to our dull Southron intelligence. We cannot here find space even to mention the discoveries which the author has made in the realm of clinical medicine, but must hasten to congratulate the printer and the printer's reader on the successful issue of their whole-hearted endeavours to add to the gaiety of the medical world. Laryngismus stridulus, we are told, is "purely a nemosis;" arteries are "arthromatous;" "loba pneumonia" must recommend itself as an intelligent anticipation of the spelling of the future; and "hypatic" is obviously more picturesque than the accepted form of the word. "Delirium" and "bronchi," "myastagnus" and "asphasia" have less to recommend them; and "albotosis" we think carries the joke a little too far. "Mecmer's disease" is a new discovery, which internal evidence inclines us to attribute to the printer rather than to the author, we hope without injustice.

It is not fair, however, to go on quoting; the anemia of Bright's disease is, the author says, "possibly owing to the spoliation of albumen." The publication of this book is certainly owing to the "spoliation" of education in the case of the author, and of common sense and common care in that of the publishers; the printer alone need feel no compunction, for his assiduous labours have much lightened ours.

A HANDBOOK OF SURFACE ANATOMY AND LANDMARKS. By BERTRAM C. A. WINDLE. Third edition. (H. K. Lewis.) Price 4s. net.

This is a very excellent little book, which is intended to be a help to the junior student while he is studying anatomy. It does not pretend to be a surgical applied anatomy, though various surgical points are mentioned.

The object is to point out to the student the importance of various landmarks, surgical and medical, and the relation of the exterior to important internal organs.

To know the practical significance of what he is learning adds very much to the value and interest of the study of anatomy. The student who reads it in connection with his anatomy cannot fail to be benefited by it.

### The Bahere Lodge, No. 2546.



MEETING of the Bahere Lodge, No. 2546, was held at Frazer's Restaurant, Oxford Street, W., on Tuesday, October 14th, W. Bro. Holden, M.D., W.M., being in the chair. Bros. Haggard, Ogle, Baker, and Atlee were passed to the Second Degree. Subsequently a number of the Brethren dined together.

### Appointments.

FROST, C. S., M.B.(Lond.), appointed Surgeon to the s.s. "Somali."

HIGGINS, A. G., M.R.C.S., L.R.C.P., appointed Surgeon to the s.s. "Rhipheus."

LEWELLYN, J. W., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Bristol General Hospital.

MALIM, J. W., M.B., B.C.(Cantab.), appointed Resident Medical Officer to the Royal Mineral Water Hospital, Bath.

OWEN, C. L. C., M.R.C.S., L.R.C.P., appointed Assistant Resident Surgeon to the Margate Sea Bathing Hospital.

PARKER, H. F., M.B., B.C.(Cantab.), appointed House Surgeon to the Surrey County Hospital, Guildford.

PRINGLE, F. G., M.R.C.S., L.R.C.P., appointed House Physician to the Royal Hospital for Diseases of the Chest, City Road, E.C.

SCRASE, J. J. S., M.R.C.S., L.R.C.P., appointed House Surgeon to the County Hospital, Huntingdon.

THORNLEY, R. L., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Ship's Surgeon to the R.M.S. "Gothic" (White Star Line).

WALKER, R., M.R.C.S., L.R.C.P., appointed Surgeon to the s.s. "Medic" (White Star Line).

### New Addresses.

CLARKE, HUNTLEY, 66, Lemon Street, Truro.

DARBY, W. S., Mowbray, Station Road, Harrow.

EDKINS, J. S., Brambles, Watford Road, Northwood, R.S.O.

LITTLE-JONES, T. C., 13, Rodney Street, Liverpool.

MEADE, C. G., Witheridge, North Devon.

MILLER, G. W., Broad Clyste, near Exeter.

WATSON, C. G., 44, Welbeck Street, W.

WILLETT, EDGAR, 22, Queen Anne Street, W.

### Marriages.

COWIN—BYERS.—On September 22nd, 1902, at Christ Church, Sunderland, by the Rev. C. G. Hopkinson, M.A., Captain Douglas H. F. Cowin, I.M.S., to Ethel, daughter of William Lumsden Byers.

MCDONALD—EDWARDS.—On August 26th, at Port Elizabeth, South Africa, at St. Mary's Collegiate Church, by the Rev. H. Mayo, W. M. McDonald, Esq., M.R.C.S., L.R.C.P., fourth son of John McDonald, Esq., of Gray's Hill, Antigua, West Indies, to Hilda Ellen Maud, elder daughter of the late Dr. Arthur Edwards, of Antigua, West Indies, and granddaughter of the late Hon. Edwin D. Baynes, Lieutenant-Governor of the Leeward Islands.





